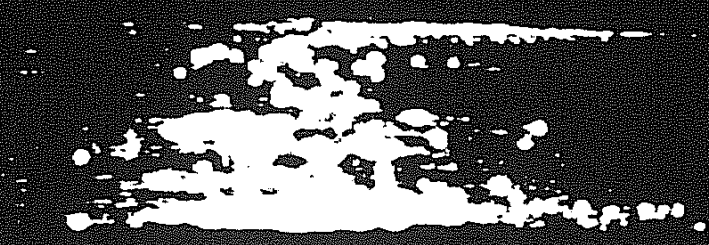
CSAT
Substance Abuse Treatment

ALCOHOL, TOBACCO, AND OTHER DRUG ABUSE

Challenges and Responses for Faith Leaders



SAMHSA

RP0898

ALCOHOL, TOBACCO, AND OTHER DRUG ABUSE

Challenges and Responses for Faith Leaders

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

November 1995

Developed by
ES, Incorporated,
Washington, DC

Pursuant to
Center for Substance Abuse Treatment
Contract No. 270-91-0016.

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ABBREVIATIONS & ACRONYMS

AA	Alcoholics Anonymous
ATODA	alcohol, tobacco, and other drug abuse
BAPCO	Baptist Pastors Council
CSAT	Center for Substance Abuse Treatment
CASSP	Child and Adolescent Service System Program
DTs	delirium tremens
EAP	employee assistance program
IV	intravenous
LSD	lysergic acid diethylamide
MDMA	methylenedioxymethamphetamine
NA	Narcotics Anonymous
PCP	phencyclidine
QAC	Quality Assurance Committee
RE-PRE	Relapse Prevention Therapy
SSD	sudden sniffing death

PREFACE

Those people and organizations involved in the various campaigns against drugs and for treatment of the addicted had hoped that by now, at the brink of the 21st century, the situation would be much different, much improved. But this is not the case. If anything, it seems necessary to escalate efforts.

One important insight that has been tremendously empowering, however, is the realization that the most significant community-based institutions in many drug-tyrannized communities are the institutional faith groups. Whether Christian, Jewish, Muslim, Native American, or any of the myriad other varieties of expression, these faith organizations—have in many communities—been the hub of renewal efforts in a number of ways and can be the loci of ongoing efforts for treatment.

Treatment for addiction requires the refocusing of values. It is a process that demands that persons admit to their powerlessness over certain substances. It requires people to reconnect to the growth potential of communities in which they had been forces against progress and positive change. It demands ongoing association with like-minded persons. In each of these particulars, the faith communities have been perennial models and carriers. They have been what the deeply respected theologian J. Deotis Roberts has called, in effect, the heart and soul of reconstruction.

It is for these reasons that the Center for Substance Abuse Treatment (CSAT) began its Interfaith Initiative. It is for these reasons, too, that CSAT's Interfaith Initiative developed the present curriculum as a training opportunity for theological students who will lead our country's faith communities.

This curriculum is comprehensive. Although it was put together specifically for particular educational institutions, it is structured so that any person with expertise in and knowledge of the field of addiction and treatment will be able to use it.

It is our hope that this curriculum will empower a new generation of workers to continue—and to win—the campaigns against drugs and for treatment in the next century.

David J. Mactas
Director
Center for Substance Abuse Treatment

ACKNOWLEDGMENTS

This curriculum could not have been completed without the help and cooperation of many people. Clifton Mitchell, Center for Substance Abuse Treatment (CSAT), provided guidance and support throughout the curriculum development process. Special thanks are also due to Dr. Cyprian Rowe, the original CSAT Project Officer for this effort, for his vision and support.

The representatives of four seminaries provided critical commentary and deserve a special word of thanks. They are: Dr. John Kinney, Dean of the School of Theology at Virginia Union University, Richmond, Virginia; Dr. Michael I.N. Dash, Associate Professor of Ministry and Director of Field Education at the Interdenominational Theological Center, Atlanta, Georgia; Dr. Delores Carpenter, Assistant Dean of the School of Divinity at Howard University, Washington, D.C.; and Dr. Donald Matthews, Assistant Professor, History of Christianity and Black Church Studies at Colgate Rochester Divinity School, Rochester, New York.

Many individuals and agencies consented to share their thoughts and resource papers to enhance this curriculum. These include: Melvin E. Banks, President, Urban Ministries, Inc., Chicago, Illinois; Rev. William Perkins, Executive Director, Atlanta Religious Mobilization Against Crime, Atlanta, Georgia; Rev. Sean P. O'Sullivan, DSW, Chairman, Florida Drug-Free Communities Project, Miami Shores, Florida; Robert C. Baxter, Public Health Consultant, New Jersey Department of Health, Newark, New Jersey; Rev. Lillian Streeter, Administrator, Freedom Now Drug Abuse Ministry, Bethel A.M.E. Church, Baltimore, Maryland; Joyce Wallace, Midwest Christian Counseling Center, Kansas City, Missouri; Anna Whiting-Sorrell, Director of the Tribal Alcohol Program of the Blue Bay Healing Center in northwestern Montana; Sharon Blackburn, First A.M.E. Church, Los Angeles, California; Marva P. Benjamin, Director, Minority Initiative, Child and Adolescent Service System Program Technical Assistance Center, Georgetown University Child Development Center, Washington, D.C.; Roger Svendsen, Minnesota Prevention Resource Center, Anoka, Minnesota; the Baptist Pastors Council of Detroit, Michigan; and the Congress of National Black Churches, Washington, D.C.

Appreciation is extended to Mary Louise Dogoloff, Dr. Sylvia Dayton-Jones, Rev. Reginald Townsend, and Dr. Cecilia Willis for their diligent work in developing the curriculum; to Nita Congress for providing exceptional and exemplary editorial support; and to Mary Brown for careful and thorough administrative support. Special thanks are due to the Cleveland Target Cities Faith Initiative for its support of the final revision of the curriculum.

This curriculum is dedicated to members of the faith community who seek to help individuals and families suffering from the effects of alcohol and other drug abuse.

INTRODUCTION

One of the most significant issues threatening contemporary America is alcohol, tobacco, and other drug abuse and its relationship to family disruption, violence, physical abuse, economic hardship, homelessness, and individual suffering—suffering ranging from such intensely painful physical conditions as lung cancer and AIDS to the psychic pain engendered by lost opportunities and wasted potential. Consequently, alcohol, tobacco, and other drug abuse poses a key challenge to the U.S. faith community.

This curriculum has been developed as part of the Center for Substance Abuse Treatment's special initiative to enhance seminary graduates' capacity to respond to the problems associated with alcohol, tobacco, and other drug abuse. The focus of this educational program is twofold:

- To educate clergy by transmitting basic information about the nature and extent of alcohol, tobacco, and other drug abuse; the process of becoming chemically dependent; and current approaches to preventing, intervening with, and treating substance abuse.
- To encourage clergy to take an active role in confronting substance abuse by sharing the experiences of other faith communities that have accepted the challenge.

OVERVIEW

In 1992, an estimated 10 million Americans were heavy drinkers. Over 11 million used illicit drugs, and 54 million smoked tobacco cigarettes. For each individual harmfully involved with psychoactive substances, at least one other person was negatively affected as a victim of a drunk or drugged driver; as the neglected child of a crack-dependent mother; as the battered spouse of an alcoholic husband; or as the frantic parent of an uncontrollable, drug-affected adolescent. The list is almost endless and crosses all socioeconomic lines.

Substance use leading to serious behavioral or health problems is commonplace in all communities, and the level of drug use in the United States today is higher than that in any other industrialized society.

The problem is so widespread and deeply embedded that the U.S. law enforcement and criminal justice systems are overwhelmed by it. Even when school and family cooperate with the public sector, efforts still fall short. In its 1988 report, the White House Conference for a Drug Free America identified one of the major missing ingredients in the country's approach to the problem: "The religious community, its leaders and members, must become actively involved in fighting illicit drug use . . ."

Underlying this recommendation is the understanding that for 6 out of 10 Americans, religious faith is the most important influence in their lives. For 8 out of 10, religious beliefs provide both comfort and support. Consisting of over 200,000 congregations with an estimated 150 million adherents (Gallup poll findings cited in Flatter 1990), the faith community is a powerful force, and—as was observed during the White House Conference (1988)—one that could potentially play an instrumental role in reducing the problem of substance abuse.

Currently, throughout the United States, thousands of faith communities are responding to the plea for involvement. The words of one religious leader, Joseph Weinberg, taken from his keynote presentation at the 1988 Interfaith Conference of Metropolitan Washington, sum up why:

> We are outraged by this senseless and brutal destruction of life. We have counselled drug abusers; we have buried the victims; and we have comforted their loved ones. Our commitment to act is drawn from the prophetic vision of a just and merciful world where each life is infinitely precious. The Hebrew Bible and New Testament proclaim that every human being is formed in the image of God. The Qur'an emphasizes that every person is created in excellence, endowed with a nature that is good. The Sikh scripture, the Guru Granth

> Sahib, identifies each one's soul with the supreme soul of God. Such teachings are the foundation for our common conviction that life is sacred. Each person has immeasurable value because life itself is a gift from the creator (Interfaith Conference of Metropolitan Washington 1988).

Yet those members of the faith community who are acting on their commitment acknowledge that the problem is pandemic and the task monumental. Their view—shared by both policymakers and substance abuse prevention and treatment personnel—is that simple, short-term solutions will not suffice; rather, long-term, continuous efforts are needed. The premise of this curriculum is that an informed and educated clergy is the key to securing and sustaining the involvement of the faith community in addressing the myriad of problems associated with substance abuse in the United States.

The Role of the Clergy

Members of the faith community esteem and respect clergy (e.g., ministers, priests, rabbis, elders, shamans) for their spiritual insight, understanding of morals and ethics, and knowledge of religious tenets and practices.

Clergy function as teachers, mentors, confidants in times of crisis and need, and spiritual advisors. Their opinions, both public and private, carry enormous weight. Their behavior and demeanor serve as models for the entire faith community.

Following are specific areas in which the clergy's involvement can have substantial positive implications for preventing substance abuse and reducing its negative impact on the faith community and the larger society.

As Teachers . . .

When the clergy speak out on an issue like substance abuse, the faith community listens. Linked by common beliefs, values, and concerns, faith community members adopt new attitudes and modify or strengthen existing ones at the behest of their clergy.

As Mentors . . .

Through personal example, clergy model responses to substance abuse and substance abusers. When the clergy support programs for those in recovery, welcome recovering abusers to the community, organize positive activities for youth, and encourage programs designed to improve parenting or cope with stress, they show the entire community that these activities are not only important, but a proper concern for faith community members.

As Confidants . . .

In times of trouble, members of the faith community turn to the clergy because they trust them to respond compassionately, intelligently, and confidentially. People who might never consult psychiatrists, psychologists, or social workers about their own or—more likely—a loved one's substance abuse problem will approach their clergy and confide their troubles to them. As a result, the clergy's opportunities for positive intervention are substantial.

As Public Advocates . . .

By virtue of their position within the faith community, clergy are respected by the larger society and can exert substantial influence over its decisions.

In the past, clergy have been instrumental in calling the public's attention to such issues as deprivation of civil rights, inadequate housing, hunger and the plight of refugees. As spokespersons for a particular denomination or representative of an interfaith coalition, clergy function as a community's conscience: While not always accepted, their ideas and recommendations are seldom ignored by the political sector. This role is especially important in calling attention to the need for substance abuse prevention, intervention, and treatment services—particularly for disenfranchised segments of a community whose needs tend to be overlooked.

As Interpreters and Facilitators . . .

In addition to speaking out, clergy also listen. Central to their roles as spiritual, moral, and ethical advisors, clergy hear and see problems first hand.

Drug prevention personnel who work with rural, minority, and immigrant populations cite the urgent need for programs that respect and respond to sociocultural differences and that recognize and confront the very real problems imposed by small populations dispersed over large distances with inadequate transportation networks and public services. Clergy working in these settings are in an ideal position to identify the problems experienced by their faith community members and to help

them and those within the health and social service sectors devise solutions for overcoming language barriers, cultural ignorance, and geographic obstacles.

In addition, clergy can interpret program eligibility requirements and procedures for faith community members and help them negotiate the health and welfare bureaucracy. They also can serve as intermediaries to ensure that well-intentioned services are sensitive, appropriate, and do not demean the target populations for whom they are intended.

As leaders of their respective faith communities, the clergy represent a largely untapped, but potent, resource in America's efforts to reduce the toll that psychoactive substances impose on all its citizens.

Description of Curriculum

While not exhaustive, the curriculum that follows is intended to provide seminarians with a basic core of knowledge about alcohol, tobacco, and other drug abuse so they will feel prepared to work within their faith communities to establish effective substance abuse ministries.

Alcohol, Tobacco, and Other Drug Abuse: Challenges and Responses for Faith Leaders consists of four modules that provide:

I. A historical view of alcohol, tobacco, and other drug abuse;

II. A summary of the effects of commonly abused drugs (including alcohol and tobacco);

III. An explanation of alcohol, tobacco, and other drug dependency; and

IV. Approaches to prevention, intervention, and treatment for substance abuse ministries.

Also included is a listing of resources for additional information about substance abuse and practical assistance in developing and implementing faith community programs.

A sampling of substance abuse programs designed specifically for faith communities is included in the appendices. Each program description illustrates an approach to substance abuse that may be useful to faith communities as they plan their own substance abuse ministries.

· MODULE 1 ·

HISTORICAL VIEW OF ALCOHOL, TOBACCO, AND OTHER DRUG ABUSE

PERSPECTIVE: This module provides a historical view of the use of mind-altering substances in the United States. In this context, the term "mind-altering" refers to illicit drugs (controlled substances such as heroin, cocaine, and the range of synthetic drugs that have demonstrable effects on human perception and behavior); spirit alcohol (beer, wine, and other forms of distilled alcohol); and tobacco. Of primary interest here are those substances that can—to varying degrees—create biophysiological and/or psychological dependence in the user.

OBJECTIVES: By the end of this module, participants will be able to:

- Describe the course of alcohol, tobacco, and other drug use from a historical perspective;
- Explore the social and human conditions associated with the early use of mind-altering chemicals; and
- Describe how the public's perception of alcohol, tobacco, and other drug use shapes public policy.

SYNOPSIS: The use of alcohol, tobacco, and other drugs to alter thoughts, feelings, and perceptions predates recorded history, although the absolute starting point of their use in human society is unknown. Findings from archaeological studies reveal that alcohol use dates back to at least 3500 B.C. in ancient Egypt, and that the Sumerians were using opium around 5000 B.C. (Szasz 1974). The Ebers Papyrus, which dates from the 16th century B.C., describes more than 700 herbal remedies that were known and used by the Egyptians (Williams 1947). And 2,500 years ago in the Mediterranean islands, leaves and flowers of the marijuana plant were often thrown on bonfires and the smoke inhaled.

Discovery of the mind-altering powers of chemicals was probably the result of trial and error as early humans attempted to satisfy basic needs—for example, drinking water contaminated by fermentation of some plant life or eating the blossom of the poppy plant.

Introduction

All manner of substances have been used by Americans throughout the Nation's history. Both colonial residents and Native Americans relied on derivatives of natural substances to cure ailments, relieve pain, and provide pleasure. Thus, the past 30-year period is not the country's first experience with a multi-drug culture. For example, from colonial times until the late 1800's, the use and abuse of alcohol was a common occurrence, and tobacco use was conspicuous. Opium was frequently used as an ingredient in patent medicines, and Vin Mariani—a cocaine-containing wine—was a popular drink (Petersen 1983).

Early Substance Habits

During the early exploration of the New World, Native Americans taught English sailors how to smoke and chew the tobacco leaf, a habit the sailors subsequently imported to England.

By 1575, smoking had increased so greatly that the Catholic Church in Mexico passed a regulation forbidding smoking in church. In 1642 and 1650, papal edicts against the use of tobacco were issued. The European states, Constantinople, Japan, and Russia all had anti-tobacco laws, but the practice continued against all opposition (Brecher 1972).

Spanish conquerors of Mexico found peyote in ritual use by the Incas, who also had the habit of chewing leaves from the *Erythroxylon* coca plant from which cocaine is extracted. The Spaniards encouraged this latter practice as a way to control the natives; while reportedly refraining from using the coca leaves themselves, they traded the leaves with the Incas for their gold and silver. Thus, "after their conquest, the Incas actually increased their coca leaf chewing" (Carroll 1985). On the other hand, the Spaniards tried to curtail the use of peyote and other indigenous herbal hallucinogens by the Aztecs, who had included substance use as part of their religious practices since before Columbus. Native American tribal use of peyote persisted in spite of Spanish opposition, and the practice continues legally today in rituals conducted by the Native American Church.

Cannabis sativa (the plant from which marijuana is obtained) was brought to the Americas by the Spaniards. Throughout the colonial period and until the end of the 18th century, it was cultivated for its fiber (hemp).

The practice of smoking marijuana was probably unknown in the United States until the 20th century. However, according to historian David Musto (1992), descriptions of the "bizarre effects of hashish" (a concentrated form of cannabis) were circulated by writers in the mid-19th century who were familiar with its use in the Middle East.

Opiates: The New 19th Century Habit

One of the first exotic (non-indigenous) substances to become a part of 19th century American culture was opium. Immigrant Chinese laborers building the transcontinental railroad migrated across the United States, bringing their opium-smoking habit with them to the West. In the early to mid-1800's, the habit was practiced openly, and opium and its preparations were easily obtainable, subject to no controls or regulations. By the end of the 19th century, substantial numbers of Americans were using opium nonmedicinally.

Opium and Medical Practices . . .

From the time of the earliest European settlers, opium was considered a valuable medicine. However, in the early 19th century, a vigorous patent medicine industry began growing in the United States. It widely and indiscriminately advertised medicines containing large quantities of opium that claimed to cure everything from "nerves" to marital problems. As physicians began to recognize opium's addictive properties and the problems they caused, they looked for other, less dangerous, remedies.

Morphine: The Universal Cure . . .

Morphine was first separated from opium by European chemists in the early 1800's. By 1832, it was being used by American pharmaceutical companies as a replacement for opium in patent medicines. Physicians believed the new opium derivative to be non-addicting, and hoped that it could actually cure opium addiction in patients.

Prevalent medical opinion held that the addiction process occurred in the individual's stomach, and that ingestion of an opiate was responsible for addiction. The hypodermic needle and syringe were introduced in 1850, and were hailed by physicians who not only hoped to use morphine injections to kill pain, but also believed that the injection process itself would eliminate the addiction problem (Levine 1974). So many soldiers were treated with morphine during the Civil War that the post-war morphine addiction prevalent among veterans came to be known as "Soldier's Disease."

Despite the negative impact morphine had on so many young lives in the late 1800's, it was commonly prescribed as a substitute for alcohol addiction—a practice that continued until the late 1930's. Physicians thought morphine was ". . . less inimical to healthy life than alcohol . . . [It] calms in place of exciting the baser passions, and hence is less productive of acts of violence and crime" (Brecher 1972).

In an effort to reduce the harmful side effects of morphine, the Bayer Company in Germany started commercial production of heroin in 1898 as an alternative pain remedy. Although heroin received widespread acceptance, the medical profession for years remained unaware of its potential for addiction.

Early Cocaine Use . . .

Pure cocaine was first isolated from the coca leaf around 1844. This discovery received little attention until 1883, when Dr. Theodor Aschenbrandt, a

German army physician, issued a supply of pure cocaine to Bavarian soldiers during maneuvers. Dr. Aschenbrandt later reported positive results, including beneficial effects on the soldiers' ability to endure fatigue during battle-like conditions (Brecher 1972, Petersen 1983).

At about the same time in the United States, Dr. William Halsted (1852-1922), prominent surgeon and later one of the founders of the Johns Hopkins School of Medicine, discovered that cocaine injected near a nerve produces a local anesthesia in the area served by that nerve. The discoverer of the first local anesthetic continued to experiment with cocaine, and soon found himself dependent on the drug. His subsequent efforts to rid himself of the habit led Dr. Halsted to switch to morphine injections, which he continued to take for most of his life (Brecher 1972, Petersen 1983).

Another early advocate of cocaine was Sigmund Freud, who reportedly used the drug himself. He also prescribed cocaine to relieve the pain of a chronically ill friend who was at that time addicted to morphine, and wrote glowing reports of the drug's success. Freud even sent cocaine to his fiancée to "make her more lively." In the July 1884 issue of the medical journal *Centralblatt fur die Gesammte Therapie*, Freud published an essay praising cocaine as a "magical drug," and continued to use it periodically to relieve depression in himself (Brecher 1972, Petersen 1983).

In 1885, a German named Erlenmeyer published the first attacks on cocaine as a possibly addicting drug; two years later Freud discontinued using and prescribing the drug, partially due to cocaine's harmful effects on the friend for whom he had originally prescribed it (Brecher 1972, Petersen 1983). However, cocaine's medicinal use continued:

> Between 1890 and 1906 . . . cocaine was a basic ingredient of numerous ointments, powders, lozenges, and wines. These products were advertised as cures for asthma, colds, corns, eczema, neuralgia, opiate and alcohol addiction, and even venereal disease (Carroll 1985).

Coca leaf flavoring was also a key ingredient of Coca-Cola, which first appeared in 1885 and was marketed as a "sovereign remedy."

Early Anti-Substance Legislation

During the last quarter of the 19th century, a number of Western States passed legislation restricting the use of opium. Nevada's 1877 law was the first actually to prohibit opium smoking. The law made it illegal to sell or dispense opium without a physician's prescription, and prohibited the maintenance of any place used for smoking or otherwise "illegally using" opium. Other Western States soon had similar laws, with most legislation directed at outlawing opium smoking rather than curtailing use of other substances.

The First Federal Legislation . . .

The Federal Pure Food and Drug Act was passed in 1906 in response to a growing concern on the part of both the Federal Government and the medical community regarding "the widespread misuse and abuse of proprietary medicines" (Carroll 1985). The act required medicines containing opiates, cocaine, and chloral hydrate to include that information on their labels. After the act was passed, the manufacturers of Coca-Cola switched from using unprocessed coca leaves to decocainized leaves. The Proprietary Association of America "dismayed at the accusation of being 'Dopers' supported the new law vigorously and 'ostracized' manufacturers who continued to put large amounts of cocaine in their products" (Musto 1992).

Subsequent amendments to the 1906 Pure Food and Drug Act required that the quantity of each drug contained be stated on medicine labels and that drugs meet official standards of purity. Public service campaigns urging people not to use patent medicines containing opiates "no doubt helped curb the making of new addicts. Indeed, there is evidence of a modest decline in opiate addiction from the peak in the 1890's until 1914" (Brecher 1972).

The Harrison Act . . .

The Harrison Act (named for its sponsor, Rep. Francis Burton Harrison of New York) was passed in 1914. This federal law required manufacturers, importers, pharmacists, and physicians prescribing narcotics to register with the Internal Revenue Service and to maintain detailed records. The act also mandated that a patient have a prescription from a physician or dentist to legally possess a

narcotic. (Cocaine was classified as a narcotic at this time.)

Fears that unscrupulous doctors were prescribing narcotics to addicts for profit, beliefs in links between narcotics and crime, and gross overestimates of the number of narcotics addicts led to a substantial strengthening of the Harrison Act in 1919. Concurrently, the Supreme Court ruled that it was illegal to maintain an addict on narcotics. In response, a narcotics unit was established within the Internal Revenue Service to carry out the Supreme Court's ruling, effectively outlawing addiction maintenance. Moreover, by the mid-1920's, federal prisons were seriously overwhelmed with addict prisoners as a result of vigorous enforcement of the Harrison Act (Musto 1992).

To both reduce overcrowding and help those suffering from addiction, two federal prison hospitals for the treatment of narcotics addiction were established in Lexington, Kentucky, and Fort Worth, Texas. Operated by the Public Health Service, these two facilities and the Public Health Division created to administer them became the nexus of what is now the National Institute on Drug Abuse (Musto 1992).

By 1930, in response to congressional pressure, the Internal Revenue Service's narcotics unit was made an independent agency—the Federal Bureau of Narcotics. The bureau, which was headed for 32 years by Harry Anslinger, evolved into the Drug Enforcement Administration within the Department of Justice (Musto 1992).

20th Century Responses to Drug Use

The opiates and cocaine were not the only targets of early 20th century efforts to control use. Alcohol and marijuana were also beginning to be seen as threats to national health and safety (Musto 1992, Brecher 1972).

Prohibition . . .

ALCOHOL. The 18th Amendment—which prohibited the manufacture, sale, and consumption of alcohol in the United States—was adopted in 1919 and eventually ratified by every State except Connecticut and Rhode Island.

Experts differ on the effects of Prohibition and the reasons for its repeal by the 20th Amendment in 1933. From the public health perspective, deaths from alcohol-related conditions declined significantly during Prohibition. However, many public policy experts believe that the corruption bred by bootlegging and the toehold gained by organized crime during Prohibition outweighed its positive health benefits. Some drug historians state flatly that the 18th Amendment was repealed because it proved unenforceable (Brecher 1972); others believe the motives were more complex and that the acute need for revenue during the Depression was at least one factor in ending Prohibition (Schwartz 1990, DuPont 1984). While no firm conclusions can be made, the issues that emerged during Prohibition continue to complicate the national response to alcohol, tobacco, and other drugs to the present day.

MARIJUANA. During the years of alcohol prohibition, marijuana use gained in popularity:

> [In New York City] marijuana "tea pads" were established about 1920. They resembled opium dens or speakeasies except that prices were very low; a man could get high for a quarter on marijuana smoked in the pad, or for even less if he bought the marijuana at the door and took it away to smoke. Most of the marijuana, it was said, was harvested from supplies growing wild on Staten Island or in New Jersey and other nearby states; marijuana and hashish imported from North Africa were more potent and cost more. These tea pads were tolerated by the city, much as alcohol speakeasies were tolerated. By the 1930's there were said to be 500 of them in New York City alone (Brecher 1972).

In 1926, two New Orleans newspapers, the *Item* and the *Morning Tribune*, published a series of exposés on the marijuana menace. The papers reported that sailors from Cuba and South America were importing large quantities of cannabis into New Orleans, and that marijuana smoking had become widespread—even among children.

> The Waif's Home, at this time, was reputedly full of children, both white and colored, who had been brought in under the influence of the drug. Marijuana cigarettes could be bought almost as readily as sandwiches (Brecher 1972).

In the Southwestern United States, marijuana use was associated with Mexican immigrants and linked to crime and violence. To quell growing hysteria there and elsewhere about the drug, the Federal Bureau of Narcotics decided to make the use of marijuana a federal offense. Subsequently, Congress passed the Marijuana Tax Act in 1937 (Musto 1992).

Midcentury . . .

During World War II, little attention was focused on domestic drug problems. Although an upsurge was expected at the war's conclusion and led to the enactment of mandatory maximum sentences in 1951 and the application of the death penalty for trafficking in heroin in 1956, perspectives on national policy did not alter much until 1962. That year a Presidential Advisory Commission on Narcotics and Drug Abuse advocated some new psychologically oriented—as opposed to punitive— approaches to the drug problem. It also recommended more lenient changes in the sentencing structure (Musto 1992).

The Sixties and Seventies . . .

By the mid-1960's, the drug picture in the United States changed dramatically. Heroin use was reaching what many clinicians termed "epidemic levels;" marijuana use by college students was on the rise and spreading downward to high school-age youth; and psychedelic drug use (primarily LSD) was growing in popularity. Use of alcohol by underage youth began a steady climb, and increasing numbers of females began to smoke, drink, and use drugs in the same way as males did (DuPont 1984).

As use of marijuana and the psychedelics in particular increased among middle-class youth, attitudes toward drugs changed. Marijuana especially was seen by some as relatively harmless, and organized efforts sprang up to legalize its use.

Despite increasing tolerance for middle-class use, inner-city heroin use was regarded as an extremely serious problem. Criminal justice and health agencies were reorganized to respond to it. The use of methadone to maintain heroin addicts was supported in major cities across the country and substantial funds were committed to both drug enforcement and drug treatment.

Today: Prevention and Education . . .

As the 1970's drew to a close with an estimated 11 percent of high school seniors using marijuana daily, drug abuse prevention and education concepts took on a new importance. National media campaigns were launched to educate the public about the health hazards associated first with marijuana, and then the underage use of alcohol and tobacco. School-based prevention programs and policies defining a school's position on student drug use were formulated. Research efforts were concentrated on identifying risk factors for adolescent use and strategies that could be used to intervene before behaviors became habitual (Strategy Council on Drug Abuse 1979, Drug Abuse Policy Office 1982).

The re-emergence of cocaine signaled another change in public perception. Like marijuana in the sixties, cocaine in the early eighties enjoyed a reputation as a "safe" drug with few harmful effects. Prescient observers warned that the United States had "forgotten the lessons of history," and was being seduced once again (Cohen 1980, Petersen 1983).

As its use escalated and its hazards were publicized, cocaine was increasingly viewed with alarm. When crack, an inexpensive form of smokable cocaine, appeared around 1985, the resulting public concern engendered congressional support for a new attack on drugs. AIDS and its relationship to intravenous drug use also spurred federal action. The 1986 Anti-Drug Abuse Treatment Act and, later, the 1988 Drug Abuse Act authorized substantial funds for treatment; focused renewed efforts on intervening with the so-called "casual" (not yet dependent) user; and, in the 1988 version, required warning labels on alcoholic beverages (Musto 1992, Kleber 1992).

In the 1990's, marijuana use is again on the rise, psychedelic drugs are making a comeback among middle-class youth, crack is entrenched in neighborhoods across the country, and inexpensive smoked and snorted heroin is also—once again—increasingly popular. Drug historians, as well as treatment and enforcement experts, are searching for "a sustainable alcohol and drug policy that will not be swept aside in frustration and resentment" (Musto 1992).

To this end, efforts are focusing on improving treatment by:

- Better matching clients with appropriate treatment responses.
- Emphasizing accountability to ensure that funds are spent on efficient and effective services.
- Recognizing that *habilitation* services (job training; help in locating housing; and developing parenting, stress avoidance, and other life skills) are as important as *rehabilitation* services in intervening with dependent users and preventing others from becoming harmfully involved.
- Training more men and women to staff programs.
- Better defining what works with alcohol and other drug abusers (especially those addicted to crack) through enhanced research and demonstration programs (Kleber 1992, Brown 1993).

· MODULE 2 ·

EFFECTS OF COMMONLY ABUSED DRUGS

PERSPECTIVE: To prevent alcohol, tobacco, and other drug abuse, and to intervene effectively with their users, it is essential to understand what effects people derive from drugs and what impact use has on their health and well-being. In this module, the drugs most commonly used throughout the United States are highlighted. Every drug described may not pose a problem in a particular community since there are distinctive variations in usage patterns from locality to locality and shifts in the relative popularity of various drugs over time. Nevertheless, most people who become harmfully involved with drugs use at least one (and generally more than one) of these substances and will experience many of the consequences discussed unless some kind of intervention is taken.

OBJECTIVES: By the end of this module, participants will be able to:

- Define the following terms: use, abuse, dependence, and withdrawal;
- List three factors that influence the effects users obtain from drugs; and
- Describe the effects that the commonly abused drugs may have on users' health.

SYNOPSIS: The effects of psychoactive drugs are complex and diverse. A particular drug's pharmacological action is not the only factor that determines the kind of effects it will have. The setting in which the drug is used; the amount or dose consumed; the age, sex, and weight of the user; the way in which the drug is used (or the method of administration); and the user's expectations about a drug all influence the effects that a particular user experiences from a drug. The presence of active or underlying mental conditions (e.g., depression, bipolar disorder, schizophrenia, attention deficit disorder) further complicate an individual's response to a psychoactive substance.

Among drug users, multiple drug use is the norm rather than the exception: Abusers seldom restrict their intake to a single substance. This practice also changes the effects users obtain from certain drugs and makes some forms of combination use far more hazardous than use of a single substance alone.

From the user's perspective, the desirable effects obtained from various drugs during the early stages of use range from the following:

- Relief of pain;
- Reduction of uncomfortable or unwanted levels of activity or feelings such as anxiety, nervousness, or sleeplessness;
- Feelings of pleasure, euphoria, disinhibition, and intoxication;
- Feelings of energy and power;
- Reduction in the need for sleep or food; and
- Changes in sensory perceptions (in some cases to facilitate spiritual journeys and insight, but more often to relieve boredom and make social interactions more exciting).

DEFINITIONS

The following terminology, based on definition in the fourth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), is commonly used in the field of substance abuse treatment and prevention to describe the various stages that can occur in alcohol, tobacco, and other drug use. These stages are seen as occurring along a continuum, with one stage merging into the next. Virtually no one begins using drugs with the idea of becoming an abuser; consequently, to describe each stage as separate and self contained would not reflect the gradual loss of control that more typically occurs.

USE: Refers to the sporadic use of alcohol, tobacco, and other drugs. Besides progressing to abuse, substance use also can result in such other serious problems as accidents, exposure to HIV, and the triggering of undesirable neurological and psychiatric effects.

ABUSE: Refers to the maladaptive pattern of substance use leading to clinically significant impairment or distress.

DEPENDENCE: When a cluster of three or more of the systems listed below occurs at any time in the same 12-month period:

- The need for greatly increased amounts of the substance to achieve intoxication (or the desired effect) or a markedly diminished effect with continued use of the same amount of the substance.
- Persistent desire or one or more unsuccessful efforts to cut down or control substance use.
- A great deal of time spent in activities aimed at getting a substance, taking a substance, or recovering from a substance.
- Important social, occupational, or recreational activities given up or reduced because of substance use.
- Withdrawal from family activities and hobbies in order to use a substance in private or to spend more time with substance-using friends.
- Failure to abstain from using the substance despite having evidence of the difficulty it is causing.
- Maladaptive behavioral change, with physiological and cognitive concomitants, that occurs when blood or tissue concentrations of a substance decline after prolonged heavy use of the substance.

TOLERANCE: The body's need for greatly increased amounts of the substance to achieve intoxication (or the desired effect) or a markedly diminished effect with continued use of the same amount of substance.

WITHDRAWAL: The development of a substance-specific maladaptive behavioral change, with physiological and cognitive concomitants, that is due to the cessation of, or reduction in, heavy and prolonged substance use.

ALCOHOL

Alcohol is the most widely abused psychoactive drug in the United States, and has the gravest public health implications. An estimated 25 percent of hospital admissions are alcohol-related (OSAP 1991) and alcohol is implicated in almost half of all fatal highway crashes, homicides, and suicides. These statistics do not account for the substantial negative impact that problem drinking has upon family functioning and productivity at work and school. Gallup polls have indicated that, over time, one family in three is affected by alcohol in some way. Rev. Joseph L. Kellerman, who writes frequently on the subject, believes that alcohol abuse is the largest single pastoral problem, directly affecting approximately 30 people in an average-sized congregation of 500 (Kellerman 1980).

BEVERAGE ALCOHOL . . .

Ethyl alcohol, a natural substance formed by the fermentation that occurs when sugar reacts with yeast, is the major active ingredient in wine, beer, and distilled spirits. Its effects depend on a person's size, weight, sex, age, and the amount of food and alcohol consumed.

Drinking slows reflexes and impairs memory, judgment, and coordination. Alcohol also makes people dizzy and talkative and can cause mild flushing. Larger amounts of alcohol cause slurred speech, disturbed sleep, and nausea and vomiting. Hangovers—where a person feels headachy, dizzy, nauseous, thirsty, and tired—are another common effect.

Many people believe that hard liquor is stronger than wine or beer. However, a 12-ounce can of beer or wine cooler has about the same amount of pure alcohol (almost 0.6 ounces) as a 5-ounce glass of wine or a single shot (1½ ounces) of whiskey. Some fortified wines—which look and taste like wine coolers and are especially popular with underage drinkers—are far more potent, with a 20-percent alcohol content. A single soft-drink-sized bottle contains the equivalent of five shots of vodka.

Who Uses Alcohol . . .

In the United States, current surveys estimate that drinking begins at about age 12. By their senior year, nearly half of all male high school students are problem drinkers. During adulthood, alcohol abuse becomes a problem for an estimated 19 million Americans. Later in life, a substantial proportion of older Americans turn to alcohol as a way of coping with major life changes (e.g., death of a spouse or loved one, retirement or job loss, failing health, or reduced income). According to noted sociologist and researcher Charles Winick (1992), drinking problems are greatest among those who are "young, male, single, residents of 'wet' regions, urban, less educated, and of lower socio-economic status."

Problem Drinking . . .

The National Institute on Alcohol Abuse and Alcoholism identifies a problem drinker as one who:

- Drinks to function or cope with life;
- Frequently drinks to intoxication;
- Goes to work under the influence of alcohol;
- Drives a car under the influence of alcohol;
- Is injured and requires medical attention as a result of his or her drinking; and
- Under the influence of alcohol, does something he or she would never do without alcohol.

Other warning signs of problems with alcohol include: frequent drinking sprees (drinking a lot in a short time or drinking to get drunk), drinking before noon, drinking alone, drinking increasingly larger amounts, and blackouts (losses of memory where the users cannot recall activities or conversations they participated in while under the influence).

Effects of Problem Drinking . . .

Immediate effects of drinking too much include traffic accidents (both vehicular and pedestrian), falls, fires and burns, and drowning and boating accidents.

Since alcohol reduces inhibitions, risk-taking behavior of all types tends to increase while under the influence. Date rape and unplanned and unsafe sexual activity are frequently linked to the use of alcohol as are child abuse, violent acts toward self and others, and unpremeditated crimes.

Long-term heavy drinking can cause a variety of other harmful effects including:

- **ALCOHOL DEPENDENCE.** Prolonged drinking can lead to physical dependence on alcohol. When dependent drinkers stop or reduce drinking, they may begin shaking, vomiting, and sweating. This is called withdrawal. Some alcoholics develop delirium tremens (DTs), during which the heart beats rapidly, blood pressure rises, and the sufferer sees things that are not really there. During the DTs, dependent drinkers become confused and agitated, and they may have seizures. Severe withdrawal can be life-threatening.
- **TOLERANCE.** Tolerance means a person needs increasing amounts of alcohol to produce the desired level of intoxication. Even though the high-tolerance user may not feel the alcohol at all, the drug is still damaging tissues and organs.
- **LIVER DISEASE.** Heavy drinking over long periods of time often leads to inflammation of the liver and can result in hepatitis. Some drinkers develop alcoholic cirrhosis, or scarring of the liver, which can cause liver failure and serious internal bleeding.
- **ULCERS AND RELATED PROBLEMS.** Heavy drinkers can damage the lining of their small intestine. They risk developing ulcers, vitamin deficiencies, and malnutrition.
- **NERVOUS DISORDERS.** Some heavy drinkers suffer Korsakoff's Psychosis (loss of memory) and Weinicke's Syndrome (confusion, difficulty in walking, eye paralysis). Many experience memory problems

and blackouts (where they function but have no memory of their actions during the blackout period).

- **CARDIOVASCULAR PROBLEMS.** Heavy drinking raises blood pressure and can cause heart failure and strokes.
- **BIRTH DEFECTS.** Drinking during pregnancy increases the risk of miscarriage and low birthweight. Some women who drink heavily have babies with Fetal Alcohol Syndrome, a leading cause of mental retardation. Others have children with Fetal Alcohol Effects, whose problems emerge later as learning difficulties and/or behavioral disorders.
- **CANCER.** Heavy drinkers may develop cancer of the mouth, esophagus, pancreas, liver, colon, and rectum. Many heavy drinkers also smoke, which increases their risk of cancer of the upper digestive and respiratory tracts.

Tobacco

Although per capita consumption of cigarettes and the percentage of smokers has dropped, smoking continues to be the single most preventable cause of disease in the United States. Each year, it kills an estimated 400,000 Americans prematurely from heart disease, cancer, emphysema, and stroke, among other conditions.

Secondhand Smoke . . .

Exposure to tobacco smoke (secondhand smoke) is linked to numerous respiratory problems including asthma, bronchitis, and pneumonia. According to the American Lung Association, inhaling secondhand smoke increases heart rate, blood pressure, and the level of carbon monoxide in the blood. For people with allergies or heart or lung disease, exposure to secondhand smoke can be both dangerous and uncomfortable.

Smoking During Pregnancy . . .

Smoking during pregnancy increases the risk of miscarriage, fetal death, premature delivery, and low birthweight. Smaller, lighter babies may have more physical problems than babies of normal size. Infants of mothers who smoked during pregnancy also have a 50 percent greater chance of Sudden Infant Death Syndrome (crib death) than infants whose mothers did not smoke.

Nicotine Dependence . . .

In addition, tobacco smoking is a major form of drug dependence. Nicotine, the principal psychoactive ingredient in tobacco, is a mood regulator that diminishes smokers' responses to stress. Adolescent female smokers often begin and continue using tobacco to control their appetites and lose weight. Regardless of their reasons for starting, many tobacco smokers also say that smoking helps them relax and reduces boredom. Once smoking becomes habitual, withdrawal symptoms occur when users stop.

Common symptoms of nicotine withdrawal include:

- Decreased heart rate;
- Headache, irritability, restlessness, and upset stomach;
- Increased eating;
- Disturbance of normal sleep patterns;
- Increased mental confusion and difficulty in concentrating; and
- Strong urges to resume smoking.

For the compulsive smoker, quitting is as hard as giving up heroin is for the addict or alcohol for the alcoholic.

Smokeless Tobacco . . .

A growing number of adolescent males use smokeless tobacco—chewing tobacco or snuff—in the false belief that it is a safer product than cigarettes. In reality, smokeless tobacco contains high levels of cancer-causing agents and is linked to an increased risk of oral cancer and cancer of the mouth and throat. It contains nicotine and is addicting.

Although an estimated 30 million adults have quit smoking since the Office of the Surgeon General released its landmark report on cigarettes in 1964, nearly 1 million adolescents begin every year.

MARIJUANA

Marijuana is the illegal drug most commonly used in the United States. An estimated 3 million Americans smoke it every day in hand-rolled cigarettes, tiny pipes, or water pipes (often called bongs).

Marijuana is a mood-altering drug. It is made from the leaves, small stems, and flowering tops of the hemp plant *Cannabis sativa*. Although cannabis contains over 400 chemicals, one substance—known as THC—is chiefly responsible for the "high" or intoxication that the drug produces.

The amount of THC determines the potency of the particular type of marijuana. Today, confiscated street samples of marijuana are 4 to 10 times more potent than those available in the 1970's. And as potency increases so do the adverse affects.

Although marijuana cigarettes (or joints) are not usually smoked as frequently as tobacco cigarettes, they are deeply inhaled, with the smoke typically retained in the lungs for several seconds. Each time a joint is smoked in this way, the marijuana user inhales nearly four times as much tar (smoke condensate) as from a high-tar tobacco cigarette.

EFFECTS ON COGNITIVE FUNCTIONS AND LEARNING . . .

While intoxicated on marijuana, users find it difficult to think and communicate clearly. The drug impairs short-term memory, ability to concentrate, and the capacity to make good judgments. Studies have shown that marijuana users have difficulty in accurately measuring distance, speed, and time. Since the drug slows reflexes and reduces coordination, users find it hard to react quickly when faced with an unexpected situation while driving a car, flying a plane, or operating machinery or equipment.

PSYCHOLOGICAL REACTIONS . . .

Although most people smoke marijuana to produce a relaxed, dreamy state, less pleasant effects often occur, ranging from mild anxiety to severe panic. When unusually large doses or potent material are smoked, users can become fearful and paranoid.

Phencyclidine (PCP—a powerful dissociative anesthetic discussed later in this module) is sometimes sprayed on marijuana and may cause a psychotic reaction. Using marijuana also can trigger a mental crisis in individuals with underlying mental illness.

PHYSICAL EFFECTS . . .

Regular use of marijuana may produce negative effects on the respiratory tract and the reproductive system. Among heavy users, sore throats, coughs, and bronchitis are common and immediate effects. Since users also inhale deeply and hold the smoke in their lungs for several seconds, experts believe that, in the long term, their lungs may be seriously damaged.

Marijuana users also frequently smoke tobacco cigarettes, drink alcohol, and take other mood-altering drugs. This kind of multiple drug use increases the risk of serious health problems.

Women who use marijuana during pregnancy, for example, often fit the multiple drug use profile. As a result, they increase their risk of having premature or low-birthweight babies. Low birthweight is a leading contributor to infant mortality in the United States.

BEHAVIORAL EFFECTS . . .

Among the most common behavioral effects observed among regular marijuana users are:

- Low tolerance for frustration, and defiant, rebellious behavior;
- Poor impulse control and unpredictable, wide-ranging mood swings including sudden outbursts of anger, crying, or laughter, and depression;
- Confused thinking—some users cannot remember what they did yesterday;
- Inappropriate responses to authority figures (supervisors, teachers, coaches, or parents);
- Taking advantage of others and constant lying;
- Poor performance on the job or in school;
- Lateness and absenteeism at work and school;
- Loss of interest in family, nondrug-using friends, and healthy social activities; and
- Brushes with the law for driving violations, vandalism, fighting, and shoplifting.

With few exceptions, anyone who uses marijuana regularly can become dependent on it. People

coping with learning disabilities, attention deficit and hyperactivity disorders, and other pre-existing psychological problems such as depression appear to be at special risk.

Lysergic Acid Diethylamide (LSD)

LSD is the most powerful of the hallucinogenic drugs. Widely used in the sixties for its capacity to produce a "mellow high" as well as changes in perception (users talked about seeing sounds and hearing colors), LSD is being rediscovered today by primarily white, middle-class urban and suburban adolescents and college students who "trip on" (use) LSD in social settings to break down the barriers between themselves and others and to make the "party scene" more exciting.

Although LSD produces a high, it also may unleash feelings of anxiety and panic. Known as bad trips, these reactions are unpredictable and can occur even among those who have had so-called good trips in the past. Other effects include:

- Distortions of time, space, and body image which can lead to accidents when LSD trippers drive, swim, or approach areas (e.g., windows and ledges) where spatial awareness is needed for safety.
- Difficulty in concentrating and thinking clearly.
- Mood swings, often ranging from a hyper interested mood to a withdrawn, disinterested mood.
- Impaired judgment leading to high-risk sexual behavior. LSD is not an aphrodisiac, but it fosters disinhibition which can lead in turn to indiscriminate sexual activity.
- Unacceptable behavior resulting from the confusion, panic, and paranoia a bad trip produces.
- The possibility of a toxic psychosis for those users already suffering from depression.
- Post-Hallucinogenic Perceptual Disorder, a complex of chronic problems consisting of anxiety, panic, phobia, depression, and a range of sensory distortions that continues to occur long after use has ceased.
- Hangover and depression the day after a trip.

Some people who use LSD also have unexplained flashbacks in which, for no apparent reason, an experience they had during an earlier LSD trip recurs days, weeks, months, or years later. Flashbacks are usually visual in nature and can be unpleasant and, in some cases, frightening.

How LSD Is Used . . .

Usually, LSD is sold as "blotter acid." Users chew or swallow small sheets of paper that have been impregnated with liquid LSD. Blotter paper contains a series of small, stamped drawings that look like children's tattoo transfers. Mickey Mouse dressed as a sorcerer, unicorns, and astrological signs are among the symbols featured. The drug is also available in tablets called microdots and in thin gelatin squares known as windowpanes.

A single dose of LSD costs about $4 or $5 and can last from 3 to 12 hours. Effects depend on the amount taken, users' expectations, and the presence of any underlying mental illness. Users become tolerant to LSD very quickly and cannot feel the effects after a few days of use. For this reason, many teen users, in particular, reserve LSD for the weekends.

Most young people who try LSD or take it regularly are already using alcohol and marijuana and risk all the problems of multiple drug use as well as the specific negative effects produced by LSD.

Phencyclidine (PCP)

PCP is a dissociative anesthetic that was removed from the U.S. market after it was discovered that patients became agitated and disoriented after use. Although PCP is popular in certain urban areas in the United States, experts believe that most people who use it do so unknowingly. PCP is often used as an additive in or a substitute for street drugs marketed as marijuana, LSD, methamphetamine, and mescaline. Ketamine, known as Special K, is an anesthetic that is closely related to PCP and sometimes mistaken for it. Ketamine is popular on some college campuses.

How PCP Is Used . . .

PCP is usually smoked in powder, crystal, or liquid form. Users frequently mix PCP with marijuana,

tobacco, parsley, and other leafy spices and substances and smoke it in homemade cigarettes.

Like LSD, a PCP high can last for several hours; it can take as long as two days to recover from its effects. Regular heavy users sometimes go on "runs" where they use the drug over and over again for several days without sleeping or eating. Afterwards, users go into a deep sleep and awake depressed.

Effects of PCP . . .

At first, PCP users feel relaxed and mildly euphoric, and then depressed. Anxiety and disorientation are common, and feelings of fear and panic may occur. Some users feel powerful and experience hallucinations and out-of-body sensations. Others become "spacey," paranoid, lapse into wide-eyed staring, and have problems speaking and moving properly.

Occasionally, PCP makes users so depressed or aggressive that they become suicidal or hostile toward others. Also, since the drug is an anesthetic and blocks feelings of physical pain, upset or angry users will fight attempts to restrain them beyond normal limits.

Regular heavy use of PCP interferes with the ability to think and remember, and many chronic users say they suffer from amnesia. Like LSD, it also increases blood pressure and heart rate and raises body temperature. At high doses, users can go into coma, convulse, and die from respiratory arrest.

Methylenedioxymeth-amphetamine (MDMA)

Ecstasy, XTC, and Adam are some of the names given to MDMA, a synthetic drug that acts both as a mild hallucinogen and stimulant. Ecstasy is not a new drug, but it is achieving a new popularity as part of the "rave" scene. Raves are underground, all-night dance parties that attract teens and college-age youth. Although alcohol is not usually a part of the rave scene, drugs like LSD and ecstasy often are. Partygoers use ecstasy for the sense of well-being and sensory distortions it produces and to stay awake through an hours-long rave event or club party.

As with most psychoactive drugs, however, the perceived positive benefits of use are outweighed by the negative. In 1985, ecstasy was classified as an illicit drug under Schedule I of the Federal Controlled Substances Act when it was found to have neurotoxic (poisonous) effects on the brains of laboratory animals. In a research setting, ecstasy interferes with the mechanism that regulates such basic functions as sleep, appetite, mood, and sexual activity in humans. It also negatively affects the part of the brain where the memory function resides. Based on experiments to date, researchers believe that the brain damage ecstasy causes may be permanent.

Ecstasy is generally sold in 100- to 150-milligram tablets. It is a relatively expensive drug—$20 per tablet is the usual price—and many people who start out using ecstasy often switch to methamphetamine (speed) which costs as little as $1 to $2 per tablet.

Effects of Ecstasy . . .

In the short term, after the drug's initial stimulant effects wear off, users frequently experience the following:

- Sleeplessness;
- Loss of appetite;
- Jaw clenching and teeth grinding;
- Inability to obtain an erection (in males);
- Inability to become aroused (in females);
- Headaches, nausea, and panic; and
- Profound hangover and depression.

Heatstroke (hyperthermia) is probably the best known of the immediate serious effects associated with the use of ecstasy. It occurs when a user's body temperature rises abnormally high, and his or her pulse increases and blood pressure decreases. These events trigger convulsions or seizures, widespread blood clotting followed by collapse, and—in some cases—terminal coma. Increased use of ecstasy in hot, crowded conditions (which are relatively rare in the United States) is likely to lead to a larger number of heatstroke complications.

Ice

Ice is a potent smokable form of methamphetamine (speed) that produces an intense, long-lasting high. Ice is an extremely addictive stimulant. As its name suggests, it is a clear, crystalline substance that looks like tiny chunks of ice. While it may be snorted or injected, ice usually is smoked in a glass pipe.

Ice is produced primarily in Korea and, for the most part, its use appears to be restricted to Korea, Japan, the Philippines, Hawaii, and the West Coast of the United States.

Effects of Ice . . .

Ice provides an intense euphoria that can last from 2 to 24 hours, depending on the amount of the drug smoked. The "crash" or depression that follows also is lengthy and can last for as long as three days.

Ice can produce the following effects:

- Sleeplessness and loss of appetite;
- Mood swings (elation, depression, paranoia) and unpredictable behavior;
- Tremor;
- Dry mouth, nausea, cramps, and vomiting;
- High blood pressure, irregular heart beat, and cardiovascular shock;
- Convulsions;
- Coma; and
- Death.

Like ecstasy, ice appears to be neurotoxic to the brain.

Cocaine

Cocaine is a powerful, fast-acting central nervous system stimulant, or "upper," that comes from the processed leaves of the coca plant native to South America. Users snort cocaine (inhale it through the nose), inject it into their veins, or smoke it to obtain an intense high or euphoria.

Crack . . .

Crack is the street name for an inexpensive, easy-to-use, smokable form of cocaine that looks like tiny chunks or rocks. Users smoke crack cocaine in small pipes and in tobacco and marijuana cigarettes. If a person already smokes tobacco cigarettes, using crack is simple to do.

Crack is widely available and costs as little as $3 per dose. When users smoke crack, they get high very rapidly. Until recently, the only way to achieve this effect was to use cocaine intravenously. Given this intense direct stimulation of the brain's pleasure center, "runs"—or binges in which users compulsively smoke crack until their supply is exhausted—are common. One of the most dangerous aspects of crack is the fact that its intense and rapid rush can be achieved through smoking—a form of drug use that is mistakenly considered safer than injection. Thus, combined with its low cost, the crack form of cocaine makes this potent drug dangerously available to people who might not ordinarily put a needle in their arm.

Although national surveys indicate that the use of cocaine is declining, the number of regular crack users remains fairly stable. Experts believe this group accounts for a significant portion of the violence, crime, child abuse, and other destructive behaviors associated with drug use. Furthermore, treating cocaine- and/or crack-dependent users is extremely difficult. At this time, no truly effective treatment is available for large proportions of users. Coupled with the havoc it wreaks on the individual user, this makes crack cocaine a major drug problem by any measure.

Effects of Cocaine and Crack . . .

Cocaine in all its forms makes users feel energetic, alert, and self-confident. When the rush or high wears off, however, a depressed let-down, called a crash, can follow. This is more likely to occur when the drug is used repeatedly (binging), as crack is generally used. Users feel tired, irritable, nervous, or out of sorts when they crash and experience an intense craving to use cocaine again.

With continued use, many users become extremely anxious and depressed when they are not snorting, injecting, or smoking cocaine. Some become paranoid and suspicious with repeated use of the drug. They start believing people are "out to get them" and take steps to protect themselves from those imaginary threats. Other users have hallucinations in which they see and feel things that are not there. Some experts believe that cocaine causes changes in the brain that make users hunger for the drug. Whether the brain is permanently affected or not,

the high that cocaine provides and the discomfort that follows when the rush wears off compels many users to return to the drug repeatedly. In some cases, prolonged use of cocaine—including smoking crack—can lead to a toxic psychosis indistinguishable from that of mental illness.

Regardless of how it is used—whether smoked as crack, snorted, or injected—cocaine can produce:

- Increased blood pressure and heart rate and constricted blood vessels—physiological changes that can produce heart attacks;
- Strokes;
- Nausea, headaches, sweating, and in some cases—seizures;
- Chest pain, difficulty in breathing, and respiratory failure;
- Trouble sleeping, loss of appetite, and reduced sex drive; and
- Drug dependence.

When *sniffed*, cocaine may, in addition to its other effects, produce:

- Loss of sense of smell, nose bleeds, and sores around the nose and upper lip;
- Problems in swallowing and hoarseness; and
- Sinus problems.

When *injected*, cocaine also may produce:

- AIDS, hepatitis, and other infections and sores at the injection site; and
- Endocarditis.

When *smoked*, cocaine may produce;

- Severe chest pain, wheezing, black phlegm, and chronic cough;
- Parched lips, tongue, and throat and extreme hoarseness;
- Bleeding in the lungs and coughing up of blood;
- "Crack lung" (pneumonia-like symptoms, but no evidence of pneumonia when x-rays are taken); and
- Singed eyebrows and eyelashes and burns on fingers and other parts of the body.

Pregnant women who use cocaine in any form take special risks. They are more susceptible to the drug's negative effects on the heart. They are also more likely to experience premature separation of the placenta—a rare and dangerous event for both mother and child—spontaneous abortion, and premature delivery than are non-users. Cocaine may cause blood clots in the brain of the fetus. It may also interfere with normal fetal development.

Cocaine babies are often born small in size. Such low-birthweight babies often have more health and developmental problems than normal-sized babies.

Breastfeeding mothers who smoke, snort, or inject cocaine pass the cocaine on to their babies: Cocaine in breastmilk makes nursing babies irritable and fussy.

No matter how cocaine is taken, over time, most regular users or those who binge weekly or even a few times per month suffer some or all of the following:

- Anxiety,
- Depression,
- Loss of pleasure in acts that are normally pleasurable,
- Lack of energy, and
- Paranoia and hallucinations.

Also, as the need for cocaine or crack becomes a main concern, heavy users lose the ability to make good decisions about the demands of daily life. Health and safety, job and family responsibilities, and personal relationships all suffer. Users talk about "falling in love with cocaine and doing anything to get it." The craving to use is so powerful that scientists consider cocaine one of the most reinforcing drugs known.

HEROIN AND THE NARCOTICS

Narcotics are a group of natural, semi-synthetic, and synthetic drugs that relieve pain and produce serious withdrawal symptoms after a period of regular use. Opiate is another term often used to describe narcotic drugs. Among the best known narcotics are morphine, heroin, codeine, hydromorphone (Dilaudid), meperidine (Demerol), fentanyl (Sublimaze and Innovar), and methadone. With a physician's prescription or in an approved program, some narcotics may be safely used for cough suppression, pain relief, surgical anesthesia,

and treatment of heroin addiction (methadone).

While all these drugs find their way to the illegal market, heroin is the drug most widely used by narcotics addicts in the United States.

How Illegal Narcotics Are Used . . .

In the United States, most narcotics addicts inject heroin into their veins. This is known as "mainlining." Addicts mainline narcotics because the drug enters the brain very quickly after intravenous (IV) injection and provides an intense rush.

Intravenous drug use is extremely risky. Addicts often reuse their injection equipment, are careless about cleaning it, and share it with one another. As a result of these behaviors, IV drug users have become the second largest population group to develop AIDS in the United States. Other problems from IV use include hepatitis, tetanus, and sexually transmitted diseases (including syphilis), collapsed veins, serious skin infections, and endocarditis (heart valve infection).

Most heroin addicts do not begin by using narcotics. They generally start with alcohol, marijuana, and in some cases—crack cocaine. Although heroin often produces unpleasant effects—including nausea and vomiting—when first used, people persist with it so as to experience the heroin high or rush that other users describe; to reduce the edginess produced by cocaine, crack, amphetamines, and ice; or to escape the pain and/or hopelessness of their daily lives, among other reasons.

Smoking opium or heroin has long been popular in the Orient where it is called "chasing the dragon." Recently, some IV drug users in the United States have switched to smoking heroin, often in combination with crack cocaine ("chasing and basing"), to avoid the risks associated with injecting. A small number of young adults who have not previously used heroin also have begun smoking (and, very recently, snorting) in the false belief that the drug is not addictive when used in these ways.

Experts believe heroin smoking and snorting will continue to gain popularity. Plentiful supplies of potent, inexpensive heroin are readily available, and concerns about AIDS have prompted many users to look for "safer" methods to administer drugs. Teens and young adults who use ecstasy and speed also are likely to be attracted to a depressant that brings them down from a stimulant high through smoking or inhalation. Drug abuse specialists worry that the practice of smoking and snorting heroin will encourage people who would never think of injecting themselves to try the drug.

Heroin Withdrawal . . .

Withdrawal from heroin is like a severe case of the flu that lasts for a week or longer. Once people become dependent on narcotics, they undergo withdrawal when they stop using. Over time, the high becomes harder to achieve, but users continue taking the drug to hold off withdrawal. Symptoms of withdrawal include:

- Extreme weakness and fatigue;
- Headache, nausea, vomiting, and diarrhea;
- Muscle cramps in arms and legs and joint pain, making it difficult to move;
- Shaking chills (which may be intense and persistent) and gooseflesh that resembles a plucked turkey (hence the term "cold turkey" for withdrawal from heroin); and
- Loss of appetite and sleeplessness.

It should be noted that people using narcotics under a physician's direction for relief of a legitimate medical problem very seldom experience any difficulties with dependence and do not usually experience withdrawal symptoms.

Other Effects of Heroin . . .

Among the many possible effects of using heroin and other narcotics are:

- Problems in concentrating;
- Constricted pupils, droopy eyelids, and impaired night vision;
- Reduced appetite and sex drive;
- Chronic constipation;
- Itchy, clammy skin and skin infections;
- Slow, irregular heart rate and decreased blood pressure;
- Mood swings;
- Menstrual irregularity;
- Higher than normal rates of tuberculosis, pneumonia, tetanus, and viral hepatitis;
- Endocarditis;
- HIV infection;

- Deep sleep, progressing to coma;
- Drug dependence; and
- Death from overdose.

In addition to the affects just cited, heroin has negative effects on pregnancy. It increases the risk of toxemia, stillbirth, premature labor, low birth weight, and death shortly after birth. Heroin babies often have serious medical problems such as Respiratory Distress Syndrome or AIDS. Many suffer from withdrawal symptoms and are difficult to care for and bond with. Later, these children may be temperamentally difficult and have problems paying attention at home and at school.

Heroin and other narcotics also are transmitted to nursing babies through breastmilk.

Methadone . . .

Methadone is a legitimately manufactured synthetic narcotic used in many detoxification programs to help addicts eliminate heroin from their systems. Gradually decreasing doses of methadone are given to help relieve withdrawal symptoms when heroin use is discontinued.

Methadone is also used as a long-acting substitute for heroin for addicts who have been unsuccessful in their previous efforts to remain drug-free. This use is called "methadone maintenance." Methadone is used as a maintenance drug because it:

- Can be taken orally,
- Is long-acting (which allows for the normalization of physiological functions disrupted by heroin),
- Does not produce a high, and
- Blocks the effects of heroin (when the dose is at an appropriate level and is administered regularly).

Inhalants

Inhalants are a group of products found in most households and workshops that produce a high when they are deliberately inhaled or sniffed. Inhalants in various forms have been, and continue to be, abused throughout the world.

Among the most commonly abused inhalants today are gasoline, glue, typewriter correction fluid, lacquer thinner, butane, fabric protector, freon, spray paint, cooking spray, and nitrous oxide. A group of products called nitrite inhalants (e.g., "snappers," "poppers," "locker room") are also abused. Unlike household solvents and aerosols which are used primarily by rural and suburban pre-teens and adolescents, nitrite inhalants are more popular among young urban adults.

How Inhalants Are Used . . .

When sniffed deliberately, inhalants produce an almost instantaneous intoxication similar to alcohol's. Abusers sniff, or huff, inhalants:

- Directly from the container;
- By spraying the product on a sock, rag, or roll of toilet paper and breathing in the fumes; or
- By spilling or spraying the product into a plastic bag or balloon and, while holding it over the mouth and nose, breathing in the vapors.

During the 14 to 45 minutes that the intoxication lasts, abusers feel giddy and lightheaded. Once the high ends, many users develop pounding headaches, upset stomachs, and bad breath. Most feel dizzy and/or sleepy. Some behave as if they were in a stupor and pass out. These effects usually disappear within one or two hours.

Since inhalants are readily available and inexpensive, they are particularly popular among rural and suburban preteens and young adolescents. For years, drug abuse specialists in the Southwest and on Native American reservations have considered inhalant abuse a special problem for their treatment populations, whose remote locations had previously limited access to mood-altering drugs. However, many experts now believe that inhalant abuse is a hidden problem in many communities, one that is frequently missed in existing hospital- and school-based surveys due to underreporting.

Experts agree that most youngsters who start using inhalants do so as a group social activity and then stop fairly quickly. Headaches, nausea, and fears about serious side effects are reasons commonly given for quitting. Some young people, however, continue to use inhalants despite the negative consequences.

Drug counselors say that disadvantaged adolescent boys who have at least one alcoholic parent and who have problems in school and difficulty in fitting in are the most likely to become heavily involved with inhalants. Nitrite inhalants tend to be a drug of choice among a certain proportion of homosexual males. However, drug users of any age and background often will use inhalants when other drugs are unavailable.

Effects of Inhalants . . .

Problems with coordination are responsible for the numerous accidents, particularly serious falls, that inhalant abusers commonly experience. Poor judgment and relaxed inhibitions often result in reckless behavior that includes destruction of property as well as violence toward self and others. When abusers sniff from plastic bags or balloons they also run the risk of suffocating.

Sudden sniffing death (SSD) is another major risk linked to inhalant use. SSD can affect both experienced and inexperienced abusers. For reasons not yet fully understood, some abusers suffer heart failure after inhaling deeply several times. Some treatment experts believe that SSD is more likely to occur if the abuser engages in strenuous physical activity after sniffing, or is surprised or scared while sniffing. For this reason, when parents or others approach suspected abusers, they should do so calmly and cautiously to prevent the possibility of triggering this fatal response.

Possible long-term effects from abusing inhalants include:

- Weight loss;
- Mood swings, depression, and paranoia;
- Poor memory, mental confusion, and serious brain damage; and
- Liver or kidney damage.

Over time, heavy users become tolerant to the effects of inhalants and must use increasing amounts to get high. It is among this group that brain damage is most often seen.

Sedative-Hypnotics

Sedative-hypnotic is an umbrella term for those prescribed medications used primarily to help people control anxiety and to sleep. Often referred to as sleeping pills or tranquilizers, sedative-hypnotics are widely prescribed in the United States.

Two classes of sedative-hypnotic drugs, the barbiturates (such as Nembutal and Seconal) and the benzodiazepines (such as Xanax, Valium, Klonopin, and Halcyon) appear to be subject to the greatest misuse and deliberate abuse.

Since the newer classes of anti-anxiety medications such as buspirine (BuSpar) appear to have minimal abuse potential, they will not be included in this discussion.

Barbiturates . . .

Barbiturates are powerful central nervous system depressants. Although physicians continue to prescribe them in the short term and on a limited basis to relieve tension and treat specific central nervous system disorders, therapeutic use of barbiturates has been largely replaced by the safer benzodiazepines.

The problem with barbiturates is that people become tolerant to their anxiety-reducing and sedating effects very quickly. However, a corresponding tolerance to their lethal effects does *not* develop, and death by overdose can occur. Also, if a person regularly abuses high doses of barbiturates and decides to stop all at once, withdrawal symptoms can be so severe that death occurs. Combining the use of barbiturates with such other central nervous system depressants as alcohol, heroin, and even over-the-counter antihistamines can be hazardous and has proven fatal for some.

In a social setting, barbiturates produce intoxicating effects similar to alcohol. Some heroin addicts mix barbiturates with heroin to produce what they describe as a "pleasurable high." Others use them alone, in pill form or by injection, to elevate their mood and become intoxicated. Crack, speed, and other stimulant abusers use barbiturates to calm down their hyperactive behavior after a binge.

Barbiturates have been implicated in suicide attempts by young and middle-aged women, although such problems have decreased with the availability of newer and safer medications. Elderly patients also have experienced problems

when they failed to follow proper precautions for use. In these cases, noncompliance is due usually to confusion rather than to a deliberate violation of physician orders.

A barbiturate problem of any type is a medical emergency and should be managed only under the supervision of a skilled health professional, preferably in an inpatient hospital setting.

BENZODIAZEPINES . . .

Today, the benzodiazepines are the most popular tranquilizers or anti-anxiety agents and are the most widely prescribed of the sedative-hypnotics. For the most part, the benzodiazepines have replaced barbiturates in medical practice because they are safer and more effective. However, even though death rarely results from benzodiazepine use alone, they can prove fatal if they are used with alcohol or other central nervous system depressants.

Unlike barbiturates, benziodiazapines are rarely used as a primary drug of abuse. Instead, they tend to be used by cocaine and other stimulant abusers to "take the edge off" and by heroin addicts to either control their withdrawal symptoms or to boost the effects of methadone. Most nondrug abusers and people who are not suffering from panic, anxiety, depression, or other disorders do not like the effects of the benzodiazapines.

With regular use, tolerance to the benzodiazepines' mood-altering effects occurs. At high doses, physical dependence also can develop. As with the barbiturates, abrupt withdrawal from regular, high-dose, nontherapeutic use of benzodiazapines is dangerous. Thus, patients using prescribed benzodiazepines should not try to discontinue their medication without physician consent.

While less risky than the barbiturates in terms of side effects, the benzodiazepines (even at prescribed doses) can interfere with a user's concentration (e.g., driving a car, operating a boat, flying a plane). Again, although death from overdose is unlikely, benzodiazepines are implicated frequently in suicide attempts.

· MODULE 3 ·

UNDERSTANDING ALCOHOL, TOBACCO, AND OTHER DRUG DEPENDENCIES

PERSPECTIVE: The effects or consequences of alcohol, tobacco, and other drug abuse summarized in Module 2 underscore the need for a compassionate, committed response to the problem. However, in order to provide constructive help to the abusers and their families within the faith community, clergy must also understand:

- How people become dependent on psychoactive substances,
- Why people are drawn to the use of psychoactive substances, and
- What services seem to be the most effective in helping them confront their problem.

OBJECTIVES: By the end of this module, participants will be able to:

- Describe the process of becoming chemically dependent;
- Highlight the individual, family, peer, social, developmental, and environmental factors that promote susceptibility to substance abuse; and
- Identify program elements that appear to be successful in reaching abusers and their families.

UNDERSTANDING THE CONDITION

One way of understanding substance abuse and presenting it to the faith community is to view it as a progressive disease. With few exceptions, when left unaddressed, substance abuse and dependency do not get better or just go away: Rather, they tend to get worse. Denial is the critical element that perpetuates and feeds use and abuse and promotes dependence. Substance abusers usually do not see themselves as such, and are generally incapable of diagnosing their own condition, calling a halt to their destructive behavior, or presenting themselves voluntarily for treatment.

Not only do chemically dependent individuals practice denial, but so do those around them. Parents, spouses, friends, coworkers, and others in their lives try to ignore the problem or find excuses for it. They tend to overlook the behavior and to avoid the discomfort of confronting it. Those who specialize in the treatment of chemical dependence call such people "enablers"—people who help the destructive behavior continue by not intervening. It also is important to recognize that virtually all use is contagious. A person is most likely to be introduced to alcohol and other drugs by a friend or loved one: This is as true of tobacco smokers as it is of heroin addicts, crack users, marijuana smokers, and alcoholics.

These principles have important implications. Understanding that chemical dependence is a progressive disease underlines the importance of early identification and intervention. The earlier the intervention, the more positive and less costly the outcome for the abuser and those who care about him or her.

The denial aspect of chemical dependence makes it ineffective to wait for abusers to admit their problem and voluntarily seek help. By understanding the enabling role that those around the abuser play, the clergy can use their considerable leverage to

break the cycle of denial and cover up, and to motivate those involved with the abuser to address his or her destructive behavior.

Lastly, the contagious nature of alcohol and other drug use means that if a faith community fails to accept the challenge of responding to an abuser's needs, it inadvertently becomes an environment in which the condition may spread to others.

Understanding chemical dependence leads inevitably to the conclusion that education, prevention, intervention, and supported recovery must be the cornerstones of any programs developed by the faith community to deal with this problem. These elements are more fully discussed later in this module.

Progression in Substance Abuse

For the most part, substance use develops along a predictable course. First, cigarettes and alcohol are used, followed by marijuana. Once marijuana is included in a person's substance use repertory, other substances such as cocaine or crack, heroin, and the hallucinogens may follow. With few exceptions, the risk of using such illicit substances as heroin, crack, and LSD is relatively low prior to the use of marijuana. It is for this reason that tobacco, alcohol, and marijuana are known as "gateway" or "stepping stone" drugs and that such heavy emphasis is placed on preventing their use.

Risk Factors for Substance Use, Abuse, and Dependence

Both animal and human research provide evidence that abused substances derive their dependency-producing properties from their reinforcing effects on the central nervous system. If a dependence-producing substance is taken often enough and in large enough quantities, most people will become dependent on it. However, there are also large individual differences in susceptibility to the development of a substance use disorder.

The basis of these differences is probably both biological and psychosocial. Although a detailed technical discussion is beyond the scope of this module, a brief review of the known risk factors for becoming substance abusers is helpful in understanding some of the reasons why people use psychoactive substances. As with other medical problems, risk factors are individual, family, and/or environmental characteristics associated with a heightened risk of developing the problem. The presence of one or more of these factors does not mean that a person will invariably become a substance abuser. Moreover, the absence of these risk factors provides no assurance that a particular individual is not, or will not, become a substance abuser. Given the extent of substance abuse in contemporary culture, virtually anyone can become involved. However, as the number of risk factors increases, so does the likelihood that abuse will occur.

Individual and Family Factors . . .

Individuals whose parents or other siblings are alcoholics or drug users are at greater risk of developing a substance use disorder than those without such a history. Having an alcoholic family member, for example, doubles the risk of a male child later becoming alcohol- or drug-dependent. Genetic factors play a significant role. There is evidence that children born of an alcoholic parent, even when raised by non-alcoholic foster parents, have much higher rates of alcoholism than those with non-alcoholic origins. Cultural factors such as being a member of an ethnic group in which heavy drinking is socially acceptable—or strongly rejected—also may markedly influence drinking patterns.

Individuals with a family history of criminality or antisocial behavior are more likely to use drugs and alcohol than those without such a history.

Inconsistent parental direction or discipline, unclear and/or inconsistent parental rules and reactions to behavior, unusual permissiveness, lax supervision or—conversely—excessively severe discipline, constant criticism, and an absence of parental praise or approval during childhood are all associated with higher rates of abuse.

Parental drug use or parental attitudes condoning alcohol, tobacco, and other drug use appear to predispose individuals to substance abuse. Since parents serve as models for their children's

behavior in so many ways, it is not surprising that individuals whose parents smoke, drink heavily, or use illegal drugs are more likely to become substance abusers than those whose parents did not.

Also, young males are more likely to become substance abusers than young females. In this sense, masculine gender is another risk factor.

Peer Factors . . .

Individuals whose friends (and/or siblings) smoke, drink, or use other drugs are much more likely to do so than those whose peers do not. Contrary to popular myth, initiation into these activities is usually through friends. The local drug pusher is far more likely to be an acquaintance who wants to share the drug experience, or who "deals" as a way of supporting his or her own drug use, than a mysterious stranger.

Social, Developmental, and Environmental Factors . . .

Individuals who are poor academic achievers and are bored by school are more likely to begin using drugs early and to become regular smokers, drinkers, and drug users than are their more successful classmates.

Individuals who feel alienated from their families and from the dominant social values of their community are more likely to use alcohol and other drugs than those with strong bonds to family and to traditional religious or ethical institutions.

Early antisocial behavior, evidence of a lack of social responsibility, fighting and other types of aggressive behavior, rebelliousness, and impulsiveness are predictive of later alcohol and other drug use.

Individuals living in a community or placed in a situation where inexpensive drugs are readily available are more likely to use drugs. For example, during the war in Vietnam, a large percentage of American soldiers without prior drug use histories used heroin because it was accessible and normative in Southeast Asia. When they returned home, most stopped immediately because using heroin was no longer acceptable or easy to do.

As mentioned above, the earlier an individual begins to smoke, drink, or use other drugs, the greater the likelihood of heavy use of substances later. Youngsters who smoke or drink are more likely to use marijuana than those who avoid tobacco and alcohol. Children who use marijuana are more likely to go on to use other substances.

Why Do People Use?

When asked to explain their alcohol, tobacco, and other drug use, adult abusers offer the following reasons:

- To change their mood;
- To alter their perceptions of self and the world around them;
- To produce novel sensations and experiences; and
- To enhance their ability to function in frightening, unfamiliar, or anxiety-producing situations.

In addition, therapists experienced in the treatment of chronic adult abusers believe a variety of other, interrelated reasons also promote use.

A substantial proportion of heroin and cocaine abusers have serious underlying psychiatric disorders. Some therapists hypothesize that using illegal drugs is a form of self-medication for this group. Others have enlarged on this idea and modified it to include those without psychiatric disorders. They believe that alcohol and other drugs are used as a way of controlling feelings of helplessness, inadequacy, and rage, or of alleviating the suffering abusers feel as a result of past victimizations, fears about intimacy, and low self-esteem (Brehm and Khantzian 1992).

Moving outside the individual to identify causes, other experts believe that multiple social crises—including lack of employment opportunities for low-skilled workers; inadequate housing and homelessness; growing numbers of female heads of household with few financial resources; increasing high school dropout rates; and cutbacks in health, welfare, and other social services—also contribute to the high rates of alcohol and other drug use. People living under such conditions feel "disaffiliated and alienated . . . a situation . . . that socializes them into a cycle of deviant behaviors" that includes substance abuse (Johnson and Muffler 1992).

Many in the faith community share the perspective of the Interfaith Conference of Metropolitan Washington (1988):

> . . . this crisis cannot be explained by social and economic conditions alone. For many there is also a sense of isolation and alienation, a profound lack of self-worth, a serious decline in moral behavior, a disturbing emphasis on one's immediate gratification regardless of the community's welfare. There is a deep and abiding spiritual emptiness in the lives of far too many people. These are the keys to understanding the rampant drug abuse among the middle class and rich as well as among the poor.

Clearly, the reasons for use are complex. Social context (including family, peers, and community norms and structure) has an enormous influence on a particular individual's susceptibility to substance use. However, both research and clinical observation of substance abusers repeatedly show that those individuals "with limited life choices and options are the ones at the greatest risk for substance abuse." (Dusenbury, Khuri, and Millman 1992).

Responses to Abuse

The challenge for those concerned about the harmful use of substances is to devise responses that both assist dependent abusers and help create an environment that tries to prevent use from occurring in the first place and—where use is occurring—limits the damage to users through early problem identification and intervention. Thus, a comprehensive response to substance abuse should include prevention, intervention, and treatment/recovery components.

Prevention . . .

In the United States, prevention is chiefly focused on efforts to prevent the onset of first use of alcohol, tobacco, and other drugs. Consequently, it is aimed primarily (although not exclusively) at children.

To this end, substance abuse education curricula are in place in the Nation's public schools; the Partnership for A Drug-Free America places informational public service announcements on television and radio and in the print media; the federal Center for Substance Abuse Prevention supports an array of innovative programs operated by local community-based organizations; and the National Clearinghouse for Alcohol and Drug Information provides free information to the public about alcohol, tobacco, and other drugs.

These and numerous other initiatives sponsored by a variety of groups, nonprofit associations, and others are designed to send numerous messages to both the general public and highly specified target segments of the population. The idea behind the multiple messenger, or "psychological inoculation," concept is to reinforce the norm of "no use" through repetition, and to ensure that groups that may not be responsive to information from one source hear it from another that they deem more credible.

In addition to providing basic information and reinforcement of societal norms, many school-based programs also provide personal and social skills training to help students learn how to solve problems, make good decisions, increase self-esteem based on increased competence, resist peer pressure, and cope with stress, among other issues.

Parents are an important target in many prevention programs. These programs try to inform parents about substance abuse; increasingly, many of the more ambitious efforts also attempt to enhance parenting skills and foster changes in those behaviors that are risk factors for children's future alcohol and other drug use (e.g., inconsistent discipline, problematic use of alcohol, lax supervision). Several community groups targeted at high-risk youth and their parents have similar goals.

Although considered *prevention* programs, many school-based and community programs featuring parenting and social skills development also fit within the *intervention* category and it is often difficult for program staff and participants to determine where prevention services end and intervention services begin.

Intervention . . .

Intervention efforts are designed to reach substance users before they become dependent. For that reason, intervention services are frequently part of referral networks for troubled behaviors, are built into prevention and/or treatment programs as a separate component, or—in

comprehensive substance abuse programs—are one of many services provided.

Employee assistance programs (EAPs) are one example of the intervention concept. An employee's poor work performance may lead a supervisor to refer him or her to an EAP for help in resolving the problems contributing to the poor performance. The referral is made with the understanding that unless the performance changes, the job is in jeopardy. If the EAP's assessment indicates that alcohol or other drug use is a likely cause of the problem, confidential counseling may be recommended. With the support of the EAP and the knowledge that job loss is a real possibility, nondependent users frequently are able to stop before the problem becomes so severe that full-blown treatment is required.

Other examples of intervention programs include special after-school and alternative school programs aimed at high-risk youth. The goal of these programs is to interrupt early substance-using behavior by engaging users in an array of activities that provide appropriate outlets for fun and recreation and increase self-esteem and feelings of competence. Specifically, these programs offer—among others—skills training, community service, and related activities; academic programs and support services to help non-achievers learn; and counseling that helps young people develop the survival skills needed to overcome the problems and challenges posed by dysfunctional family and community environments. These intervention programs help children change course before they become dependent and maintain their non-user status. Student assistance, peer and cross-age counseling, in-school and neighborhood drop-in counseling, and student health services are among the most popular types of intervention services for youth.

First offender and special programs for those charged with driving under the influence are examples of intervention programs for youth and adults sponsored by the criminal justice system. Again, with the added outside pressure provided by court-mandated participation in assessment, counseling, and/or educational programs, a proportion of nondependent users are able to change their substance-abusing behavior.

TREATMENT . . .

Despite efforts to prevent and intervene with substance use before it becomes habitual, many adolescents and adults become dependent substance abusers. Their dependency and the behavior that accompanies it have a variety of negative impacts on their lives and seriously impair their capacity for positive functioning in the family or friendship circle and at school, work, or in the community.

A range of treatment options are available to respond to the variety of substance abuse problems and abusers. Options generally fall into one of the following categories; very often, more than one form of treatment is needed.

DETOXIFICATION. The purpose of detoxification is to rid the body of psychoactive substances and help the abuser through the physiological process of withdrawal. Usually, detoxification for heroin, cocaine, and depending on the abuser's physiological and psychological status, alcohol is done on an outpatient basis. Withdrawal from sedative-hypnotics almost always requires hospitalization; in some cases, so does withdrawal from alcohol.

At one time, detoxification was viewed as a stand-alone treatment that could treat substance abuse without any further services or only the most minimal of follow-up counseling sessions. Now, detoxification is generally seen as the first step in a series of treatment approaches that prepares the abuser for either a 28-day inpatient program or a long-term residential or outpatient treatment regimen.

INPATIENT PROGRAMS. Highly structured hospital-based programs generally lasting 28 days have been popular treatment programs for adult alcoholics, individuals with both psychiatric and substance abuse problems, and alcohol- and drug-dependent adolescents who are "out of control" and do not respond to initial attempts to treat them on an outpatient basis.

Inpatient programs are expensive, and almost all require some form of insurance coverage to meet the costs.

METHADONE MAINTENANCE. Methadone maintenance treatment is reserved for narcotics addicts who have made previous unsuccessful attempts to become drug-free. Regular, controlled oral doses of methadone are given to maintenance

patients on a daily outpatient schedule as a replacement for heroin. Unlike their reaction to heroin, patients do not become tolerant to the effects of methadone; thus, when the dose is sufficient, methadone lasts for at least 24 hours, enabling patients to function in a normal way.

Effective methadone maintenance programs usually insist that patients participate in behaviorally oriented counseling, vocational counseling/training, and urine testing.

While federal regulations require that patients be at least 18 years old to be eligible for methadone maintenance services, methadone maintenance is being used, with a special exemption, in the treatment of some adolescent heroin addicts. The results so far are promising.

Longer acting versions of methadone have been developed and are being approved for use as maintenance drugs. The objective is to make continued maintenance less disruptive for long-term, successful patients.

THERAPEUTIC COMMUNITIES. Although the early therapeutic communities—Synanon, Daytop Village, and Phoenix House—were started for heroin addicts, most welcome all types of substance abusers today.

As their name suggests, therapeutic communities are alternative residential programs that use positive group pressure to restructure the lives of substance abusers.

Treatment in a therapeutic community is intensive and extensive, lasting anywhere from 6 to 18 months and requiring residents to adhere to a predetermined schedule of counseling, education, and household duties, as well as strictly enforced rules of behavior.

While therapeutic communities treat relatively small numbers of abusers, they have traditionally been resources for innovative approaches to treating abusers and training staff.

OUTPATIENT PROGRAMS. The majority of substance abuse treatment programs fit into the outpatient category. Outpatient programs take on a variety of shapes and sizes depending on their purpose, the types of substance abuse being treated, and the age of the abusers.

Many offer regularly scheduled individual and group counseling and urine testing for the abuser, as well as family therapy for parents, siblings, and spouses. Some outpatient programs have methadone maintenance components, and some adhere to a totally drug-free approach. Some programs place a major emphasis on job training and retraining, financial management, parenting, and the development of other life skills for abusers: They attempt to provide one-stop, comprehensive services for their patients. Others emphasize support groups to help abusers remain substance-free and prevent relapse or minimize its impact, and to assist family members in coping with an abuser's return to the family unit and new, healthier status. These programs frequently refer patients to other community agencies for health, welfare, and vocational services.

Some outpatient programs are deliberately organized to provide follow-on services for former residents of therapeutic communities or patients at 28-day hospital-based programs. Many of these outpatient programs emphasize participation in recovery groups and regular, ongoing patient and significant other involvement in some form of self-help.

SELF-HELP. Alcoholics Anonymous (AA) is the best known of the self-help programs and is the model for a multiplicity of others, among them Narcotics Anonymous and Cocaine Anonymous.

AA is a fellowship of former alcoholics and other drug abusers who believe that they have a chronic condition and view themselves accordingly as "recovering"—not cured. Using the principles contained in the 12 steps that provide the basic framework for the AA fellowship, members strive for sobriety "one day at a time," with the support of their peers and the help of a higher power. Essential features of AA's 12-step philosophy and program also are integrated into many 28-day hospital-based, therapeutic community, and outpatient programs.

AA and its spin-offs can be found in virtually every community of the United States, and many hold their meetings in faith community facilities. There is no cost for participation (with the exception of a voluntary contribution for coffee). Anyone attempting to grapple with their dependence on substances is welcome.

Al-Anon and Alateen are special self-help groups for abusers' spouses, family members, and children (12 and older) that address their problems and provide information and support as they cope with the process of an abuser's recovery.

Some substance abusers are able to achieve sobriety with self-help programs alone. Others participate in self-help after receiving formal treatment in a hospital, residential, or outpatient setting; still others use self-help as an adjunct to treatment or as a safety net when they feel their substance-free status is being threatened.

It is common for a substance abuser to try a number of different approaches to treatment—and to make several treatment attempts before achieving success. Alcohol and other drug abuse is a chronic, lifelong disease, which by definition is subject to relapse. Although methadone maintenance has made stable functioning achievable for many heroin addicts, there is no such treatment yet available for those dependent on cocaine and crack, and treating these forms of abuse is both difficult and, to a great extent, ineffective. Nevertheless, if an abuser is motivated to change his or her behavior and has the support of family, friends, or a caring community, recovery is not only possible but sustainable.

NOTE

In addition to the definition of intervention just described, the term has another, very specific, meaning for alcohol and other drug abuse treatment professionals. When an active alcoholic or drug abuser cannot respond to pleas from family or friends to seek help, treatment specialists may decide to conduct an "intervention" with the abuser and the significant others in his or her life that literally forces the abuser to confront the harm and pain the substance abuse problem is causing and accept treatment as the only possible response. Because of the intense emotion this kind of intervention produces, its proper conduct requires great skill. Local affiliates of the National Council on Alcoholism and Other Drug Dependency, Al-Anon, and community-based substance abuse treatment programs can be consulted for help in assessing the need for, and in conducting, this type of intervention.

· MODULE 4 ·

SUBSTANCE ABUSE MINISTRIES: APPROACHES TO PREVENTION, INTERVENTION, AND TREATMENT

PERSPECTIVE: Today, no domestic issue captures the attention of the faith community to the extent that drug abuse does. Faith community members, especially the clergy, deal on a day-to-day basis with the consequences of substance abuse on the American family. Unfortunately, the ability of the faith community to direct change is diminished by the fact that their expectations at this time exceed their knowledge of treatment modalities, accessible substance abuse resources, or effective models. This module is designed to provide participants with information about various approaches to treating substance abuse, and help them focus on the implications for faith community involvement in substance abuse ministries.

OBJECTIVES: By the end of this module, participants will be able to:

- Describe two approaches for treating substance abuse,
- Explore the obstacles that may prevent involvement of the faith community in substance abuse ministries,
- Describe strategies for alleviating these obstacles and their relationship to establishing substance abuse ministries.

INTRODUCTION

The abuse of beverage alcohol has been an issue within the faith community for decades. Following the repeal of Prohibition, organized religion took a strong public stand on alcohol abuse and alcoholism. It was involved in the development of educational programs designed to enhance prevention. Through the pulpit, it also sought to deepen understanding of the problem to facilitate compassionate responses to users and their families. In addition, the faith community lobbied vigorously for legislation providing treatment for alcohol abusers and underwrote numerous private treatment services with direct financial support and in-kind contributions for facilities and staff (Flatter 1990).

Clergy have acknowledged the virulence of the drug abuse problem as early as 1961. In that year, David Wilkerson, an Assemblies of God minister, founded Teen Challenge, a drug-free religious therapeutic community that has grown and expanded its operations to include centers in the United States and abroad. Also, in many inner-city neighborhoods, Black Muslims offer at-risk youth and young adults a structured, drug-free alternative to life on the streets.

In 1970, the Executive Council of the United Church of Christ called upon its local churches to provide accurate information about alcohol and drug abuse; develop substance abuse counseling ministries; initiate rehabilitation services; foster prevention programs; support legislation and public policies aimed at controlling drug trafficking and assisting substance abusers; and combat the moral climate that fosters substance abuse through institutional failures—e.g., "spiritual emptiness, discrimination, poverty" (United Church of Christ 1970).

Lutheran Social Services and Catholic Charities USA, among other denominational organizations,

also responded with programs that became " . . . ecclesiastical social service delivery systems. Religious belief provided the basis and framework for involvement, but was not necessarily emphasized in treating individuals." Services were "based primarily in hospitals and other community satellite centers" (Muffler, Langrod, and Larson 1992).

These efforts were and remain vitally important. However, they do not encompass the majority of local congregations, which tend to ignore the problems of illicit drug use within their own communities. For the most part, the faith community confines its activities to sponsoring and providing space for Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings or to subsidizing services for those in need—e.g., the homeless (Flatter 1990; Muffler, Langrod, and Larson 1992).

In effect, many in the faith community are meeting their obligations with respect to substance abuse while at the same time distancing themselves from genuine involvement. The Rev. Sean O'Sullivan, DSW, who directs substance abuse prevention services for the Catholic Archdiocese of Miami, likens the faith communities' nonresponsiveness to the "sleeping giant—waiting for the kiss of life" (O'Sullivan 1988).

Obstacles to Meeting the Substance Abuse Challenge

Pondering why the faith community has been so reluctant to meet the challenges posed by substance abuse, Father O'Sullivan and others offer several explanations.

Many clergy are in a state of denial and do not believe that substance abuse (particularly illicit drug abuse) affects members of their congregations. This lapse in understanding may be due to:

- An honest lack of awareness about alcohol, tobacco, and other drug abuse and the number of lives it touches;
- False pride in the "goodness" of their congregations and families;
- The notion that the faith community is a sanctuary from the realities of modern life, and any recognition of problems or direct involvement with those affected by them taints the community;
- A belief that the presence of substance abuse in the community indicates that the clergy has failed to carry out its responsibilities adequately; and
- The clergy's inability to recognize their own substance abuse problems (O'Sullivan 1988, Flatter 1990, and Griffin and Svendsen 1991).

Other obstacles that inhibit the faith community from establishing active, congregation-based substance abuse ministries are beliefs—shared by some clergy and lay people—that chemically dependent individuals are morally bankrupt, incorrigible, or simply lack the willpower to overcome their problems on their own. Other clergy, whose understanding of substance abuse may be more humane, serve congregations that exhibit an "us versus them" mentality; these clergy members have been hesitant to confront the substance abuse issue head on because they are fearful of their congregation's reaction (Flatter 1990 and Griffin and Svendsen 1991).

Some clergy believe that if they redirect already limited staff and financial resources to alcohol, tobacco, and other drug abuse, the resulting strain will lead to staff burnout and program failure (Griffin and Svendsen 1991).

Still others misunderstand the disease concept of chemical dependence. They believe, because a public health model is used to characterize the process of chemical dependency and to provide a framework for developing a response, that substance abuse rightfully belongs within the purview of the *medical* community rather than the *faith* community. Still other clergy who would like to respond are intimidated by the intervention and treatment aspects of substance abuse; they do not understand that they can play an important role in facilitating both (Griffin and Svendsen 1991; and Muffler, Langrod, and Larson 1992).

Overcoming Obstacles to Substance Abuse Ministries

Despite these obstacles, some clergy are working with their faith communities to create effective substance abuse ministries that meet the needs of their own members and the larger community that surrounds them. These model programs are diverse. They are drawn from different denominations and provide a variety of services ranging from prevention to intervention to treatment/recovery. However, all share certain leadership features that enabled them to overcome the roadblocks cited above. These features include:

- **A CLEAR CONCEPTION OF THEIR ROLE AS POLICY MAKERS.** Clergy who have led successful efforts to create substance abuse ministries first take a clear, informed, responsible, and visible position regarding substance abuse issues themselves. They see themselves as catalysts for action within their faith communities. They work hard to translate their philosophy about substance abuse into a written policy statement that can be shared with faith community leadership and influential members. In addition to clarifying the clergy's position on substance abuse, the statement has symbolic value. It says the faith community's leader is concerned about the problem, sees it as important, and is willing to speak out publicly about it.
- **A COMMITMENT TO THEIR ROLE AS TEACHERS.** Having first educated themselves about substance abuse and its impact, they use the pulpit, youth and adult education programs, the ritual of worship, and faith community bulletins and other literature to convey messages about all aspects of abuse. Recognizing that people are uninformed and confused about the issue, they use their skills and authority to educate and expand awareness.
- **AN INFORMED UNDERSTANDING OF THE ROLES** that both clergy and the faith community can play in initiating and sustaining treatment for substance abusers and supporting their recovery. Clergy who have spearheaded effective substance abuse ministries recognize that people affected by substance abuse (including both the abuser and significant others) are in crisis and need guidance and reassurance. They understand that until the question of abuse is addressed and the individual in need is sober, other efforts to help are futile. Effective substance abuse ministries spring from a genuine insight about the harm that substance abuse causes and a real conviction that the faith community not only has a stake in resolving this problem, but an obligation to do so (Flatter 1990; Florida Religious Leaders Interfaith Committee 1991; Griffin and Svendsen 1991; Muffler, Langrod, and Larson 1992).

Launching a Substance Abuse Ministry Program

Beyond holding a shared philosophy about the role of the faith community in addressing substance abuse, clergy who have established effective substance abuse ministries have followed similar steps in launching their programs.

First and most important, they used their policy-making and teaching roles to win over a group of faith community members to assist them in establishing the substance abuse ministry. Once a core group was identified, they initiated a planning process that consisted of assessing the problem and the resources available to respond to it, devising an expanded faith community (as opposed to a clerical) policy about substance abuse, obtaining broad-based faith community input to the proposed ministry and identifying training for those involved in conducting the ministry (Griffin and Svendsen 1991, Catholic Charities USA 1993). These steps are detailed below.

Assessment and Planning . . .

Assessment and planning activities go hand in hand and are the foundation of every effective substance abuse ministry.

Once interest has been aroused in and commitment expressed by the core group, it is tempting to jump right in and react. However, undirected, unplanned activity achieves little and is a primary reason for staff burnout—and, ultimately, program failure. Successful faith community programs begin with a

clear-eyed assessment of need and an honest appraisal of the resources available to respond.

Faith communities differ greatly in their organization and governance. Some are hierarchical; others are consensual; still others blend elements of both. Depending on the particular situation, clergy may ask the core group to do a preliminary assessment of needs on their own or may appoint a formal group consisting of a representative of each constituency within the faith community. Regardless of which strategy is used, the goal is the same: to define the particular substance abuse problems affecting faith community members and rank them in order of urgency.

To get as many perspectives as possible on substance abuse as it is affecting various segments of the faith community, an assessment group should be set up. The group should include youth leaders, senior citizens, homemakers, etc. The assessors should expand on their own insight by seeking input from any affiliated school, family, or youth camps, or from the local AA or NA chapter that uses the faith community's facilities.

Once the assessment is completed, the core assessment group expands into a formal planning committee with members from each constituency within the faith community (if a formal assessment group was formed, it may simply evolve into the planning committee). The planning committee conceptualizes and oversees the development and implementation of a faith community's substance abuse ministry; consequently, a high level of commitment is essential.

To avoid misunderstandings about what committee membership entails in terms of time and effort, clergy have found it helpful to explain the criteria for involvement in advance. Clergy from effective programs agree that a representative, action-oriented planning committee is extremely important for two reasons:

- It ensures that key faith community perspectives and interests are reflected in the final plan.
- It removes much of the burden from clergy and staff, thereby avoiding the burnout and resentment that too often sabotages substance abuse ministries when a few feel they are doing all the work.

Also, in faith communities where clergy's tenure is limited to a few years, a strong planning committee with broad-ranging lay participation helps ensure that there will be consistency and continuity in original program intent over the long term. (Florida Religious Leaders Interfaith Committee 1991, Griffin and Svendsen 1991, Catholic Charities USA 1993).

Policy Establishment . . .

Once a planning committee is established, its first step is to review the preliminary needs assessment and the faith community's substance abuse policy, if it has one. If no policy exists, the committee's next step is to formulate one. If a policy does exist, the committee should examine it carefully, compare it to the views expressed by the clergy and members during the assessment, and modify it, if necessary, to better reflect the overall faith community's philosophy about substance abuse. The policy provides the philosophical framework that the planning process follows. Further, it sets forth the goals that the planning committee strives to reach through the services and procedures it defines in its final plan for the substance abuse ministry (Florida Religious Leaders Interfaith Committee 1991, Griffin and Svendsen 1991, Catholic Charities USA 1993).

Community Input . . .

As in any other enterprise, the more participants invest in planning a substance abuse ministry, the greater ownership they feel in the resulting product and the more likely they are to do their best to make the program work. Clergy who have implemented effective substance abuse ministries not only sought the input of faith community members during the planning phase, but also invited their participation in the program itself, and actively solicited opinions about the program's functioning once it was operational.

Obtaining input from the faith community can be time-consuming and tedious, even for highly organized planning committees. However, the ideas presented through the process—as well as the problems uncovered—help the committee fashion a plan that is more responsive to the faith community's needs and ultimately more likely to be accepted (Flatter 1990, Florida Religious Leaders Interfaith Committee 1991, Griffin and Svendsen 1991, Catholic Charities USA 1993).

TRAINING . . .

Substance abuse is a complex issue. To help ensure that services addressing it are appropriate, clergy working with the planning committee identify training issues for themselves, staff, and lay volunteers and build in strategies for making training a priority (Florida Religious Leaders Interfaith Committee 1991, Griffin and Svendsen 1991, Catholic Charities USA 1993).

In many urban and suburban areas, training in substance abuse prevention, intervention, and treatment is readily available at community colleges, university hospitals, inpatient substance abuse treatment programs, and mental health centers; and through a variety of institutes, conferences, and seminars publicized in newspapers and professional journals.

In rural areas, or for those responding to specialized populations, more creative solutions to obtaining needed training may be necessary. The Midwest Christian Counseling Center, for example, provides specialized training in substance abuse counseling to inner-city pastors serving predominantly African American faith communities. Unlike the more generic programs available, the Midwest training seminars concentrate on issues that have special relevance to inner-city African American substance abusers and their families. They also promote networking with follow-on treatment programs that work effectively with young African Americans. Nine substance abuse ministries are currently availing themselves of Midwest's training opportunities. (See appendix A for a more detailed description of the Midwest training program.)

On the rural mid-Atlantic Delmarva peninsula, an organization called DELMARVA Rural Ministries was established to respond to a variety of health and social service needs that could not be met by distant institutions and the few health care providers available to cover the region. DELMARVA Rural Ministries provides practical peer training in establishing substance abuse ministries through workshops and support groups conducted by clergy who have already succeeded in launching such programs. (See appendix B for a more detailed description of DELMARVA Rural Ministries.)

In areas without substance abuse ministries, Al-Anon and Alateen as well as open meetings of AA provide excellent opportunities for information sharing, support, and training. Because of their ministering function, clergy are automatically included in the Al-Anon and Alateen fellowships and can attend open meetings of AA. While none of these organizations are professional, they do follow time-tested principles and rely on methods that have been helpful to millions of people (Catholic Charities USA 1993).

Training helps clergy, staff, and volunteers involved in substance abuse ministries improve their skills; it also helps renew enthusiasm and provides opportunities for networking. These latter are especially important benefits when people are working with a problem that demands as much time and energy as substance abuse does.

RELIGIOUS VALUES

Another vitally important characteristic shared by all effective substance abuse ministries is their adherence to their particular religious values and the integration of those values into the services provided (Muffler, Langrod, and Larson 1992). Effective substance abuse ministries are firmly grounded in religious values. Clergy and others involved in the ministry use their religious beliefs as a positive force for preventing, intervening with, treating, and supporting recovery from substance abuse (Weinberg 1988; Flatter 1990; Muffler, Langrod, and Larson 1992; United States Catholic Conference 1990).

The important role that religious values play is perhaps most obvious in faith community-sponsored treatment programs and in the support the clergy and larger faith community provides during recovery.

While clergy are sometimes criticized for characterizing substance abuse as a sin, violation of sacred law, or abomination (among other labels for moral/spiritual failings), the concepts of forgiveness from sin, atonement, the possibility of a new life, of being "born again," and conversion are powerful incentives to undergo treatment and to adhere to a therapeutic plan (Muffler, Langrod, and Larson 1992).

The values-laden support systems that faith communities provide also can be critical in helping prevent relapse. Within the fellowship provided by the faith community, recovering abusers feel a

sense of belonging and security. Not only do they believe that "pastors, elders, and others in the congregation care," they also can look to them as models of appropriate behavior (Muffler, Langrod, and Larson 1992).

New York City's Broadway Presbyterian Church's substance abuse program exemplifies the value of faith membership for those in recovery. Not only do former abusers receive rehabilitation and life skills training, they are also welcomed into the life of the faith community where they are encouraged to participate in prayer and worship.

While both secular and religion-based residential therapeutic communities use concepts of group support and encouragement to maintain a drug-free life, the emphasis on religious affiliation gives former abusers a group identity that is socially approved and that can continue after they leave the therapeutic community. Researchers who study the methods and outcomes of various approaches to substance abuse treatment see this positive identification as another strength of religiously based programs (Muffler, Langrod, and Larson 1992).

An example of the importance of religious identity and values can be found in the Blue Bay Healing Center. Distressed by the ineffectiveness of their detoxification program, the Confederated Salish-Kootenai Tribal Council reconsidered their approach to alcohol and drug dependency and opted for a new direction based on the "life-preserving, life-enhancing values" of their traditional culture and a "return to traditional Indian practices." They organized an after-care program that brings family and the returning abuser together to facilitate a positive transition back to reservation life. At Blue Bay, the recovering abuser and family members are immersed in traditional tribal values and rituals, and supported throughout their stay by staff and tribal members who model positive behaviors. By helping those in recovery reclaim their tribal identity, Blue Bay Healing Center promotes their rehabilitation. (See appendix A for more detailed information about Blue Bay.)

While religiously oriented programs are not for everyone, they do offer a different approach—and a commitment to the possibility of change—from that found in many publicly funded programs. The idea of community, of being able to start over, of obtaining a positive group identity that endures after the treatment experience makes faith community-sponsored programs and services very attractive to a substantial number of substance abusers who would not otherwise be reached by existing secular programs (Muffler, Langrod, and Larson 1992).

In summary, then, clergy who have shepherded the development of effective substance abuse ministries have:

- Thought through their own responsibility for leadership on this issue carefully;
- Sought faith community participation from the outset;
- Clarified their ideas in a written statement that is further detailed and expanded in a formal faith community policy;
- Supported a vigorous community planning process for program development;
- Emphasized the need for competent staff and volunteers (including themselves); and
- Sought training to enhance their substance abuse prevention, intervention, and treatment skills.

Above all, they have remained true to their religious beliefs and have exemplified those values in the services provided through the substance abuse ministry.

Prevention, Intervention, and Treatment Models for Substance Abuse

The remainder of this module offers a variety of service ideas and models for consideration by substance abuse ministries. Not every example will work in every faith community, but substance abuse ministries may find that by borrowing and modifying elements of an idea or model, they can construct a program that will work effectively in their particular setting.

Since one objective of this curriculum is to encourage seminary graduates to think about substance abuse in terms of prevention, intervention, and treatment/recovery, service ideas and models have been grouped under these categories. The descriptions that follow provide only a limited sampling of the kinds of services being offered in U.S. faith communities. More examples can be located through the organizations listed in appendix G.

Prevention Program Ideas

Faith communities are an ideal setting in which to offer substance abuse prevention and education.

The Pulpit . . .

Clergy can reach an entire congregation from the pulpit, with sermons on all aspects of substance abuse. The problem of abuse can be examined from multiple perspectives within a particular religious framework. Some clergy, for example, present it as a form of idolatry; others talk about it as violating the conception of the body as a temple; still others describe it as a form of despair or hopelessness.

In homilies accentuating such positive values as love, charity, or social responsibility, the obligation to help those dependent on substances can be highlighted. Risk factors for abuse, as well as characteristics that help protect individuals from succumbing to abuse can all be incorporated in a reflection that is shared with the faith community. In this regard, the United Church of Christ recommends that its ministers always try to balance their descriptions of substance abuse problems with positives where possible.

References to substance abuse also can be integrated into other parts of a worship service. The congregation can be asked to pray for those suffering from the problems or rejoice with those in recovery.

Healing services can be offered specifically for recovering abusers and their families as can retreats devoted to facilitating the return of the former user to the family or to sustaining recovery and building defenses against relapse.

To foster understanding about chemical dependence and help generate more humane communal responses to it, some Jewish congregations have invited members who are also substance abuse professionals to participate in regularly scheduled services as guest speakers. Not only do such events provide an opportunity for faith community members to hear about substance abuse from someone who shares their religious and ethical value system and can place the problem in an appropriate religious context, but they also demonstrate the importance that the clergy (rabbis) attach to it.

Bishops and others who are esteemed within a faith community's structure have prepared messages devoted to substance abuse. When these are shared with the congregation, they too reinforce the importance ascribed to the subject, as well as provide instruction.

Religious Education . . .

Basic information about substance abuse, conditions encouraging use, and strategies for preventing use can be incorporated in the full range of educational programs that faith communities offer children and adults.

YOUTH. Youth are a major focus of secular and religious prevention efforts. Most faith communities offer Saturday or Sunday school; additional religious education classes during the week; and numerous youth fellowship groups for social, recreational, and community service activities. These all serve as ready-made opportunities to reach young members of the congregations with vital information about substance abuse prevention. The National Council of Churches in Christ, the Christophers, National Teen Challenge's Turning Point Program, and the Board for Social Ministry Services of the Lutheran Church-Missouri Synod are among the organizations that have developed materials on substance abuse for use in faith community-sponsored youth education programs.

The materials can be used as prepared by their curriculum developers or—as is frequently done—modified and supplemented by pamphlets, videos, and portions of other curricula prepared by a variety of religious and secular organizations. In general, no matter how well-conceived a generic program is (even when it is denominationally specific), it does not precisely fill the needs of an individual congregation: Some "tinkering" is required. Modifying a standard program to reflect conditions within the congregation and surrounding community usually enhances it and promotes acceptance by youth.

When those in charge of youth groups and/or youth education are uncertain about prepackaged materials, they often tap resources within the faith community for advice. Health care providers; social workers; teachers; counselors; and those involved in Al-Anon, AA, or NA fellowships can usually help customize a program to fit the special needs of local youth. An added advantage of consulting such resources is that they will often agree to conduct a class or participate in a lock-in or

retreat for adolescents to answer questions about substance abuse.

Effective substance abuse prevention requires more than the provision of information. The faith community teaches by example as well as words. If the faith community has not already done so, it should ensure that youth's behavior relative to alcohol, tobacco, and other drugs while on the community's premises or while engaged in faith community-sponsored activities (whether on or off the premises) is clearly spelled out. Consequences for violations of these rules and procedures for carrying them out should be defined, written up, and distributed to faith community youth, their parents and guardians, and all those involved in the faith community's youth programs (volunteer youth leaders, coaches, facilities cleaning staff, bus and van drivers, etc.).

Faith communities also play a large role in preventing substance abuse through the recreational, social, and cultural activities they offer their youth. With growing numbers of children being raised in single-parent homes or families where both parents work, regular contact with positive adult role models is assuming greater importance. To respond to this need, some faith communities have devised innovative programs for enhancing opportunities for constructive adult-child relationships.

The First Community Baptist Church in Detroit conducts a "Laymen's Rites of Passage Boys' Group" that meets on a weekly basis. Adult male church members act as positive role models to boys aged 4 to 14. They work with them to teach decision making and coping skills, they provide models of self-discipline, and—through their relationships with one another in the group—they communicate and demonstrate positive values.

As a result of their participation, the boys in the group have shown improvement in their academic performance and behavior at school. Further, unlike many of their peers, they have not come in contact with the criminal justice system. "Rites of Passage" and related programs help develop those personal traits that protect youngsters against the use of drugs and alcohol.

Other faith communities have modified their traditional preparation for such key events as confirmation to include a lengthy commitment to service toward others, as well as a guided peer group process designed to examine personal, religious, ethical, and moral values. Substance abuse is one of many behaviors explored in this context.

ADULTS. The faith community has always provided opportunities for guided discussions about major life-determining, life-threatening, and life-altering topics. These programs have a particular impact on those adults who are not in other formal learning settings or who have not acculturated to life in the United States because of language or other sociocultural differences. Substance abuse can be introduced to adults through special education sessions or workshops devoted to the topic, or as part of health carnivals or other "wellness" events organized by the faith community as part of its larger commitment to health and social justice issues.

Good parenting is a major factor in substance abuse prevention. Most people never receive any training in the fundamentals of child development, imparting values, instilling discipline, setting limits, or other parenting techniques. Through its parent skills training workshops, the faith community has an excellent opportunity to provide such learning experiences for parents. Catholic Charities, Lutheran Social Services, and B'nai B'rith International are among the faith community organizations that encourage this approach to substance abuse prevention.

B'nai B'rith's program "Parent Power: Keeping Our Kids Drug Free" reflects a commitment to family-based religious life and instruction that is central to Judaism. Prior to launching its program, B'nai B'rith discerned that parents in Jewish congregations across the United States did not understand the threat that substance abuse posed for their children, did not recognize the symptoms when they occurred, and were uncertain about how they should respond. Based on its impressions of what was needed and a recognition of its particular strengths (e.g., providing information quickly to large numbers of Jewish adults and youth), B'nai B'rith devised a simple print educational program that parents could pursue at home with their children. The program was relatively inexpensive and could be repeated to reach successive waves of parents as their children approached adolescence.

As with so many other effective substance abuse efforts, B'nai B'rith planned its program with the needs of a very specific population in mind. While it used widely available information resources as a base, it modified them for accessibility and acceptability to the target audience.

The B'nai B'rith program also recognizes its limitations: It refers program users to other resources to fill in the gaps for specialized knowledge and to provide a level of expertise that it does not have. (See appendix A for more information about this program.)

When the faith community provides education for adults and children about the impact of substance abuse on their lives, it uses the power of its teaching role to prevent behaviors that interfere with its members' moral, ethical, and spiritual development.

Intervention Program Ideas

Intervention for substance abuse consists chiefly of problem identification and referral for assessment. Most clergy routinely provide identical services, but for different problem areas, through the pastoral counseling they give faith community members.

However, despite their knowledge and proven skills in handling the basics of the intervention process, clergy and faith community ministries have been reluctant to include substance abuse, doubtless for the same reasons that underlie their resistance to establishing substance abuse ministries. This is unfortunate, because when the faith community responds at this level, it opens up an avenue of help to people who would not pursue other alternatives.

Unless a specific incident occurs (e.g., a child is caught possessing drugs at a school-sponsored event), most people do not seek help for a substance abuse problem. What normally happens is that a person requests pastoral counseling because a marriage is in trouble or an adolescent's behavior is disrupting family life. Often, substance abuse may play a role in these problems. But unless the counselor brings it up in a nonthreatening way for consideration, the issue is seldom raised. Since the presence of active substance abuse will virtually derail any effort to help with other areas of concern, the failure to identify substance abuse as a possible problem sabotages the counseling process and makes it ineffective.

Many clergy and faith community members participating in a substance abuse ministry are afraid to become involved as substance abuse "interventionists" because they have unrealistic ideas about what intervention entails.

Intervention is primarily about identification, education, and referral; that is, asking whether substance abuse might be a contributing factor to the problems an individual or family is experiencing, then providing some basic information about substance abuse and its symptoms, and— if there is agreement that substance abuse may be occurring—offering suggestions about the next steps to be taken.

To do this effectively, the clergy or members of the faith community who agree to serve as interventionists must first educate themselves about substance abuse and its symptoms and effects so they can raise the issue compassionately and nonjudgmentally. Professional mental health providers and those involved in self-help groups can be excellent resources for learning how best to raise sensitive issues and respond appropriately, how to provide reassurance, how to encourage positive movement toward addressing the problem, and how to preserve confidentiality throughout this process. Numerous organizations offer pamphlets and booklets on how and when to talk to suspected abusers, what kinds of questions to ask, and techniques for persuading all concerned to proceed with an assessment. Hazelden and the National Council on Alcoholism offer materials that substance abuse ministries have found especially useful because they are clear, concrete, and geared toward the concerned nonprofessional.

At this point, a word about assessment may be in order. When clergy or members of a substance abuse ministry counsel individuals to seek help for what may be an abuse problem, they are not making a diagnosis or any kind of determination as to the severity of the problem or type of treatment it requires. Instead, they are facilitating the next step. They help people confront what they already know or suspect, empathize with their situation, and steer them in the direction of whatever positive help may be available for assessment purposes. Trained assessment personnel (*not* interventionists) evaluate the individual's alcohol and drug use history, decide if a problem exists, and structure a plan for treatment. The interventionist functions as a bridge to move the person from inaction to assessment.

Interventionists need to know about the resources available to faith community members for substance abuse assessments and treatment. This

knowledge is more than just compiling a list of organizations, addresses, and eligibility requirements. Effective interventionists research and evaluate resources by visiting service sites, talking to staff, and checking on their reputation with others in the community. Interventionists also look for other important qualities in their resources beyond ascertaining basic competence. For example, if a faith community is largely Spanish-speaking, an interventionist will want to know if assessment and treatment programs are bilingual and culturally sensitive and have location, hours, and costs reasonable for faith community members.

Ideally, appropriate resources would exist in every community; in reality, this is seldom the case. However, if interventionists believe a program has important services to offer faith community members, a substance abuse ministry can undertake services of its own to make the assessment and/or treatment program more accessible and acceptable. It can provide transportation and babysitting services for assessment appointments, send a bilingual faith community member as an interpreter, and provide encouragement and reassurance throughout the assessment process to help faith community members keep their appointments.

Interventionists can also develop procedures for making referrals to assessment and/or treatment programs. If there are waiting lists or delays in scheduling appointments, substance abuse ministries can suggest or offer interim services. For example, family members can be encouraged to attend Al-Anon, or—if abuse has been admitted—the abuser can be directed to NA or AA. Also, interventionists within the substance abuse ministry can provide ongoing support until a treatment slot becomes available.

The links that interventionists establish between community-based substance abuse services and substance abuse ministries have positive benefits once treatment is begun and after it concludes. Once the substance abuse ministry understands the treatment methods a program follows, it can help reassure the abuser's family both during the treatment process and later, during the transition period when the abuser and family adjust to the new realities of the abuser's recovery and his or her new alcohol and drug-free life.

Treatment/Recovery Program Ideas

In many parts of the country, treatment resources do not exist, have months-long waiting lists, or are inappropriate for a variety of reasons. One option available to faith communities is to escalate their commitment to the concept of substance abuse ministries significantly and establish a treatment program.

Implementing an independent treatment program requires substantial physical and financial resources, as well as a cadre of appropriately trained staff and volunteers. It is a major decision, but one that, when made thoughtfully, can exert an enormous influence on the recovery of a community's substance abusers.

A number of treatment programs established by faith communities were borne out of frustration with the inadequacy of existing services. The Queen of Peace Center in St. Louis was developed to meet the specialized needs of young adolescent, chemically dependent girls, who required the structure provided by a residential program as well as the opportunity to receive an education. Emmaus House is East Harlem is designed to serve homeless drug-dependent men and women, including those with AIDS. The Way Out Home for Addicts is geared toward a largely Hispanic population and offers both treatment services and worship in Spanish. Teen Challenge residential substance abuse programs provide assistance targeted specifically to "street kids" and former gang members.

The BAPCO Pastors Council of the Greater Detroit Area operates an outpatient treatment program as one of many services within its comprehensive program to confront substance abuse. Freedom Now, the substance abuse ministry of the Bethel A.M.E. Church in Baltimore, Maryland, is a small outpatient program that teams each substance-abusing participant with a recovering lay counselor. The Freedom Now model has been replicated by a number of churches in Maryland and Pennsylvania looking for approaches that work effectively with African American substance abusers.

Many of the treatment programs conducted by faith communities fill a special niche by providing services to those whose needs are not easily met in public programs and those for whom a spiritually

oriented, communal, and supportive approach is both necessary and meaningful.

A review of effective faith community-sponsored treatment programs isolates several factors contributing to their success. These include:

- A thorough preplanning assessment that investigates funding sources, barriers to program implementation, and staff and facilities requirements, among other concerns.
- Development of a detailed mission statement that clearly delineates the treatment program's goals and philosophy.
- Identification of the program's support base, including political and community advocates for a citizen's advisory board, media, other treatment and health/welfare/social services, and sources of internal faith community support (e.g., volunteers).
- A carefully considered treatment design that specifies every aspect of the service components to be offered—from the type of treatment to the credentials and experience of the staff to be recruited.
- A detailed screening and referral process that defines client eligibility criteria, gatekeeping procedures, and policies for maintaining confidentiality.
- A viable information system capable of tracking client services, treatment outcomes, funding, and scheduling requirements.
- A comprehensive training plan for clergy, staff, and volunteers.
- A coherent management structure that specifies each organizational and clinical task and the staff position responsible for implementing it.
- A well-defined evaluation scheme designed to measure the effectiveness of the services provided by the treatment program and to identify emerging problem areas.

For further elaboration of these points, see appendix D, which provides detailed plans for establishing a substance abuse ministry.

As mentioned earlier, a major appeal of treatment programs connected to local faith communities is their sense of enduring community. When treatment is completed, the recovering abuser is not isolated or abandoned. Instead, he or she can continue the fellowship begun in treatment through ongoing participation in the life of the faith community. The faith community not only supports the hard-won discipline and lifestyle changes obtained during treatment, but it offers a highly functional "family" that provides spiritual sustenance as well as continuing help in meeting the normal responsibilities of daily life.

Operating an independent treatment program is not feasible for many faith communities. However, individual substance abuse ministries can band together in interfaith coalitions and lobby for the creation or improvement of treatment services in their communities.

The faith community has enormous influence. Now is the time to unleash that power in the interest of all those afflicted by substance abuse—to demonstrate, by example, that substance abusers are worthy of help and can be healed.

· APPENDIX A ·

SUBSTANCE ABUSE MINISTRIES IN ACTION: INTERVENTION/TREATMENT MODELS

PERSPECTIVE: This appendix presents several examples of faith community-based substance abuse intervention/treatment programs. These examples are intended to serve as models of various approaches to substance abuse ministry that are possible. They are not comprehensive, since the types of approaches possible are as numerous as the faith communities attempting them. Rather, they are intended to show the kinds of programs being implemented today in various faith communities. The models presented are:

- BAPCO, developed by the Greater Detroit Council of Ministers, Detroit, Michigan;
- Blue Bay: Peace Through Sobriety, developed by the Native American Development Corporation and the Blue Bay Healing Center, Flathead Indian Reservation, Montana;
- The Community Support Group of Atlanta Masjid, developed by the Muslim community in Atlanta, Georgia;
- Freedom Now Ministry, developed by the Bethel A.M.E. Church, Baltimore, Maryland;
- A multilayered program including both treatment and prevention strategies, developed by St. Sabina Roman Catholic Church, Chicago, Illinois;
- One Church—One Addict, developed by Rev. George Clements, Coordinator of Anti-Drug Programs for the American Alliance for Rights and Responsibilities, Washington, D.C.;
- Parent Power: Keeping Our Kids Drug Free, developed by B'nai B'rith Commission on Community Volunteer Services, Washington, D.C.; and
- Street Psych: A Crime and Substance Abuse Prevention Project for Inner-City Minority Families and Teens, developed by the Midwest Christian Counseling Center, Kansas City, Missouri.

BAPCO SUBSTANCE ABUSE TREATMENT AND PREVENTION PROGRAM: STANDING IN THE GAP

Overview

The BAPCO Pastors Council of the Greater Detroit Area is the educational and charitable arm of the Council of Baptist Ministers. BAPCO is comprised of nine pastors from some of Detroit's most prominent black churches. Through their congregations, these pastors represent over 18,000 black men and women; through the services they provide, their reach is even greater.

BAPCO was organized in 1984 to address the growing substance abuse needs of its local ecumenical community. Historically, the Detroit Area Baptist Churches have been reluctant to confront the issue of chemical dependency, particularly that of its own members. This position is not unique to the Baptist Church. Few organized church groups have faced up to this problem with a systematic and organized approach.

BAPCO established in 1988 a comprehensive Substance Abuse Treatment and Prevention Program that is designed to meet the needs of adults, youth, and families within the local faith community, as well as in the broader Detroit community. BAPCO's substance abuse program provides outpatient treatment and counseling, a network of church-based Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) programs and related support groups, community outreach, and education/prevention activities.

Funded by the District Health Department through the Office of Substance Abuse Services, the goals of the program are as follows:

1. Support religious and personal growth by developing those attitudes and skills needed to support the pursuit of a productive lifestyle free from the effects of alcohol and other chemicals, and
2. Promote social change and action by networking within the total religious community.

Program Approach and Methodology

BAPCO recognizes that treatment for alcoholism and other drug dependencies varies with each individual and family. Assessment of client needs is conducted by professional staff to determine if residential inpatient treatment is required.

The following outpatient treatment services are offered by the BAPCO program:

- Assessment and referral,
- Self-help group involvement (NA, AA),
- Individual counseling,
- Family counseling,
- Group therapy,
- Spiritual counseling,
- Vocational readiness referrals, and
- Didactic lectures.

Individual, group, and family therapy are the primary modalities used in the client's treatment regimen. Individual sessions are scheduled according to the client's need, with a minimum of one visit per month. Group therapy meetings are scheduled twice per month and family therapy as indicated. Other therapeutic modalities used to meet client needs include marital counseling, conjoint therapy, vocational counseling, leisure counseling, and behavioral therapy.

An initial treatment plan, consisting of a minimum of one goal and the objectives to initiate preliminary treatment, is developed at intake. A master treatment plan is developed for each client as soon as possible after the biopsychosocial assessment has been completed, but no later than one month after acceptance into the program. Through the treatment planning process, which includes a comprehensive assessment of the client's needs (biopsychosocial assessment, mental health assessment, and vocational needs assessment), a complete conceptualization of the client's problems and needs is developed. A treatment regimen is

then developed to meet those needs and enhance the client's recovery effort.

The project operates a 24-hour-a-day contact system to monitor any crisis that its clients might have outside of normal business hours, as well as to respond to any referrals received during that time.

Each participating church has appointed at least two liaisons who are trained to serve as the first point of contact within their respective churches. The telephone numbers of these people are posted in their respective churches, and are placed on file with the project director and staff. Any incoming calls after working hours are screened and assessed by the liaisons, then passed on to the full-time staff, if necessary.

Intake and Admission Procedures

Any applicant requesting admission who manifests a chemical dependency problem and who, after being assessed by a professional therapist, is deemed suitable for treatment is admitted into the program. This assessment is made during a comprehensive clinical intake completed by the therapist within two visits.

Before or upon admission into the program, a variety of client information is collected, including:

- Data on background and history including information on family, education, occupation, and legal and court-related considerations.
- The name of the referring agency, if appropriate.
- Information on the client's present substance abuse problem, and on his/her history of substance abuse, including information about prescribed drugs and alcohol; substances used in the past, including prescribed drugs; substances used recently, especially those within the last 48 hours; substance(s) of preference; frequency with which each substance is used; previous occurrences of overdose, withdrawal, or adverse drug or alcohol reaction; history of previous substance abuse treatment received; and year of first use of each substance.
- Information on other counseling services received, including the agency, type of service, and date service was received.

During the intake process, every effort is made to ensure that each client and his/her family members have a clear understanding of the treatment program. Program goals, rules, and regulations, the hours during which services are available, treatment costs and payment arrangements, discharge procedures, and any family participation in the treatment process are explained.

Monitoring of Treatment Process

Initial treatment services are based on the assessment information gathered at the time of intake, in accordance with the initial treatment plan outlined in the progress notes completed at intake. While the client may be involved in a variety of treatment services during the first 30 days, the primary emphasis is on completing the psychosocial assessment.

A written treatment record is maintained for each client in treatment. This record:

- Provides accurate documentation of each client's status at the time of admission;
- Serves as a basis for treatment planning, coordination, and implementation;
- Provides a means of communication among staff involved in the client's treatment;
- Facilitates continuity of treatment and the determination, at any future date, of the client's condition and treatment at any specified time;
- Documents observations of the client's behavior, ordered and supervised treatment, and response to treatment;
- Provides data for use in training, evaluation, and quality assurance measures;
- Documents protection of the rights of the client, parents, siblings, or other family members in the client's treatment program.

Program Monitoring

To better ensure that its program is performing in a manner consistent with original expectations, BAPCO created a Quality Assurance Committee (QAC). QAC is composed of the program director, program therapist, and a representative of an evaluative consultant firm.

QAC's function is to design and implement a quality assurance program of BAPCO's Substance Abuse Treatment and Prevention Program. In performing this function, QAC has the authority to identify areas of concern within the program's administrative and clinical components and to develop priorities of investigation based on the possible impact of the area of concern on client care. QAC develops corrective actions for identified problems.

QAC meets at least monthly to review program activities and make recommendations for identified areas of concern, and reviews and monitors progress made. QAC generates an annual progress report which contains an evaluation of the program's performance in meeting its goals and objectives, and how BAPCO intends to improve the quality of care and other areas needing improvement.

Other Supportive Services

To meet the divergent needs of its clients and their families and ensure the success of its treatment efforts, BAPCO operates a wide variety of programs. Several of these are highlighted below.

Relapse Prevention Therapy . . .

Approximately half of the addicts who get sober remain that way. Of the remaining half, many stay sober for a while, then relapse one or more times before they accept their new lifestyle. The rest go through a "revolving door," getting sober and then relapsing until they die.

BAPCO has developed a program to provide Relapse Prevention Therapy (RE-PRE) to its clients, as well as to other people referred to it by partner agencies and organizations. The goals of RE-PRE are to give chemically dependent people who do not respond to traditional treatment methods an understanding of the relapse process, a knowledge of their own relapse patterns, and knowledge of how to avoid relapse.

HIV/AIDS Education . . .

Nationwide statistics indicate the frightening exponential rise of the incidence of AIDS and HIV infection. The African American community has been disproportionately affected.

Responding to the community's great need for safe sex education, BAPCO has incorporated factual, nonjudgmental AIDS training into all programming. Through a project funded by the Detroit Health Department, two high-risk populations have been targeted—African American women and fellowships of NA and AA.

Women are reached in natural gathering places such as beauty salons, churches, schools, and parenting groups. Members of NA and AA and their families are offered information on reducing high-risk behaviors of intravenous drug use and unprotected sexual activity. The primary goal is a more informed public.

Chemical Dependence Education . . .

Presentations are made to community and church residents, including youth in Detroit public and Catholic middle schools and to BAPCO's educational outreach programs. Designed to create a greater awareness of the drug problem afflicting society, the workshops enhance individuals' ability to cope with or help others experiencing any type of drug problem.

Effective Parenting Program . . .

Using the cultural strengths and history of the black family, a 12-week parenting program has been developed to improve parenting skills and communication within the family. The program particularly targets families of persons in treatment. The comprehensive training includes stages of child development, communication/listening, behavioral management techniques, problem solving, self- esteem, black history, and role modeling.

Summer Youth Project . . .

In conjunction with the Detroit Catholic Pastoral Alliance, BAPCO conducts an 8-week summer program designed for 40 high-risk youth, ages 11 through 13. Through a combination of 12 workshops and 10 field trips, the program is designed to impart spirituality and develop social consciousness, cultural enrichment, and drug abuse awareness. Workshop topics include substance abuse information, decision making, health education,

stress management, drama and modern dance, attitudes, self-actualization, and black history. Field trips are made to Greenfield Village, the Museum of African American History, the Detroit Zoo, Cedar Point, Cranbrook Science Institute, Detroit Science Center, Motown Museum, and Channel 50 TV station.

The Summer Youth Project combines fun with a historical, cultural, and business awareness previously unknown to participants. Even for youth with behavioral difficulties, the Summer Youth Project has proven successful. Participants have accepted responsibility for their behavior and showed exceptional social growth and development. Many of the youth served by the project are the children of people in treatment.

Laymen's Rites of Passage Boys' Group . . .

Sons of single parents who reside in First Community Baptist Church's neighborhood meet weekly with laymen from the church. These church members act as role models to the boys. They present a spirit of teamwork, enforce discipline, teach decision-making and values clarification skills, and identify the coping skills that have enabled them to survive and excel; they share these characteristics and strategies with the participants.

Frequently a difficult population, these 4- to 14-year-old boys have shown improvement in their academic performance and school citizenship marks, as well as a noted lack of involvement with the criminal justice system. A large number of the boys have parents who are in treatment.

2nd Chance Mentorship Project . . .

BAPCO works collaboratively with 2nd Chance, a mentorship program developed for high-risk youth from a foster care background. BAPCO's role is to provide interactive workshops designed to prevent self-destructive behavior and contribute to positive lifestyle growth. Workshop topics include increasing self-esteem, values clarification, conflict resolution, and substance abuse education.

Conclusion

The BAPCO Substance Abuse Treatment and Prevention Program is successful for several reasons:

- Its approach recognizes the redemptive spirit of mankind and realizes that everyone is capable of being restored to health and wholeness through true love and caring. It therefore does not operate within a service system, but rather within a family concept based upon love, caring, mutual respect, and trust.
- BAPCO recognizes that commitment without competence is incomplete. It therefore ensures that all people working within the program—whether professionals or volunteers—are well trained.
- BAPCO views the human therapist as a vehicle through which God works His curative miracles. Therefore, in its therapeutic practice, BAPCO is mindful of the true source of the healing power that it attempts to harness on behalf of those it serves.
- BAPCO is aware that good stewardship depends on good organization and strong administration. It therefore practices high standards of management in carrying out its mission.

Churches wishing to take on the responsibility of recapturing the soul lost to the abuse of illegal and/or legal drugs, alcohol, and other substances must understand that they are engaging in business that must be taken seriously if success is to achieved. The effort requires a major commitment of time and other resources, including human resources.

Credit

This narrative has been taken from material developed by the Congress of National Black Churches, Inc., while under contract to the Office for Treatment Improvement, Alcohol, Drug Abuse, and Mental Health Administration, U.S. Department of Health and Human Services (Purchase Order #91MF35645401D). For more information on this model, contact the Congress of National Black Churches, Inc., 1225 I Street, NW, Suite 750, Washington, DC 20005-3914, (202) 371-1091.

BLUE BAY: PEACE THROUGH SOBRIETY

BLUE BAY: A TRIBAL APPROACH

At Blue Bay, the Confederated Salish and Kootenai Tribes of the Flathead Indian Reservation in northwestern Montana have taken control of their battle against alcohol abuse. They have empowered themselves to utilize their resources and call the shots. They have worked together to define the enemy, establish the purpose of their campaign, and develop an action plan that is based upon clearly articulated tribal principles.

Blue Bay is a Salish-Kootenai effort; it is a celebration of tribal self-determination and dignity.

This [narrative] looks at the process by which Blue Bay was designed and operates.

It explores how the Salish and Kootenai Tribes see the problem of alcohol abuse on their reservation, and it describes the value and principles on which the tribes operate their prevention and treatment campaign.

The [narrative] also looks at the resources upon which the Salish-Kootenai have called and reviews the action plan and strategy which are now Blue Bay.

Finally, a step-by-step outline summary of the Blue Bay approach is presented.

HOW IT HAPPENED: THE PROCESS

In designing and operating Blue Bay, the Salish-Kootenai people used a simple process. "We used six basic steps," says Anna Whiting-Sorrel, Director of the Tribal Alcohol Program which administers the Blue Bay Healing Center.

"First, we looked at the problem face-on. We asked who is being hurt and how?

"Then we assessed our tribal values, asking what is important to us and how the problem threatens those values.

"We identified four healing principles that could help us address our problem in a way which supported our tribal values.

"Next we looked at our resources and determined what we have within us and our system that can help us gain control over the problem.

"We then outlined an action plan and implemented it.

"Finally, we evaluated and started the whole process over again."

WHAT WE DISCOVERED: THE PROBLEM

The Salish-Kootenai people determined that their tribal communities had what they considered a serious problem with alcohol abuse.

"From our tribal statistics," Anna Whiting-Sorrel says, "we saw that alcohol and drug dependency is the leading cause of death among Indian people. We learned that such dependency is a disease and is FATAL if not treated. We learned that alcohol and drug abuse affect not only the abuser, but each family member, the community, and the tribes.

"From recent research, we saw that children raised in homes where alcohol and drugs are abused are at high risk to abuse themselves. We realized our young people today are forced to make decisions about their own use at a younger age than before. Also, there are many more substances they can use to 'get high.'

"We also saw that our youngsters were making the important decision whether to use or abuse alcohol and other substances without good information and skills. We saw that they often choose alcohol and drugs because that's the decision their friends and family members have made."

In addition, the Confederated Salish-Kootenai Tribal Council determined that the tribal alcohol program, as it was operating in the early 1980's, was not working. The program, which had focused on detoxification was—the council felt—not providing the necessary range of services. Prevention and aftercare were not being adequately addressed.

"The detox services had become a revolving door," says a Blue Bay staff member. "Spin dry. Three

hots and a cot. People did not see detox as different. Sooner or later, people who returned to the community from detoxification were readmitted to detox because of the same behavior that had put them there in the first place."

"Detox," the Blue Bay staff member continues, "was a well-intentioned program, but it came to be seen as no more than a flop house. It did not offer health. It did not offer a continuum of services. It was too narrow in scope."

In 1984, the Salish-Kootenai Council started to ask a new series of questions. What was missing in the tribes' efforts to address problems of alcohol and substance abuse? Why weren't efforts working? What was important to the Salish-Kootenai people that was causing tribal efforts to fail?

What We Realized: Our Values

"When we started looking at what is important to us," Anna Whiting-Sorrell says, "We realized that— for the Salish-Kootenai people—children, the family, the community, and the tribes are the center around which everything that is worthwhile to us revolves.

"Our culture and our tradition are, in turn, important because they are the primary means by which we display, preserve, and enhance our family, community, and tribal identity."

Alcohol and substance abuse, the Salish-Kootenai saw, was threatening the tribes' very being. It was destroying children [and] their families and communities.

Culture and tradition were identified as a primary means for attacking the problem, and four healing principles, based on principles presented in workshops by the Four Worlds Development Project in Canada, were identified.

What We Identified: Our Healing Principles

Anna Whiting-Sorrel outlines the healing principles which the Salish-Kootenai embraced. They are uncomplicated, she says.

1. "The solution for the Salish-Kootenai problem with alcohol and substance abuse must come from within the communities. Others may assist, but we the people must be the subject of our healing process and must direct that process ourselves in our own way.
2. "The future is separately linked to the past. We must discover the life-preserving, life-enhancing values of our traditional culture. We must also come to understand the debilitating historical process we have undergone as a people. We must unite in a common vision of what human beings can overcome, and build a new future for our children that is based solidly on the values' foundation of our own culture.
3. "In order for our people to be able to become competent directors of our own healing and development, an ongoing learning process is required. This learning process will systematically educate our children from the time they are in their mother's womb until they pass out of this world.
4. "The well-being of the individual is inseparable from the well-being of the community. Individual healing and the healing of the entire community must go hand in hand."

What We Identified: Our Resources

The Salish-Kootenai people looked at themselves and saw that there were a great number of people in the tribes who were healthy. These people would be the community's primary resource. These people would model healthy, drug-free behavior for those having difficulty with substance abuse and for children, all of whom need appropriate adult role models. As demanded by their first healing principle, the Salish-Kootenai would use themselves to heal themselves.

The Salish-Kootenai people also realized that they had the means for linking the future to the past, the second of their healing principles. For 15 to 20 years, a movement had been gathering momentum on the reservation. This movement, which advocated a return to traditional Indian practices, was beginning to make itself visible. Its time had come and it was ripe for use as a primary tool in the war against alcohol and drugs.

With their own people and traditions, the Salish-Kootenai realized that they could accomplish the third healing principle. Where possible, they would resurrect the old tribal learning processes. Where not possible, they would create new ones.

The very act of working together, in the tribal tradition, would be the resource that would assure the fourth principle, the hand-in-hand healing of the individual and the community.

The tribes' resources are interdependent. The people, the values, the traditions, the networking all flow one into the other. Recognition of this provided the core of what was needed to fight alcohol abuse on the reservation.

What We Created: Our Action Plan

With a recognition of their values and their re sources, the tribes prepared an action plan for fighting alcohol and drug abuse.

Three goals were established:

1. To foster personal recovery from alcoholism for high-risk individuals;
2. To develop a system for helping tribal youngsters consciously choose NOT to abuse alcohol and other substances; and
3. To intervene in the generational/cultural cycle of substance abuse.

The concept of a healing center, to act as a focus for the tribes efforts, was explored. Such a healing center would provide a core, a visible place out of which to operate.

The idea of the healing center was found to have merit. It would be community-based. It would accommodate individuals, families, and community groups. It could be designed to operate using traditional Salish-Kootenai systems. It could put the Salish-Kootenai healing principles into operation. It would be a visible expression of tribal unity and pride.

In 1987, after the planning years, the Blue Bay Healing Center became a reality. Ten acres of land on the north shore of Flathead Lake were earmarked for use in healing tribal members who were struggling with alcohol and substance abuse. The land included a number of old lodges and cabins that had previously been part of a commercial resort and economic enterprise.

Using funds from a variety of sources, including limited funds from the Indian Health Service and funds from the Federal Office for Substance Abuse Prevention, Blue Bay provides a new component in the continuum of services offered by the Salish-Kootenai to fight alcohol and substance abuse.

The Blue Bay component merges prevention and aftercare in a manner that is based on community and family participation. It is intended to supplement the tribes' treatment programs. It is based on a concept that prevention and aftercare flow one into the other in a circular continuum which has no beginning or end.

How We Operate: Our Strategy

Blue Bay operates on the four Salish-Kootenai healing principles:

1. It is community designed.
2. It is a part of the Salish-Kootenai culture and tradition, evolving to meet today's needs.
3. It offers a learning process to educate Salish-Kootenai families in the values and practices of their tradition.
4. It focuses on the individual as a part of the tribal community and the tribe as a part of the individual.

Twelve workers staff Blue Bay. These workers are— so to speak—on duty 24 hours a day. "Working at Blue Bay," one staff member jokes, "really wrecks the basketball season for me. I find I am on call even during intermission. When you work at Blue Bay, you are always identified with the program and its purpose. You have [to] model good behavior. You have to be willing to examine your own life and face your own issues. And you have to be available to talk and listen. You've got to show that recovery is possible, that you feel it is of primary importance, and that you are there to help."

Blue Bay Healing Center is unusual in its approach. The Salish-Kootenai value family. When an individual returns to the reservation from substance abuse treatment, he/she wants to be with family members. But the individual needs some transition and adjustment time. If that is not

provided, the substance abuser returns to his/her old environment and abusive patterns resume.

Why not utilize the family as a resource? Why not bring the family into the transition and adjustment process? Why not include them in the recovery learning process? Focus on the individual as part of the family. At Blue Bay, the Salish/Kootenai do just that.

When an individual returns from residential treatment, he or she is joined by family members at the Blue Bay Healing Center. Together the family heals. They spend a period of time in an environment supported by center staff and recovering tribal members. Together they learn about alcoholism: that it is a disease, how it affects the alcoholic, how it affects other family members, the role and games each person plays.

At Blue Bay, families also learn how to have fun together. They live in an environment that proudly practices Indian tradition. Role models are provided. Parenting and intra-family communication techniques are explored. Resources are identified and each family member is shown where to go for help when it is needed.

Space, meals, and a predictable routine are provided. Youngsters are given responsibilities. Each family member pitches in to help. Trained staff are available for counseling and teaching.

Blue Bay Healing Center also functions as a learning center for specific groups within the community. Special short-term live-in programs are provided for young children whose [mother and/or father], for example, abuse alcohol.

These youngsters are brought together in various age groups as individuals who share the bonds of the Salish-Kootenai heritage. Together, they learn from tribal members who understand the youngsters' environments. The children are taught about alcoholism. They learn what it is and what it does. They learn that they are not responsible for a parent's drinking problem. They learn that they have a choice about whether they themselves drink. They learn how to recognize the positives in their families. And they learn where they can get help. They learn they are not alone. They learn they are a part of a culture and heritage of which they can be proud.

Blue Bay is a place of support. It hosts a number of support groups where tribal members can get in touch and express their feelings. Alcoholics Anonymous and Children of Alcoholics meetings and workshops to discuss grief and suicide are held at the center.

Blue Bay Healing Center is a celebration. Its atmosphere is positive. It champions activities—dances, hiking, swimming, camping, and rafting. One monthly community-wide sober recreational event is held at Blue Bay. All community members are encouraged to use the facilities. It is an uplifting and exciting place to be. Blue Bay demonstrates that people who are not drinking can be more than just sober. They can be happy and have fun.

Blue Bay [is] an Indian program [that] unites the past, the present, and the future. The resident manager and caretaker at Blue Bay is a man of dignity with Indian braids and stories of times past. He is quiet, steady, and kind. Children love him. He speaks of tradition.

The counseling and cultural staff are younger. All Indian, they have different degrees of association with tradition. Most are college educated. Most have lived away from the reservation for long periods of time. A few have been on vision quests. Some participate in sweats.

But the point is, as different as each is from the other, all Blue Bay staff are a part of a vital, evolving tribal experience.

As the visitor enters Blue Bay, he [or she] enters the Salish-Kootenai tribal community.

The Six-Step Process

1. We looked face-on at the problem of alcohol and substance abuse in our communities, asking who is being hurt by what and how.
2. We assessed our tribal values, asking what is important to us and how is that being damaged by alcohol/substance abuse.
3. We adopted four healing principles which honor our values and help us attack alcohol/substance abuse.
4. We looked at our resources, asking what do we have within our tribes and communities that will help us gain control over alcohol and substances.
5. We outlined our action plan.
6. As we implement our strategies, we evaluate and adjust, starting the cycle again with step 1.

Credit

This narrative has been reprinted with the permission of the Native American Development Corporation and the Blue Bay Healing Center. The original work was published, under the guidance of Robert L. Bennett, by the Native American Development Corporation, a nonprofit tax-exempt organization wholly owned and controlled by Native Americans. The original text was written by Nancy Gale based on interviews with Anna Whiting-Sorrell, Administrator of the Blue Bay Healing Center, and her staff.

The original text was later expanded by the Congress of National Black Churches, Inc., to include the spiritual aspects of the alcohol and substance abuse treatment modality used by the Blue Bay Healing Center. The Congress of National Black Churches prepared its document (reprinted here) while under contract to the Office for Treatment Improvement, Alcohol, Drug Abuse, and Mental Health Administration, U.S. Department of Health and Human Services (Purchase Order #91MF35645401D).

COMMUNITY SUPPORT GROUP OF THE ATLANTA MASJID

OVERVIEW: APPROACH OF THE NATION OF ISLAM TO ADDICTION TREATMENT

Apparently one of the most successful groups in dealing with the treatment of addictions is the Nation of Islam. This has been true for a number of years, and continues to be so.

The Nation of Islam's approach to treatment does not consider a treatment method to be separate from life as a whole. Instead, the Nation's approach is to incorporate the person into the (drug-free) way of life.

Initially, should the person entering recovery need to "get over the hump" of withdrawal, that person might be put into seclusion with one or several brothers in attendance. This seclusion might last as long as three days, or until the person has "sweated it out." At this point, the "new person" would take his or her place in the group, knowing that to remove one's self from the group would be risking failure in one's recovery.

This idea of resocialization means that the recovering addict is put into a family. The family and its way of life become the ongoing maintenance group.

FOCUS: THE ATLANTA MASJID COMMUNITY SUPPORT GROUP

In a time of stress, trauma, disease, and economic chaos, the community needs a spiritually focused group of concerned citizens. The Community Support Group of the Atlanta Masjid serves as the agency to educate, as well as establish emotional and professional support to, individuals or families of the Masjid and local community.

In supporting the need for recovery, the Support Group of professionals acknowledges that individuals can change for the better with proper understanding. We support the 12-step Alcoholics Anonymous program and have provided our own eight-step program. Our program's focus is on stressing to individuals that they can recover and will not be addicts, alcoholics, or diseased people for the rest of their lives.

[In our program], the subcommittees of the Support Group represent an identified need and are supported by an element leader and associate. The areas collectively addressed include family life, parent education, marital and couples counseling, consultation and education, codependency recovery, adult children of dysfunctional families, crisis intervention, divorce mediation, adolescent support group, and chemical dependency recovery, to name a few.

HISTORY

The Muslim community in Atlanta, Georgia, has been addressing the ills of substance abuse, alcoholism, immorality, and other diseases of the heart and mind for more than 20 years. Many of the converts to Al-Islam have used the recovery program to clean themselves of the addiction to alcohol and substance abuse and have been able to remain "clean" for years.

THE EIGHT-POINT RECOVERY PROGRAM

STEP 1. Recognition and Repentance

STEP 2. Attachment

STEP 3. Therapy and Support

STEP 4. Deprogramming

STEP 5. Fundamentals

STEP 6. Repair

STEP 7. Re-Entry

STEP 8. Building and Propagation

Credit

This narrative has been taken from material developed by the Atlanta Masjid of Al-Islam. For more information on this model, contact the Atlanta Masjid, 560 Fayetteville Road, Atlanta, GA 30316, (404) 378-1600.

FREEDOM NOW!: THE SUBSTANCE ABUSE MINISTRY OF BETHEL A.M.E. CHURCH

The Freedom Now Ministry is a spiritual drug rehabilitation program that really works. The secret of Freedom Now is that it addresses all three parts of the drug abuser—the spirit, soul, and body—which require healing. The ministry serves those who are suffering legal or illegal addictions.

Freedom Now matches each participant with a lay counselor, usually someone who has been healed from an addiction and understands what the participant is going through. These leaders have maintained a drug-free status for one year, have been saved, and are involved in a power cell such as studying the Word of God. They are provided with in-service training and development opportunities on how to facilitate spiritual groups and spiritual counseling.

There are group meetings once a week as well as one-on-one counseling sessions. Although some may receive deliverance and healing right away, they are still put on the five-step spiritual nutrition plan to build their bodies back up.

Freedom Now recently started an AIDS program, which is aimed at educating addicts and the community in helping prevent AIDS from spreading. In March 1988, Freedom Now held its first conference on AIDS and drugs. It received a mayoral citation as the first black church to have such a conference.

Nutritional Plan

The Freedom Now Ministry operates by a five-step spiritual nutritional plan:

1. To be converted and see the need to be free from substance abuse.
2. To purge the body periodically with juices and distilled water.
3. To eat a nutritious diet.
4. To use the Correction Connection Plan of vitamin supplements.
5. To study God's Word to modify behavior and grow spiritually.

These five steps minister to spirit, body, and soul. In step 1, participants are enjoined to accept Jesus Christ as their savior and to give up their healing to Him: with this action, they are assured that most of their troubles are over.

Steps 2, 3, and 4 may be the most unusual component of the program. Freedom Now recognizes the physical damage long-term addiction can do to the body, and offers a program of cleansing and replacement of lost nutrients; this can have a remarkable effect. This detoxification program is supplemented by Dick Gregory's Correction Connection, a nutritional supplement that puts back the vitamins and minerals that have been lost or replaced because of abuse.

Step 5 deals with abusers' adjustment to a new drug-free lifestyle. Several Freedom Now programs support this adjustment, notably the Housing Program, which provides housing for substance abusers and is part of a support system in which the Word will be all-pervasive. The goal of the Housing Program is to teach, love, and guide those who are addicted but believe that Jesus can heal. Another support element is a complete educational program, which includes a literacy tutorial program, a GED program, and an associate degree program, all offered inside the church. Plans are also under way to have a program within the house at which people can learn how to work with computers.

Group Sessions

In addition to the spiritual nutritional plan, other services offered are four group sessions held on Thursday evenings. Each evening begins with a one-hour prayer session, after which the participants break out into four groups, described below.

ORIENTATION AND EDUCATION (RELAPSE GROUP). In this group, first-time participants are educated over the course of four weeks about relapse. The teaching comes from a social learning model developed by John Johnson, a professor at the Washington Area Council on Alcoholic and

Drug Abuse Administration. The purpose of the group is to educate substance abusers about relapse symptoms, to teach them about different internal and external things that can trigger relapse, and to help them cope with the triggers in their environment. The teaching also removes any misconceptions about relapse that abusers may have heard on the street. Group members also study the 12-step deliverance plan (see below).

- **SPIRITUAL STEP GROUP (SUPPORT GROUP FOR RECOVERING ADDICTS).** At this group session, individuals support one another in recovery. They begin each session with a sharing time, during which they discuss their problems and experience catharsis (an "emptying out" of themselves). They become a family, supporting one another. They share phone numbers to serve as prayer partners to one another. Recovering addicts become sponsors to these group members.

  Next, they join the Relapse Group for a 15-minute teaching on the 12-step deliverance plan. The 12 Steps to Freedom are similar to those used by Alcoholics Anonymous, but the difference is that the Freedom Now steps recognize God as the higher power beyond the individual, without whose help no meaningful change can take place. This teaching is spiritual therapy; participants do not receive much more church or Bible study than this, since many of the participants are not ready for church, and would return to the streets if they were to receive too much Bible teaching. Instead, the group becomes their church until they are ready. The recovering addict leaders nurture and support these people until they become spiritual enough to be on their own.

  At the end of the teaching, there is an invitation to Christian discipleship. Substance abusers are invited to accept Jesus as their savior. When they accept Jesus, they move to the first spiritual step of the Freedom Now plan. After they internalize this, they move to the second step.

- **FAMILY SUPPORT GROUP.** Here, the family is educated about substance abuse-related problems. The family also is taught how to minister to the addict in the home. The group endeavors to support family members with intensive prayer, "emptying out" sessions, and by acting as an extended family when needed. The group is intended for people who are in relationships with one or more persons who are substance abusers or have addicted personalities. The group shares experiences, gives praise reports, and continues to seek God's guidance for their own lives and the lives of those they care for.

  Most Family Support Group participants discover that they have very low self-esteem. Many have experienced hurts in their youth in dysfunctional family situations. They try to cover and conceal their hurts in conjunction with the way they deal with their addicted loved ones. The group uses a workbook that deals with one-way relationships. The information in this workbook helps the family to be healed of the codependency problems that relate to substance abuse. They learn that codependency is the problem in all of them that makes them love, care, or give for the wrong reasons. Family members become enablers to their loved ones. The Family Support Group participants use the relationship assessment model to discover their own relationship dynamics. They learn how not to be enablers, and learn to recognize the destructiveness of codependency.

- **BORN TO BE FREE.** This newest session is a children's group, in which children are nurtured in a spiritual direction. Most of the participants are children born affected by drugs or born into a drug-related environment. The children are ministered to whenever necessary. The purpose of the group is to nurture the children in a spiritually new direction through the teaching of prayer, Bible study, self-esteem building, drug prevention, and the love of God.

Summary

Freedom Now is a disciple-making ministry. Ministers talk with individuals daily, calling them and teaching them the Word so that they will in turn be able to disciple others. To date, Freedom Now has ministered to over 1,000 persons. Many have been set free from addiction and are working toward spiritual growth.

Word of the work of Freedom Now has reached the community. Several people have been referred from the courts who have long histories of drug abuse and involvement with other programs that had not worked for them; these people are now growing spiritually in Freedom Now.

Freedom Now has become a model. Other churches have called on Freedom Now to help them start a drug or AIDS program in their parishes. At least six drug programs have been founded in Baltimore, and one in Pennsylvania, based on the Freedom Now program. The ministry is known internationally, and was featured on the MacNeil/Lehrer News Hour. The ministry worked closely with the Congress of National Black Churches in a recent conference designed to help consolidate church efforts against "The New Slavery"—community problems such as drugs and AIDS.

Credit

This narrative has been adapted from information provided by Bethel A.M.E. Church. It is reprinted here with the permission of Bethel A.M.E. Church. For more information on this model, contact Bethel A.M.E. Church, 1300 Druid Hill Avenue, Baltimore, MD 21217.

MULTILAYERED PROGRAM: ST. SABINA ROMAN CATHOLIC CHURCH

Key Motivating Insight

What moved the pastor and parishioners of St. Sabina's Roman Catholic Church [in Southside Chicago] to begin their multifaceted program was the realization that drugs were touching the lives of all the parishioners in ways both active and passive. There was an aggressiveness from the street. Young people were visually assaulted by the presence of drug trafficking on their streets. Older people were fearful of the violence that accompanies such traffic and how that would affect both them and their families.

Key Spiritual Insight

Drugs come from spiritual bankruptcy. If one knows his/her divine destiny and purpose in God, one then realizes that he/she has the strength and divine purpose to turn his/her life around. Insight→strength→purposive living→personal and community fulfillment. Since drug use is primarily a spiritual problem with clear psychological and psychophysiological ramifications, there must first and foremost be a spiritual underpinning to the ways with which these problems are dealt.

St. Sabina's does not offer residential treatment. It does, however, work closely with agencies that can provide residential services when absolutely necessary. There is an understanding between the parish and these agencies that cooperation between them requires that there be a quick response to a request for help.

The community of St. Sabina has committed itself to aggressively attacking the plague of drugs by the following:

1. There is a comprehensive drug education program in St. Sabina school for grades K through 8. This program would include naming and recognizing drugs. Children receive abundant bad information from the street. This is a way of giving specific and useful information and at the same time recognizing that these young people are raised around drugs and drug dealers i.e.,—users.
2. There are Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) meetings and classes on Tuesday, Wednesday, Friday, and Saturday. There are Big Brother and Big Sister support programs. Maintaining their anonymity, some NA and AA members talk to the elementary school children at intervals during the school year.
3. There are two youth facilities. The Martin Luther King Center is committed to discussion, tutoring, computer learning, and drop-in services. The ARK offers both educational programs such as GED preparation, physical and spiritual fitness programs, self-defense, and basketball. Both of these programs offer positive alternatives throughout the week for youth involvement.
4. There are both counseling and referrals for treatment for users through "Reach Out and Touch," a community treatment referral organization that began out of the church in response to the fact that if a would-be client has no money or insurance, there is no place for him/her to go.
5. GED classes and job referrals are offered to recovering addicts to enable them to re-enter society.

Credit

This narrative has been taken from material developed by the St. Sabina Roman Catholic Church. For more information on this model, contact St. Sabina Roman Catholic Church, 1210 West 78th Place, Chicago, IL 60620, (312) 483-4300.

ONE CHURCH—ONE ADDICT

CHURCHES AND THE PROBLEM OF DRUG ADDICTION

The Nation's drug problem has many sides to it. Many institutions—the medical and mental health system, the criminal justice system, the educational system—are involved in addressing the problem of drugs. Each of these institutions addresses the problem of drugs from its own perspective.

From a church perspective the question arises, do the churches, the religious institutions in our society, have anything unique to contribute to the Nation's efforts to reduce the problems associated with drugs? How do the religious institutions of our society relate to the health, justice, and educational institutions as they grapple with the problems related to drug abuse?

Churches provide meaning in the lives of the majority of Americans, for churches are still primary places of community in our society. What the churches can uniquely contribute to the Nation's struggle to reduce the problems associated with drug addition is therefore a socially and morally integrated community which has a positive effect on mental health and crime, and which is a powerful source of public education.

Five very practical points about churches speak to the potentially powerful contribution they can make in battling the drug problem:

1. **CHURCHES HAVE MATERIAL RESOURCES**—halls, meeting rooms, auditoriums, finances, classrooms that can be used as part of their contribution to combating the drug problem.
2. **CHURCHES HAVE HUMAN RESOURCES**—doctors, nurses, teachers, counselors, lawyers, families, volunteers who want to make a difference in the lives of individuals and in society and who can be mobilized to address the problem of crime.
3. **CHURCHES HAVE A VAST REACH**—every town, village, neighborhood, and city in the United States has churches—that can be used to reach the vast numbers of people who have problems with drug addiction.
4. **CHURCHES HAVE NEEDS**—e.g., every church has members who are recovering addicts who need social support to prevent their relapse, and every church has adults with children who need help to prevent the involvement of their children with drugs—which, if addressed by churches, would reduce the effects of drug-related problems.
5. **CHURCHES HAVE LEADERS**—a network of trained ministers, priests, rabbis, clergy, youth ministers—who are key to enlisting and mobilizing the churches in a national program to reduce drug addiction.

Because churches are connected to the everyday lives of their members, they can be said to be in the frontline of social problems. Thus, services provided by the church are said to be "community-based."

The social institutions of the health care system, the criminal justice system, and the education system, however, tend to provide more specialized services than those provided by the church. These more specialized services tend to be provided in situations somewhat separated from the "frontlines" (e.g., in hospitals, prisons, schools). The One Church—One Addict program, however, can be a bridge to join the more specialized services of health care, criminal justice, and education with the more generalized, community-based services of the churches.

ONE CHURCH—ONE ADDICT PROGRAM GOALS

The program hypothesis behind the One Church—One Addict movement is:

- if the churches are mobilized through their leaders, and
- if the resources of the churches are used in an organized fashion so that each church addresses one problem of drug addiction and one problem of drug prevention, then
- people who are affected or threatened by the problem of drug addiction will experience increased levels of social and moral integration and of practical support, and

- the One Church—One Addict movement will reduce the negative effects of drug addiction and increase the positive effects of drug prevention in the lives of church members and in society.

Thus, the goals of the One Church—One Addict movement are to:

1. Increase the levels of social and moral integration and of practical community-based support around the drug problem.
2. Reduce the negative effects of drug addiction.
3. Increase the positive effects of drug prevention in the lives of church members and in society.

Program Design

The basic idea for the One Church—One Addict program is that each church congregation that participates in the program agrees to embrace wholeheartedly at least one recovering addict and accompany that addict in the recovery process for a period of one year. Each congregation also agrees to undertake at least one drug prevention activity in its community.

The congregation receives training from the One Church—One Addict program in providing the following services:

- Identifying people in the community in need of community-based help in the process of their recovery from drug addiction;
- Making referrals to community agencies that offer appropriate professional services for recovering drug addicts;
- Caring appropriately for a recovering addict—providing friendship, job referrals, warmth, belonging, role models, and an aura of respectability for the recovering addict;
- Doing relapse prevention;
- Supporting and teaching families in the congregation to take constructive action about drug abuse on the part of family members; and
- Implementing drug prevention activities (e.g., training teenagers in how to report to an authority that people they know are using or dealing drugs in school).

Program Elements

These are the key organizational elements of One Church—One Addict:

- A national office,
- A broad base of support within the national religious leadership,
- A broad base of support within the national antidrug leadership and research community,
- State boards of key religious leaders within each State,
- The support of the State Governor and "drug czars,"
- Policies and procedures for each State board,
- Protocol for classifying potential participants,
- A uniform training program for church committees,
- A national newsletter for ongoing education,
- A management information system for program management and evaluation,
- A research design for program evaluation,
- Church committees in each member church.

These are the key operational elements:

- Agreed-upon eligibility criteria (classification instrument) for participants,
- Procedures for church committees to use in assessment and referral of potential participants,
- Standards and procedures for minimum level of ongoing support activities between the church committees and participants, and
- Standards and procedures for periodic reports by church committees to the national office.

Conclusion

There is growing public debate and conversation about increasing the role of all churches in the Nation's fight against substance abuse. Many churches simply need direction in how to play a part in this struggle.

One Church One—Addict lays out a sustainable and national plan that (1) identifies an appropriate role for the churches and (2) provides a model for turning the motivation of the churches into action.

One Church—One Addict will mobilize churches to provide recovering addicts with the crucial social support necessary to sustain them in their recovery process. Treatment programs cannot provide this level of social support. The vital support provided by One Church—One Addict to recovering addicts will increase the effectiveness of drug treatment programs and help ensure that the huge investment of the Nation's financial resources in drug treatment and prevention pays dividends.

The One—Church One Addict program seeks to assist churches to actualize the love of God in our world. The program is a call for the church to show, in a practical way, its love for the addict and its hate for the addiction. In this way, it is hoped that the churches will make their contribution to the reduction of the devastating societal problems that stem from drug addiction in our present day society.

Credit

This narrative has been taken from materials developed by One Church—One Addict (Clements 1993, Clements and Conner 1993). For more information on this model, contact One Church—One Addict, American Alliance for Rights and Responsibilities, 1725 K Street, NW, Washington, DC 20006, (202) 785-7844.

PARENT POWER: KEEPING OUR KIDS DRUG FREE

Overview

Most Americans consider drug and alcohol abuse to be the number one problem in our society today. Substance abuse ruins lives. It ruins the lives of the abuser and of the family. It is a key factor in our high crime rate. It impacts on the lives of the innocent who are victims of drug-related crime. It is rampant and widespread—pervading every segment of our society and every area of our country.

B'nai B'rith's Community Volunteer Services (CVS) Commission is joining the war on drugs. Our focus is on parents and how we can prevent substance abuse in our children.

To this end, CVS has developed a kit for parents. The kit, "Parent Power: Keeping Our Kids Drug Free," and a videocassette, "A Gift for Life" (produced by the American Council for Drug Education), are made possible in part through a special grant from the Plough Foundation. The kit is designed to be used at home by parents with their children so as to get parents involved in the fight against substance abuse.

Parent Power

Substance abuse experts agree that caring and informed parents are the best defense against drug abuse by kids. And they add a word of advice—parents should begin *early* to get their message across.

How does a parent do this? Most parents want to protect and nurture their children. But in the face of the drug problem, many feel helpless. They feel they lack the proper opportunity and the right words. Some feel that they themselves are poorly informed about the effects of drugs. Others simply don't believe that drugs will find their way into their neighborhoods and homes.

But no parent can afford to ignore the threat drugs present. Clearly, education of parents is the first step toward helping young people stay drug free.

Kit Contents and Use

The manual and other materials in the B'nai B'rith kit helps provide parents with the facts and skills they need to help our young people combat drugs. The kit includes a videotape, "A Gift for Life." The accompanying manual includes a summary of the videotape's guiding principles in the form of a 12-step program. It contains important "Points for Parents" [reprinted below]. The section entitled "Beating Peer Pressure" provides valuable tips on helping kids develop the drug refusal skills they need. "What to Do When You Suspect Substance Abuse" helps determine when intervention is necessary, and how to proceed. In addition, the manual contains the names, addresses, and telephone numbers of state and national drug resource centers.

The kit also contains several pamphlets that describe the properties and effects of some widely used drugs. A pamphlet, "Talking to Children About Drug Abuse," helps set the stage for communication. All of these should be read and discussed at home.

After using the kit, parents should spread the word to other parents. They should organize a network of informed parents dedicated to working together to set safe guidelines for their children. Parents are urged to remember the words at the conclusion of the video: **"Parent power is stronger than peer pressure!"**

Points for Parents

1. Supplying kids with information is not enough. They need *values*. Parents are the best and most natural transmitters of values.
2. Have rules of behavior: curfews, friends, proper dress, parties. Continually reinforce the clear message that drugs and alcohol are not permissible. Be sure kids know the consequences for breaking the rules.
3. Listen to, don't just hear, what your children and their friends are saying.

4. Be willing to discuss anything with your children. But remember, discussion does not mean debate.
5. Check the values and lifestyles of your children's caretakers: daycare providers, camp counselors, friends, parents of friends.
6. Set up a parent peer group to support the rules and values you have set. You'll find that they're probably much like your own.
7. Most of all, be prepared to confront a child if behavior seems suspicious or if you find evidence of substance abuse. Don't just threaten—be ready to carry out consequences for unacceptable behavior.

Credit

This narrative has been taken from material developed by the B'nai B'rith Commission on Community Volunteer Services. For more information on this model, contact B'nai B'rith International, 1640 Rhode Island Avenue, NW, Washington DC 20036, (202) 857-6582.

STREET PSYCH: A CRIME AND SUBSTANCE ABUSE PREVENTION PROJECT FOR INNER-CITY MINORITY FAMILIES AND TEENS

STREET PSYCH: HISTORY AND CONCEPT

Over the past five years, the Midwest Christian Counseling Center (MIDWEST) has been approached by black ministers requesting counseling assistance with the mounting problems of street crime, violence, and drug abuse in their neighborhoods. As these pastors have shared their challenges and needs with MIDWEST staff, they have spoken of the following problems regarding psychological care for their people. While destructive behaviors abound, black persons have inadequate financial resources and poor insurance coverage to pay for the high cost of mental health resources and treatment centers. African Americans express attitudes of impatience with traditional therapy seen as unproductive activity or "just talking." Treatment is perceived as demeaning, threatening, and a violation of confidentiality regarding one's struggles. Mental health care is for "crazy people" who have fallen from grace because of an erosion of faith in their religious system.

Furthermore, past experiences with most service providers confirmed parishioner beliefs that therapists are unfamiliar with economic hardship, insensitive to racial and cultural issues, and antagonistic to spiritual values. Little understanding of important extended family and church family networks was conveyed during the therapeutic process. Counselors appeared to be young and professionally too inexperienced with the realities of life, death, and fortune which face members of the minority community on a daily basis.

Recognizing the paucity of mental health resources, the shortage of trained minority counselors, the centrality of church and pastor, and the inherent strengths and resources within the African American community, Street Psych was recently framed in response to repeated requests from black pastors for MIDWEST assistance. This project will introduce innovative techniques for preventing and resolving "street" problems—particularly those of crime, violence, drug and alcohol abuse—using an unorthodox delivery system.

Pastors of black churches, considered by many parishioners to be part of their extended families, have ample family access, meaningful influence, and essential credibility within their communities. These ministers offer vast reservoirs of untapped power to make permanent behavioral changes within their constituencies. In the words of Bishop Floyd Perry, a leader in the predominantly black Pentecostal group, Church of God in Christ, which claims 3 million U.S. members, "the Church is the answer in the battle against drugs and crime . . . Treatment is the band-aid, it only patches the problem, but the churches must do the healing. We have to reach out to our youth, to help change men's lives."

Black pastors and church leaders will be trained by MIDWEST clinical staff to effectively utilize cultural strengths found in the minority community, such as survival skills, strong extended kinship networks, family relationships, and powerful spirituality and religious orientation, to prevent and resolve dysfunctional behaviors. Pastors will be enabled to help parishioners use faith systems and imagery to promote and enhance their mental health and that of their families.

RISK FACTORS

The Street Psych project will address significant risk factors at three levels: Community, Personal/Family, and Individual/Peer.

COMMUNITY RISK FACTOR . . .

1. **ECONOMIC AND SOCIAL DEPRIVATION.** The population of congregational members participating in the Street Psych project will include the following:
   a. Children and their families who live in deteriorating and crime-ridden

neighborhoods who are at risk for engaging in delinquent behavior;

b. Children who have behavior and adjustment problems early in life, who are at greater risk for substance abuse and related crime;

c. Children and families who come from economically deprived areas who are therefore at greater risk for becoming involved with drugs.

2. **LOW NEIGHBORHOOD ATTACHMENT AND COMMUNITY DISORGANIZATION.** Members of churches participating in Street Psych may experience drug problems because they reside in neighborhoods where people may have little attachment to community.

3. **TRANSITIONS AND MOBILITY.** Children of families in each participating parish are at risk for drug use and other behavior problems because of high levels of school transitions caused by the magnet school busing program, housing or rent problems, and other mobility factors. It is known that communities characterized by high rates of mobility are at an increased risk for drug abuse and related crime.

4. **COMMUNITY NORMS FAVORABLE TO DRUG ABUSE.** Families and their children who are members of Street Psych participating congregations may be characterized as follows:

   a. Community attitudes favorable to drug use which put families at increased risk for abuse and related problems;

   b. Community standards that are unclear toward drug and alcohol use which put young people at a higher risk for drug abuse.

Personal/Family . . .

The Street Psych project addresses the following family-focused personal risk factors.

1. **FAMILY HISTORY OF ALCOHOLISM.** Those congregation members of Street Psych participating churches whose children are born or raised in families with a history of alcoholism are at greater risk of developing alcohol and other substance abuse problems.

2. **FAMILY MANAGEMENT PROBLEMS.** It is expected that Street Psych congregants may be experiencing the following:

   a. Family management and parenting problems which increase the risk of drug abuse within a family unit including failure of parents to monitor their children, and excessively severe or inconsistent punishment.

   b. Family-related factors that put children and their parents at increased risk for substance abuse problems such as marital conflict and divorce, death and grief, sexual and physical abuse, etc.

Individual/Peer Risk Factors . . .

The Street Psych project will address individual and peer risk factors that challenge individuals, particularly youth who experience the following:

1. **EARLY ANTISOCIAL BEHAVIOR.** Children in early school years, of Street Psych families, may demonstrate aggressive behavior which puts them at higher risk for drug abuse.

2. **ALIENATION AND REBELLIOUSNESS.** Children and adolescents of Street Psych families may also exhibit the following characteristics:

   a. Feeling separate from mainstream society which may promote greater risk for drug abuse;

   b. Failure in trying to be successful or responsible which can promote greater risk for drug abuse;

   c. Antisocial behavior such as misbehaving in school, skipping school, and getting into fights which puts them at greater risk for becoming involved with drugs or alcohol.

3. **FRIENDS WHO USE DRUGS.** Children of families participating in the Street Psych programs are more likely to associate with peers who are using drugs, a factor that makes them much more likely to use drugs themselves.

Street Psych Project Objective, 1992

1. Pastors from 10 inner-city black churches will participate in the project. Five have already been recruited.
2. A 15-member Steering Committee of MIDWEST Board and Advisory Board members, the MIDWEST Project Director, pastor participants, community representatives, funders, and representatives of community institutions will be established and will meet on a bimonthly basis.
3. An initial and ongoing needs assessment (three hours for each congregation) of pastor training needs and related congregant needs will be conducted with each of 10 pastors.
4. Nine Problem Identification and Assessment Techniques Training Seminars of three hours in length each, will be provided for 10 pastors and church leaders participating in the project.
5. Six Congregant Problem-Solving Techniques Seminars of three hours each will be provided for 10 pastors and church leaders participating in the project.
6. Four hours per week of on-site resident therapist services will be allocated to each of 10 participant churches.
7. Pastors and the resident therapist will identify and train one or two church leaders within each congregation to organize and lead parishioner peer group topic and support meetings.
8. Telephone hotline crisis intervention services (average one hour per week for all participating churches) will be available to 10 pastors and affiliated lay church leader participants in the project.

Street Psych Project Activities

Recruitment of Pastors . . .

Recruitment will involve one-on-one dialogue between the Street Psych Project Director and prospective pastor participants and the distribution of a brochure and/or training syllabus which will describe the project concept and training components.

Project Advisory Council . . .

This council will be established to provide supervision, advice, and guidance to the Project Director, staff, and pastor participants. The council will help to determine pastor needs and help measure success of the project, based upon project objectives. The council will also assume responsibility for renaming of the project and redefinition of project concept and activities, if needed, in response to perceived pastor and congregant attitudes and needs.

The council will meet monthly for the first three months of the project and thereafter will meet on a bimonthly basis to ensure project continuity and to review achievement of project objectives.

Needs Assessment of Pastors and Congregants . . .

Because success of the project will depend upon an optimum relationship between MIDWEST staff and each of the participating pastors, initial and ongoing assessment of pastor training needs based upon estimated prevalence and characteristics of crime, violence, and substance abuse among church congregants will be conducted by the Project Director using one-on-one interview sessions with each pastor.

By reviewing congregant attitudes and characteristics in depth with the Project Director, pastors will gain enhanced understanding of how protective factors can reduce risk factors related to drug use and drug-related dysfunctional criminal behavior. The needs assessment will help pastors to identify cultural strengths, survival skills, extended kinship networks, and strong family relationships in the congregation so that they may later reinforce positive behavior patterns in congregant families and individuals.

This assessment will attempt to determine the most available and effective openings for influence in each church by reviewing congregant characteristics including incidence of criminal or dysfunctional behaviors, addiction, and related factors such as divorce, single parenting, ages of children and adolescents, number of families, income levels, extended family relationships, etc. The assessment will also identify pastor-observed cultural strengths among members of his/her congregation.

This assessment will help to ensure that the pastor's role and position of leadership in his/her congregation is maintained and respected during his/her participation in the project.

One-hour assessment interviews will take place at project onset and at 3- and 5-month intervals after initial participation in the project.

Resident Therapists . . .

The services of an on-site intervention specialist within each participating church will support pastor intervention and peer group activities, and through such support promote positive family and social relationships. The availability of a trusted, skilled intervention specialist will provide congregants with an outlet to discuss personal problems, and thus will enhance their feelings of well-being, self-esteem, and control over their lives. Such well-being leads to greater self-confidence and a feeling of investment in the future. In addition, intervention specialists will reinforce negative attitudes towards drugs and promote ethical behavior and morality.

Intervention specialists will help mitigate against many risk factors faced by youth by offering timely family interventions that promote positive relationships before problems are further exacerbated; cause greater harm to youth; or place them at greater risk for substance abuse, violence, and crime.

Four hours of therapist time per week will be allocated to each of the 10 participating churches in this project, following the initial needs assessment interview with each pastor. The Project Director will assign the MIDWEST therapist whose skills best match needs of each congregation. This therapist will work for and with the pastor and will in effect become the church's resident psychologist. The therapist will be available during these four weekly hours to provide services deemed by the pastor and Project Director to be those most appropriate to the needs of each congregation.

Services offered by resident therapists may include group therapy meetings for congregants and the training of lay group leaders (see below). In addition, individual and family therapy may be offered by each resident therapist.

Resident therapists will also provide extensive pastor training. Resident therapist pastor consultation will include assistance with pastor counseling methods, advice on the use of faith imagery and cultural pride to promote mental health, assessments of congregants, supervision of pastoral care and counseling, and referrals for congregants who require more intensive mental health care.

To provide continuity for pastors and congregants, and to ensure continuing success for the constituents of each pastor, these activities will be ongoing for a two-year term, or for an additional year following the first year of the project.

Lay Church Leader Groups . . .

Each pastor may wish to identify several lay church members to become leaders of parishioner support groups organized around topics of parenting and single parenting, family relationships, substance abuse, teen issues, cultural strengths and identity, street violence, rape and sexual abuse, male role modeling, etc. Groups also may include regular Alcoholics Anonymous, Alateen, Narcotics Anonymous meetings, and specialized teen peer support groups. In that these groups will include outreach to adolescents, group leaders also may be selected from the teen population.

Group leaders will be trained by the pastor and resident therapist to organize groups and to provide effective group leadership. For example, potential group leaders will be given group process skills, learning the formation and stages of groups, guidelines for the conduct of groups, expectations for group achievement, guidance for interaction between family systems and group therapy of peer support groups, etc. Group leader training will be designed to enable resident group leaders to operate independently at the end of a two-year participation period in this project.

All groups will meet on-site at participating church locations and will be led by group leaders in conjunction with the pastor and/or resident therapist. Groups will meet regularly on a weekly, biweekly, or monthly basis, based upon the discretion of congregant participants, the group leader, pastor, and resident therapist. Group leaders will refer persons requiring personalized attention to the pastor and/or resident therapist associated with each congregation, who may refer parishioners to outside community mental health resources if appropriate.

A program brochure describing the Street Psych project, concepts, and activities will be prepared for distribution to parishioners at each church location. This brochure will present information in lay terminology that conveys an understanding of African American cultural identity and congregant

needs. The brochure will assist group leaders to recruit congregants for participation in group meetings.

Peer support groups based within congregations will play an important role in bonding congregants to each other and their families. Peer groups will give congregants an opportunity to be active contributors and members of groups—a significant protective factor, particularly for youth.

Youth support groups will promote the attachments of adolescents with non-drug users and foster anti drug norms, thus promoting positive moral beliefs and countering the norms of drug acceptance and use in the wider community. Youth support groups will provide a specific system of rewards and recognitions. They will establish a framework for acceptable and unacceptable behavior, and through rule setting establish consequences for violating policies, including those prohibiting substance use. A clear system of rewards and recognition of behavior is an important bonding factor for youth.

In addition, youth support groups will provide members with ongoing opportunities to learn about and create positive relationships with others, will offer them a sense of investment in the future, and encourage strong beliefs about right and wrong.

Clinical Training for Pastors . . .

Inasmuch as most pastors have not received prior training in psychological and family systems theory, this series of nine seminars of three hours each will constitute the foundation and frame of reference for all ensuing pastoral counseling activities. Seminars will take place at MIDWEST offices over a 20-week period, following initial pastor/congregation assessments.

The clinical training component of the Street Psych project will greatly enhance positive relationships with others and will reinforce pastor teachings and beliefs about what is right and wrong. Intervention training will give ministers a stronger role in teaching youth and their families moral solutions to their problems. Problem identification and assessment techniques training will enable pastors to promote and enforce positive relationships within congregant families, and among neighbors and peers.

Once ministers have mastered the skills of identifying risk factors and assessing family and individual problems, they will be able to intervene competently, and through such intervention, relate religious morals and those of their church to the negative value of drug use in their congregant communities. The pastors will have a greater opportunity to instill ethical behavior, positive social bonding, and antidrug attitudes.

Consultation Seminars . . .

This second series of seminars will take place upon completion of the clinical seminars noted above. This series will consist of 15 three-hour sessions over a 30-week period at MIDWEST offices during the first year of the project. These sessions will give pastors the opportunity to present actual cases and situations with which they are working, transforming the theoretical concepts learned in clinical seminars into practical application. Two MIDWEST staff psychologists will supervise, teach, facilitate, and offer clinical leadership during these sessions. Pastors will be encouraged to interact, offering problem-solving techniques and solutions to the cases presented.

On-Call Telephone Consultation . . .

Professional hotline crisis intervention backup for ministers will enhance the ability of such ministers to diffuse and resolve crisis situations. Peaceful resolution of crises among the congregant population will help congregants feel safer in their community. Telephone crisis intervention services will help pastors to promote among congregants the protective factor of investment in the future.

On-call telephone consultation will be available to each pastor and lay church leader participating in the project. This resource may be used for suicidal and other crisis matters, referral inquiries, case management, and in other ways deemed appropriate and important by the participants.

While formal consultation seminars above will be limited to the first year of the project, on-call telephone consultation will be offered to pastor participants for a 3-year period, or 2 years beyond the first year of the project. All Street Psych MIDWEST clinical staff will share the telephone consultation responsibility.

Street Psych Project Evaluation

Progress of the project will be monitored by the Project Advisory Council which will seek to measure project success based upon review of completed project objectives. Beyond this, however, evaluation of project results will be measured upon conclusion of project year two by a review of the following project outcomes anticipated to result from project activities. A MIDWEST project evaluator trained in statistical methods and computer use in psychological research will conduct the evaluation. Project evaluation will attempt to quantify project outcomes by using available pre- and post-psychological test instruments and by developing new test measures as needed. Review and identification of test instruments and the development of new test measures to be used will take place during the first year of the project.

- Reduced criminal and violent behavior in parishioner families.
- Prolonged reduction in drug and alcohol use by parishioners, especially teens.
- Reduced sexual acting out and teen pregnancy in the parish.
- Improved and renewed interest in learning and self-improvement by parishioners.
- Improved self-esteem and estimates of self-worth by parishioners.
- Improved relationships with and between parishioners.
- Improved quality of interaction within family systems and improved family and extended family relationships for parishioners.
- More effective utilization of personal strengths, power, and resources for parishioners.
- More effective utilization of faith systems to heal personal dysfunctional behaviors.
- Reduced negative symptoms, acting out behaviors, and coping mechanisms among teens.
- Improved pastoral care and counseling skills for pastors.
- Greater pastor sensitivity and awareness of the mental health needs of parishioners and their extended families.
- Reduced parishioner threat and stigma of utilizing mental health resources.
- Increased referrals to community mental health resources such as Swope Parkway Health Center, Samuel Rodgers Community Health Center, MIDWEST, etc.
- Improved psychological resource accessibility and relevance for the African American community.
- New lay persons identified and trained to assist pastors in their pastoral and mental health care roles.
- Good mental health models promoted by pastors and lay leaders within the parish that continue after formal completion of the project.

Notes

This narrative has been reprinted from a document provided by the Midwest Christian Counseling Center. It is reprinted here with the authors' permission. For more information on this model, contact Midwest Christian Counseling Center, Suite 403, Plaza Parkway Building, 4620 J.C. Nichols Parkway, Kansas City, MO 64112.

For more information on cultural and racial sensitivity with regard to service provision, see appendix C.

· APPENDIX B ·

THE IMPACT OF SUBSTANCE ABUSE ON FAMILIES AND COMMUNITIES IN RURAL ENVIRONMENTS

PERSPECTIVE: Research findings to date reveal that alcohol, tobacco, and other drug use is a special concern for seminary students targeting populations in rural environments. This appendix provides students with detailed information on alcohol and other drug abuse problems among families and communities in rural environments.

OBJECTIVES: Participants will be able to:

- Describe the general characteristics of rural settings,
- Describe substance abuse problems among families and communities in rural environments, and
- Describe the sociocultural characteristics of rural faith community members.

DEFINITION OF RURAL AMERICA

What is rural America? Wargo et al. (1990) define a *rural state* as "1 of 18 States with a population density of 50 persons or fewer per square mile." These States are Alaska, Arkansas, Arizona, Colorado, Idaho, Iowa, Kansas, Maine, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, and Wyoming. The Rural Information Center defines a *rural city* as an open area with a population of up to 20,000, or a town with rural characteristics that is outside a metropolitan area and has a population up to 10,000.

ENVIRONMENTAL CHARACTERISTICS

Traditionally, the rural community consisted of a village and open farming country set in a remote and isolated area. The villagers and farmers shared common institutions and life styles. The residents were dependent upon each other for most essential services and did not have an extensive complement of institutional services. Although the community usually had a general store and/or a local district school, the rudimentary nature of other social institutions imposed religious, political, and educational responsibilities on the family alone.

Over the last three decades, however, the rural community has changed:

- Only a small percentage of rural communities consist of a village and open farming country.
- Because of major interstates, only a small percentage are isolated from urban/metropolitan areas.
- The complement of institutional services to rural communities has increased moderately.
- Many rural residents commute to nearby urban centers for work, trade, education, health services, and recreation.
- For many, the rural community has become only a place of residence—a refuge from the urban center.

- The shift from a manufacturing economy to an information and service economy has devastated the rural economic base.

In the traditional rural social pattern, most of which was still intact as recently as 40 years ago, everyday life was lived among comparatively few people and within the confines of a relatively small area. The average person's basic needs—food, clothing, shelter, recreation—were satisfied by his/her family and community. In return, he/she contributed what he/she had to offer to the same family and community, cementing his/her place in a stable if limited society. For the citizen of yesterday's country town, life was organized on a relatively small scale.

Today, the technological explosion has transformed the U.S. economic and social structure. Although rural areas have been less severely affected than the cities, the changes in lifestyle have been extensive. Notably, rural residents are no longer confined to the boundaries of a single community for shopping, medical services, employment, or social life. The forces that have brought a new quality to life in rural America have also had an impact on the religious institutions in rural environments (Byers and Quinn 1978).

Economic Characteristics

Poverty—a very real issue in rural communities—often goes hand in hand with drug and alcohol abuse. In Kentucky, for example,

> poverty in the country is not as noticeable as in metropolitan areas but is often more profound and pervasive. For example, homelessness is not a problem in some districts [unless] you count remodeled chicken coops, junked cars and the classic old school buses (State ADM Reports 1991).

Many people in rural areas are unemployed, and teenagers cannot find jobs to fill empty time. "Teens are more likely to turn to sex and drugs when other options seem unobtainable" (State ADM Reports 1991).

Alcohol, Tobacco, and Other Drug Use Problems in Rural Communities

Alcohol, tobacco, and other drug use is a special concern for seminary students bound for a rural church ministry. In many rural areas of America, such abuse poses a serious threat to residents' health.

Research findings indicate that unlike cities, where cocaine is the drug of choice, rural areas see abuse of more accessible, cheaper substances such as alcohol and inhalants. The prevalence rates for other drugs, such as inhalants, may be higher in rural areas than elsewhere (Wargo et al. 1990, State ADM Reports 1991).

Another problem facing rural communities is the lack of treatment centers for residents with an alcohol, tobacco, and other drug abuse problem.

Alcohol . . .

Alcohol is by far the most widely abused drug in rural areas. Total alcohol, tobacco, and other drug abuse rates in rural States are about as high as those found in nonrural States. Alcohol abuse treatment and arrests are higher in rural areas than in nonrural areas: 1.4 percent versus 1.2 percent. Drinking in rural areas begins early and increases quickly (Gibbons, Wylie, Echkerling, and French 1986). One-third of the children surveyed in a rural mid-Atlantic town had their first drink on their own by the age of 10 (Gibbons, Wylie, Echkerling, and French 1986). At 11 and 12 years of age, rural children were drinking as many as 14 to 18 beers as part of their Friday and Saturday nights out. Excessive drinking by these young people is extremely dangerous, because alcoholism occurs far more quickly in children and adolescents and can take root in as little as 6 to 18 months. For school-aged youth, the most powerful predictor of alcohol use is grade level. In a longitudinal study conducted in a rural community, 90 percent of 7th graders were found to be light drinkers; by the 12th grade, only 39 percent were light drinkers, and 13 percent were heavy drinkers (Wargo et al. 1990).

Rural youth in Michigan and Wisconsin were found to use alcohol at about 3 ½ times the rate of the national average for similar age groups (Sarvela and McClendon 1987). A survey of 600 junior and senior high school students in northwest Ohio revealed that 69 percent had used alcohol at least once, and that 27 percent reported drinking four or more drinks at a sitting. Approximately 19

percent had driven under the influence of alcohol, and 35 percent had ridden in a car with an intoxicated school-aged driver; 35 percent had refused a ride from a friend who was intoxicated, while 43 percent had tried to stop a drunk friend from driving (Sarvela, Newcomb, and Duncan 1988).

Other Drug Use . . .

Arrest for drug abuse violations in rural counties skyrocketed by 54 percent from 1984 to 1988. In areas with a population of less than 100,000, arrests increased significantly, from close to 200,000 to 250,000 (FBI 1988). More than ever before, cocaine and heroin use is found in rural areas. Most prison inmates in rural States have abused alcohol, other drugs, or both. Arrests for cocaine and heroin—two of the most highly addictive drugs—rose by almost 20 percent in rural areas between 1984 and 1988 (State ADM Reports 1991). Cocaine and opium arrests have soared, increasing almost 20 percent in areas with populations under 100,000 (FBI 1988). Marijuana arrests are dropping, but still outnumber cocaine arrests by two to one in rural areas (Kelly 1989). Also, according to data from the U.S. Department of Justice's Bureau of Justice Statistics,

> rural areas may be ideal for manufacturing "crank," an extremely dangerous form of injectable methamphetamine which causes hallucinations, heart attack, and sometimes death. "Crank" is manufactured in rural, isolated labs where its strong odor cannot be detected (FBI 1988).

The Lack of Treatment Facilities and Health Care

The lack of institutional services or treatment facilities and health care professionals is a major problem in rural areas. Most treatment facilities and health care professionals are located in urban, metropolitan areas, which are not readily accessible to rural residents. Moreover, these facilities often have waiting lists, and people seeking treatment may have to wait months before they are admitted.

Drug program specialists in rural communities cannot compensate for the lack of treatment facilities. A General Accounting Office report on rural drug abuse suggested that rural communities should pool resources and coordinate services to compensate for the shortage of professionals. This collective approach, however, may be logistically and financially difficult for small rural communities.

Rural Faith Community: A Changing

The faith community has always been a refuge for people in crisis, and religious institutions remain the most stable and visible institutions throughout urban and rural America. Recently, a new organizational resource for the rural faith community has developed in response to changed conditions inside and outside of the rural faith—area ministries.

There are three primary types of area ministries:

- **SUPPORT AREA MINISTRIES** minister to the ministers themselves and to faith workers of all types—part time or full time, clerical, religious, or lay. This ministry may vary from one group to the next, but essentially it responds to the desire for a community of peers that can enrich the life of rural faith community leaders and stimulate their work.
- **ADVISORY AREA MINISTRIES** exist to influence policy and encourage other units within the faith community to undertake programs. A coalition of priests, for example, might be asked by a diocesan personnel board to comment on proposed guidelines for clergy assignments in rural areas. Conversely, the same coalition might strongly urge the diocese to establish a special program for migrant farm workers.
- **ACTION AREA MINISTRIES** specialize in a particular sort of ministry; ecumenical ones, for example, generally focus exclusively on social ministry. The focus is a matter of individual choice; the theoretical range of an action organization covers the whole of the religious institution's mission.

Area ministries can be advisory bodies, or they can provide direct support to faith community leaders in their lives and work. These organizations range in size and complexity from a committee set up by two religious institutions to direct a joint program to elaborately structured councils operating in 20 counties.

Used appropriately and effectively, the area ministries can provide clergy, lay persons, and the faith community at large with detailed information on effective responses and strategies to address drug and alcohol abuse among families and

communities in rural environments. The faith community can—indeed, *must*—use area ministries to establish *substance abuse ministries* that provide for coalition building, workshops, media campaigns, sermons, reference materials, and support groups to help individuals coming out of substance abuse treatment programs.

Area Ministry in Action: DELMARVA Rural Ministries

In 1972, DELMARVA Rural Ministries set out to develop a coalition of farmworkers and religious and community organizations to coordinate the development, organization, and implementation of charitable programs, activities, and strategies relating to the housing, health, nutritional, educational, employment, family, and community needs and problems of migrants and seasonal farmworkers and low-income rural individuals.

Over the past two decades, DELMARVA has expanded its services to include the following:

- **NUTRITION CRISIS RELIEF:** a system of quality controlled food package distribution designed to prevent or alleviate hunger among farmworkers. This program fills a vital gap between periods of employment—that is, between crops, between harvesting contracts, and during periods of severe weather that preclude full employment.
- **SELF-HELP:** group efforts catalyzing cooperative working skills to improve low-income households' nutritional levels and to leverage community resources. The Brown Bag Club is the core program through which members receive 20 pounds of privately donated food on a regular basis upon meeting cooperatively determined requirements.
- **NUTRITION/LIFE SKILLS:** educational activities whose purpose is to promote understanding of the relationship of good nutrition and good health to other life skills. These activities include reality-based shopping, storage and food preparation/preservation methods, and a variety of life skills incorporated to help reach the objective.
- **PREVENTION EDUCATION AND COUNSELING SERVICES:** provided to individuals and families in their homes; at labor camps; in shelters, jails, and hospitals; and at DELMARVA office facilities. A culturally sensitive educational curriculum has been developed around the biochemical effects of substance abuse and the effects on families. The curriculum includes information for farmworkers on drinking and driving laws, information to conduct more community awareness campaigns about substance abuse, and information on HIV-positive individuals and on behavior leading to AIDS. It also stresses issues of acculturation and improvement for the Hispanic population.
- **HISPANIC OUTREACH PROJECT:** attempts to reach as many Hispanics as possible in Kent and Sussex Counties, Delaware, to educate them about substance abuse prevention. The project is conducted in conjunction with the State of Delaware Department of Health and Social Services, Bureau of Alcoholism, Drug Abuse, and Mental Health.
- **HIV/AIDS PREVENTION SERVICES:** this area is becoming a growing concern as the number of deaths due to AIDS-related meningococcal infections or brain abscesses has increased.

Note

For more information on DELMARVA Rural Ministries, Inc., write to DELMARVA Rural Ministries, Inc., 26 Wyoming Avenue, Dover, DE 19901.

· APPENDIX C ·

TOWARDS A CULTURALLY COMPETENT SYSTEM OF CARE

PERSPECTIVE: The following material discusses the concept of cultural competency, which is the practice of ensuring that service delivery takes place in a culturally appropriate way to meet the needs of culturally and racially diverse groups. The information provided here was originally written to describe cultural competency as it relates to the care of minority children who are severely emotionally disturbed. However, the discussion applies equally well to working with substance users/abusers.

The cultural competence model explored [here] is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. The word culture is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of service to meet culturally unique needs . . .

Cultural competence may be viewed as a goal towards which professionals, agencies, and systems can strive; thus, becoming culturally competent is a developmental process. One might envision responding to cultural differences by imagining a continuum that ranges from cultural destructiveness to cultural proficiency. There are at least six possibilities . . . along this continuum, including:

- Cultural destructiveness,
- Cultural incapacity,
- Cultural blindness,
- Cultural precompetence,
- Cultural competence, and
- Cultural proficiency.

The culturally competent system of care is made up of culturally competent institutions, agencies, and professionals. Five essential elements contribute to a system's, institutions', or agency's ability to become more culturally competent. The culturally competent system would: (1) value diversity, (2) have the capacity for cultural self-assessment, (3) be conscious of the dynamics inherent when cultures interact, (4) have institutionalized cultural knowledge, and (5) have developed adaptations to diversity. Further, each of these five elements must function at every level of the system. Attitudes, policies, and practices must be congruent within all levels of the system. Practice must be based on accurate perceptions of behavior, policies must be impartial, and attitudes should be unbiased.

A culturally competent system of care serving children of color who are emotionally handicapped must be based on a set of underlying values and principles, such as:

- The family as defined by each culture is the primary system of support and preferred point of intervention. The system must recognize that minority populations have to be at least bicultural, and that this status creates a unique set of mental health issues to which the system must be equipped to respond.
- Individuals and families make different choices base on cultural forces; these choices must be considered if services are to be helpful.

Inherent in cross-cultural interactions are dynamics that must be acknowledged, adjusted to, and accepted. The system must sanction and in some cases

mandate the incorporation of cultural knowledge into practice and policy making. Cultural competence involves working in conjunction with natural, informal support and helping networks within the minority community, e.g., neighborhoods, churches, spiritual leaders, healers, etc. Cultural competence extends the concept of self-determination to the community. Only when a community recognizes and owns a problem does it take responsibility for creating solutions that fit the context of the culture. Community control of service delivery through minority participation on boards of directors, administrative teams, and program planning and evaluation committees is essential to the development of effective services. An agency staffing pattern that reflects the makeup of the potential client population, adjusted for the degree of community need, helps ensure the delivery of effective services. Culturally competent services incorporate the concept of equal and nondiscriminatory services, but go beyond that to include the concept of responsive services matched to the client population.

In reviewing the delivery of effective services cross culturally, it is clear that four models frequently appear:

1. Mainstream agencies providing outreach services to minorities,
2. Mainstream agencies supporting services by minorities within minority communities,
3. Agencies providing bilingual/bicultural services, and
4. Minority agencies providing services to minority people.

Three of these four service models emphasize cultural values and helping systems: mainstream-supported minority services within minority communities, bilingual/bicultural agencies, and minority agencies providing services to minority clients.

In designing services to meet the needs of minority clients in the context of their culture, the following should be considered:

- The concept of least restrictive alternatives;
- Community-based approaches with strong outreach components;
- Strong interagency collaboration, including natural helpers and community systems;
- Early intervention and prevention;
- Intake and client identification to reduce differential treatment of minority youth;
- Assessment and treatment processes that define "normal" in the context of the client's culture;
- Developing adequate cross-cultural communication skills;
- The case management approach as a primary service modality; and
- The use of home-based services.

Planning for cultural competence—which assures appropriateness of care for minority populations involves assessment; support building; facilitating leadership, including the minority family and community; developing resources; training and technical assistance; setting goals; and outlining action steps. While this process is not unique to the development of cultural competence, it is particularly well-suited to the effort because of the scope and complexity of the issues. Such planning must be approached with the developmental nature of the acquisition of cultural competence in mind. Not all agencies will approach the issues in the same way, and each will have a different timeline for development. Through the use of this or similar planning approaches, organizations can avoid feeling that the task is unmanageable, and each can develop at its own pace in ways that make sense in the context of the organization.

Finally, it is felt that the theoretical knowledge base and practical ideas contained [here], together with training and technical assistance, could go a long way toward improving the service delivery system for minority youth, adolescents, and their families.

CREDIT

The information in this appendix has been taken from the Executive Summary of *Towards a Culturally Competent System of Care* (Cross, Bazron, Dennis, and Isaacs 1989). It is reprinted here with the authors' permission. This document is available in full from the Child and Adolescent Service System Program (CASSP) Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Road, N.W., Washington, DC 20007.

· APPENDIX D ·

THREE STRATEGIES FOR ESTABLISHING A SUBSTANCE ABUSE MINISTRY

PERSPECTIVE: Three strategies that can be useful to the faith community in developing a response to issues related to substance abuse treatment and intervention programs are provided on the following pages. Numerous other models and approaches to substance abuse ministries are being used successfully across the United States; those included here are examples of these, but do not represent a comprehensive sample.

The first strategy was developed by Griffin and Svendsen (1991) in their alcohol and other drugs planning guide for congregation members. The second was developed by the Florida Religious Leaders Interfaith Committee (1991) as part of its planning guide for the faith community. The third was developed by ES, Inc., as a result of an extensive review of the literature and databases on process models for starting faith community substance abuse treatment ministries. These three strategies can be used by the faith community, in urban or rural settings, regardless of denomination.

STRATEGY 1: FAITH COMMUNITY PLAN TO PREVENT ALCOHOL, TOBACCO, AND OTHER DRUG USE PROBLEMS

Each congregation should determine the particular functions it can and will undertake, as well as its contribution to the chemical health of the broader community. A number of suggested steps in developing a comprehensive response are described below. Using these steps as a guide for your local congregation or organization can simplify your task.

1. ESTABLISH A PLANNING GROUP, COMMITTEE, TASK FORCE, OR COMMISSION.

a. The best way for this planning process to begin is for the congregational council or governing body to establish a planning group, committee, task force, or commission. It is essential that this planning group include representatives of the various committees or subgroups within the congregation. This broad representation will ensure that those persons affected by the program will have input into its development from the beginning; it will also ensure support from these groups when the program is implemented.

b. People to be included on the planning group should represent clergy, lay leaders, youth, religious educators, parents, women, the elderly, members recovering from chemical dependency, those involved in Alcoholics Anonymous, Al-Anon, and others. The planning group's purpose is to develop a position or policy and coordinate the development of ongoing efforts of the congregation to meet the chemical health needs of its members.

c. Occasionally a congregation may need outside assistance as it assesses needs and plans a chemical health program. A consultant can be used, but the leadership and ownership of the process should remain within the congregation.

2. DISCUSS THE SPIRITUAL, THEOLOGICAL, AND PASTORAL ISSUES RELATED TO CHEMICAL HEALTH.

Once the planning group has been formed, it is essential that all involved discuss the spiritual, theological, and pastoral issues related to chemical

health. It is important that the group develop a mutual understanding of chemical health issues in order to be more effective in planning programs.

3. REVIEW EXISTING CONGREGATIONAL POLICIES, PROCEDURES, AND PROGRAMS.

After developing an understanding of chemical health issues and the role of the congregation, the planning group should review existing congregational policies, procedures, and programs, as well as needs and resources concerning chemical health. The level of activity and involvement in chemical health varies from one congregation to another. Some congregations have well-developed programs, while others have never considered this an appropriate area for congregational involvement. At the same time, local needs and resources for meeting the needs within the congregation and the broader community—should be identified.

4. DRAFT POLICY AND DEVELOP A PLAN DEFINING THE CONGREGATION'S ROLE.

Once the planning group completes its review and assessment of existing programs, needs, and resources, the next steps are as follows.

a. Write a first draft of a position/policy paper.

b. Develop a plan that defines the role of the congregation in promoting chemical health and preventing alcohol and other drug use problems.

The first draft of both the position paper and the plan should be distributed to all clergy and lay staff; congregational council members; and committees, boards, councils, and circles for review and input. This process ensures that what is being developed will be communicated to all persons affected by the program and solicits their input prior to the council's adoption of a final position and plan.

5. ADOPT A FORMAL POLICY AND PLAN.

The congregation should now be ready to formally adopt the position and plan. If the process described here was followed closely, the adoption of the final position or policy by the congregational council is a formality, because the necessary support, communication, and input already have been gathered.

6. RECEIVE TRAINING AND IDENTIFY RESOURCES.

Once the final draft of the position and plan has been approved by the council or governing body, appropriate clergy, lay staff, and lay leaders will need to receive training. Resources also will need to be identified. Once the training has been completed and the necessary resources are in place, the planning group is ready to implement a program that has been designed to meet the congregation's specific needs.

CREDIT

For more information on this strategy to develop an intervention/treatment program, contact the Minnesota Prevention Resource Center, Health Promotion Resources Division, Minnesota Institute of Public Health, 2829 Verndale Avenue, Anoka, MN 55303.

Strategy 2: Establishing a Substance Abuse Ministry

The faith community must begin to develop networks comprised of local, regional, and national faith community-based treatment ministries. The following steps are essential to developing an effective faith community substance abuse ministry.

1. ESTABLISH AN ADVISORY GROUP.

The governing body of each religious institution should establish an advisory group, committee, or task force composed of clergy, lay leaders, youth, religious educators, parents, elderly, and others to assess, plan, implement, and evaluate ongoing program efforts to intervene with and prevent alcohol, tobacco, and other drug abuse problems.

a. Develop a policy that identifies the role of the religious institution in developing intervention/treatment programs for alcohol, tobacco, and other drug abuse.

b. Identify persons within the religious institution or community who can respond to members who are experiencing alcohol, tobacco, and other drug abuse problems.

c. Provide opportunities for professional leadership to develop the skills needed to identify specific behaviors of concern and to make appropriate interventions.

2. DEVELOP AN OUTREACH PROGRAM.

Each religious institution should develop an outreach program that encourages use of the building and facilities for self-help activities including Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, etc.

a. Identify clergy members or staff to be responsible for integrating intervention efforts into the institution's ongoing religious programs.

b. Provide opportunities for clergy members and lay professional staff to develop knowledge and skills necessary to integrate intervention and health promotion in the institution's ongoing preaching and religious education programs.

3. COMMUNICATE INTERVENTION SOURCES.

Each religious institution should communicate to all members the sources available within the religious community for intervening with persons experiencing chemical abuse problems.

a. Communicate the success of recovery as part of the community's ongoing preaching and adult education programs.

b. Communicate to all members the religious community's key role in providing support to persons affected by the chemical abuse of a family member or someone else.

c. Establish and/or sponsor programs to enhance parenting skills.

4. ESTABLISH/SPONSOR FAMILY COMMUNICATION PROGRAMS.

Each religious institution should establish and/or sponsor programs to support and improve family communication.

a. Provide information about the potential negative role that drugs and alcohol can play in the lives of people dealing with stress; suffering; grief; and physical, spiritual, and emotional pain.

b. Participate with other community groups in creating an awareness of chemical abuse problems.

c. Provide healthy activities that recognize and emphasize both the spiritual and social needs of each individual.

5. ESTABLISH SUPPORT SYSTEMS.

Each religious institution should establish a group of support systems for members returning to the faith community after completing therapy or treatment for a chemical abuse problem. Each religious institution should strive to establish a community of caring people within which authentic acceptance and reconciliation are possible, and within which each person's self-worth is acknowledged and nurtured.

6. UNDERSTAND INDIVIDUAL ABUSE PATTERNS AND PROBLEMS.

Each religious institution should provide clergy and lay members with opportunities to examine individual chemical abuse patterns, and develop an understanding of chemical abuse problems and the specific objectives of intervention and prevention.

7. TRAIN CLERGY AND LAY MEMBERS.

Each religious institution should offer training for clergy and lay members. The training should help them:

a. Develop skills to identify specific behaviors of concern and to make appropriate interventions and/or referrals.

b. Develop skills to integrate prevention and health promotion messages into the institution's ongoing preaching and religious education programs.

c. Develop skills to become involved in the spiritual recovery of those members who complete therapy or treatment.

d. Recognize drug and alcohol dependency as a disease or condition that can be treated and arrested.

e. Develop an awareness of the role of the religious institution as part of other community efforts to respond to chemical abuse problems.

8. DEVELOP PROCEDURES.

Each religious institution should develop procedures to follow when a clergy, staff, or lay member identifies individual behavior that may indicate a chemical abuse problem or when a member seeks help.

a. Develop procedures for involving the family of members who are experiencing chemical abuse problems.

b. Develop procedures for responding to medical emergencies, e.g., overdose or withdrawal situations, violence, etc.

9. IDENTIFY RESOURCES.

Each religious institution should identify local, regional, and state treatment resources available to the religious community. In addition, each institution should establish a cooperative relationship with existing public social service agencies and private human service organizations.

CREDIT

The information on this strategy has been adapted from Florida Religious Leaders Interfaith Committee 1991. It is printed here with the authors' permission. The information contained here cannot be reproduced in any manner without the written permission of the publisher.

For more information on this strategy, contact Reverend Sean P. O'Sullivan, DSW, Chairperson, Florida Religious Leaders, Florida Drug-Free Communities Project: Religious Leaders Response to Substance Abuse, 9401 Biscayne Boulevard, Miami Shores, FL 33138.

Strategy 3: Process Model for Establishing a Faith Community Substance Abuse Treatment Center

One option available to religious institutions is the establishment of a substance abuse treatment program to be independently housed and managed. The implementation of an independent treatment program requires significant physical and financial resources, as well as a cadre of appropriately trained staff and volunteers. The steps presented here will help you decide if this an appropriate strategy for your religious institution. If so, it will guide your religious institution through the critical steps of the implementation process.

1. CONDUCT A PREPLANNING ASSESSMENT

a. Determine who will be involved (e.g., lay members, coalitions, program directors, clergy members).

b. Identify the target population (e.g., congregational members, community members, youth, young adults, adults, males, females, clergy members).

(1) Identify sources of information about the target population.

(2) Develop a profile on the target population.

(3) Determine the substance abuse and treatment needs of the target population.

c. Determine the priorities of potential funders.

(1) Whom are you competing with for funds?

(2) What are the potential areas/reasons for competitors to support treatment?

(3) What are the limitations established by your organization or the lender (e.g., church and state)?

d. Determine the financial incentives for providing drug treatment.

e. Determine the sources of research data.

f. Determine the cost of treatment.

g. Determine what treatment resources currently exist.

h. Identify barriers to implementation.

i. Identify program space and housing requirements, such as scheduling of program activities with ongoing activities.

2. DEVELOP A MISSION STATEMENT

The mission statement should include the program goals and philosophy on chemical abuse. This statement should reflect the program's goals for the community, staff, and participants/clients.

3. IDENTIFY THE PROGRAM'S SUPPORT BASE.

a. Determine who will be involved (e.g., treatment professionals, clergy members, lay members, congregational members).

b. Determine where the money is to come from (e.g., Federal Government, state, city, county, private foundation, religious institution's budget, fund-raising events).

c. Establish a citizens' advisory board.

(1) Determine selection criteria for board members.

(2) Involve community members in the selection process.

(3) Develop a goal statement and role for board.

d. Establish a linkage with local officials.

(1) Inform local officials about your services.

(2) Ask local officials to pledge their support.

(3) Ask local officials to serve as advocates for the program

e. Solicit political support.

(1) Inform state and local politicians about your services.

(2) Ask state and local politicians to pledge their support.

(3) Ask state and local politicians to serve on a political advocacy board for the program.

f. Establish a linkage with the local media.

(1) Prepare press releases.

(2) Prepare public service announcements.

(3) Submit short feature stories to grassroots papers on program services rendered to community members.

(4) Contact television and radio talk show hosts regarding guest appearances.

g. Solidify internal support groups.

(1) Determine the role that each group will play in the delivery of services.

(2) Meet with each board to discuss its role and to clarify/address any concerns.

(3) Internal support groups are official boards, circles, lay members education board, ministerial team, or other groups.

h. Identify community treatment resources.

(1) Determine how to access their services.

(2) Identify a single point of contact within each agency.

(3) Establish a verbal or nonverbal agreement with each agency for referral, information exchange, etc.

i. Identify volunteers to support program services.

(1) Develop a recruitment strategy for volunteers.

(2) Develop a volunteer pledge.

(3) Develop a volunteer agreement form.

j. Determine the long-term planning/program sustainability.

4. DEVELOP A TREATMENT DESIGN.

a. Determine target population for services.

b. Develop recruitment strategy to inform target population about services.

c. Prepare an individualized treatment plan.

d. Establish a process for taking urinalysis (if appropriate).

e. Select staff.

(1) Determine the specific number of staff needed.

(2) Determine the minimum requirements to perform.

(3) Set aside some vacancies for recovering staff members only.

f. Determine space and/or housing requirements for the program.

g. Determine cost implications of the program.

h. Match client needs to design/identify approaches.

i. Design client management approach, addressing case management, confidentiality procedures, and rules and regulations of the client management style.

j. Clearly define program model.

k. Develop and coordinate program curriculum.

(1) Address daily and weekly scheduling of staff and volunteers.

(2) Develop preventive health care services.

(3) Develop activities that are culturally sensitive.

(4) Address gender issues (who will work with females and who will work with males).

(5) Address elderly issues (who will work with the elderly).

l. Develop a clinical assessment.

m. Perform treatment selection.

n. Select treatment advisor.

5. PREPARE SCREENING AND REFERRAL PROCESS.

a. Determine client eligibility criteria, considering age, type of drug use, treatment history, criminal justice involvement, psychological status, history of violence, etc.

b. Develop clinical assessment that details clients' substance abuse histories.

c. Establish gatekeeping procedures, including selection, acceptance, and termination procedures.

d. Establish policy for maintaining confidentiality.

6. DEVELOP AN INFORMATION TRACKING SYSTEM.

The information generated from the previous steps should be monitored through this tracking system. The system should document:

- If confidentiality procedures are being followed;
- Treatment process and outcome for each client;
- Funding sources (committed and solicited);
- Scheduling of staff and volunteers; and
- When events need to happen early, later, etc.

7. DESIGN TRAINING.

In order for religious institutions to use clergy, lay, and congregational members to implement a treatment program, training is required.

a. Develop a training plan.

b. Develop group treatment protocols.

c. Ensure that training sessions address HIV/AIDS intervention, cultural sensitivity, women's issues/gender issues, elderly issues, delineation and definition of roles, job functions (for staff), team building (for treatment coordinator and religious leaders) to ensure that staff are working together in coordinating relationships.

d. Design training.

(1) Address critical confidentiality issues for treatment personnel.

(2) Address personnel issues, including disciplinary procedures, client rights, and life safety procedures.

(3) Address treatment issues for volunteers.

8. ENSURE EFFECTIVE MANAGEMENT STRUCTURE.

The effectiveness of any program is based on its management structure; the effective management of a treatment program is essential. Client progress in treatment largely depends on the program management structure. There are several program management issues that should be addressed at the program planning phase; these include the following:

a. Management of clients: who will be the case manager.

b. Development of unit milieu blending treatment and discipline.

c. Coordination of treatment and other activities.

d. Licensing/certification (not universally appropriate).

e. Development of implementation plan.

f. Development of a financial budget.

(1) Address equipment and supplies, including access to them, ordering, control versus noncontrol (i.e., who owns them, who buys them, equipment maintenance, etc.).

(2) Develop operating budget.

(3) Identify revenue sources.

(4) Specify number of staff needed.

(5) Identify program space and housing requirements.

(6) Identify volunteers, interns, and others who can supplement staff.

(7) Determine cost implications of program design.

(8) Training and upgrade training.

(9) Financial accountability audit.

(10) Identify in-kind contributions.

(11) Evaluate program.

9. PREPARE A PROGRAM EVALUATION.

In addition to the above program management concerns, every program should have a well-defined evaluation component. The evaluation component helps program staff to measure the effectiveness of their services.

a. Determine how staff/client needs and attitudes will be evaluated.

b. Determine who will be responsible for the evaluation.

c. Determine how process and outcome data will be collected.

d. Determine what instruments, methods, and procedures will be used for evaluation.

e. Determine cost estimates for the evaluation.

CREDIT

The information on this strategy has been derived from a model by ES, Incorporated.

· APPENDIX E ·

LITERATURE CITED

Birchett, Colleen, ed. 1992. *Biblical Strategies for a Community in Crisis: What African Americans Can Do.* Chicago: Urban Ministries, Inc., Press.

Brecher, Edward M., and the Editors of Consumer Reports. 1972. *Licit and Illicit Drugs.* Boston: Little, Brown and Company.

Brehm, Nancy M., and Edward J. Khantzian. 1992. "A Psychodynamic Perspective." In Joyce Lowinson, Pedro Ruiz, and Robert B. Millman, eds., *Substance Abuse: A Comprehensive Textbook.* Baltimore, MD: Williams & Wilkins.

Brown, Lee. 1994. *National Drug Control Strategy: Reclaiming Our Communities From Drugs and Violence.* Washington, DC: The White House.

Byers, David M., and E. Quinn. 1978. *New Directions for the Rural Church: Case Studies in Area Ministry.* New York: Paulist Press.

Carroll, Charles R. 1985. *Drugs in Modern Society.* Dubuque, IA: Wm. C. Brown Publishers.

Catholic Charities USA. 1993. *Substance Abuse Agency Resources Guide.* Alexandria, VA.

Clements, George. 1993. "One Church—One Addict Program Outline." Washington, DC: American Alliance for Rights and Responsibilities.

Clements, George, and Roger Conner. 1993. "One Church—One Addict Case Statement." Washington, DC: American Alliance for Rights and Responsibilities.

Cohen, Sidney. 1980. *Cocaine Today.* Rockville, MD: American Council for Drug Education.

Cross, Terry L., Barbara J. Bazron, Karl W. Dennis, and Mareasa R. Isaacs. 1989. *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed.* Washington, DC: Child and Adolescent Service System Program Technical Assistance Center, Georgetown University Child Development Center.

Drug Abuse Policy Office. 1982. *Federal Strategy for Prevention of Drug Abuse and Drug Trafficking.* GPO Pub. No. 0410120000-3-0. Washington, DC: U.S. Government Printing Office.

DuPont, Robert L. 1984. *Getting Tough on Gateway Drugs.* Washington, DC: American Psychiatric Press.

Dusenbury, Linda, Elizabeth Khuri, and Robert B. Millman. 1992. "Adolescent Substance Abuse: A Sociodevelopmental Perspective." In Joyce Lowinson, Pedro Ruiz, and Robert B. Millman, eds., *Substance Abuse: A Comprehensive Textbook.* Baltimore, MD: Williams & Wilkins.

Federal Bureau of Investigation (FBI). 1988. *Crime in the United States.* Washington, DC: U.S. Department of Justice.

Flatter, Charles H. 1990. "The Faith Communities' Response to Alcohol and Other Drug Abuse: A Call to Action." Rockville, MD: American Council for Drug Education.

Florida Religious Leaders Interfaith Committee. 1991. *Drug-Free Communities Guide.* Miami Shores, FL.

Gibbons, S., M. Wylie, L. Echkerling, and J. French. 1986. "Patterns of Alcohol Use Among Rural and Small Town Adolescents." Based on the Student Alcohol Inventory administered to 650 students in grades 7-12 in a small, mid-Atlantic town and surrounding county. Abstract from *Adolescence* Vol. XXI, No. 84:892.

Griffin, Thomas, and Roger Svendsen. 1991. "Alcohol and Other Drugs A Planning Guide for Congregations." St. Paul, MN: Minnesota Institute of Public Health, Minnesota Prevention Resource Center.

Interfaith Conference of Metropolitan Washington: Pastoral Reflection On Drugs and Violence. 1988. Conference report document. Washington, DC.

Johnson, Bruce D., and John Muffler. 1992. "Sociocultural Aspects of Drug Use and Abuse in the 1990's." In Joyce Lowinson, Pedro Ruiz, and Robert B. Millman, eds., Substance Abuse: *A Comprehensive Textbook.* Baltimore, MD: Williams & Wilkins.

Kellerman, Joseph L. 1980. *Alcoholism: A Guide for Ministers and Other Church Leaders.* Raleigh, NC: Department of Human Resources.

Kelly, J. 1989. *USA Today,* December 20, p. 23. Based on data disseminated by the U.S. Department of Justice's Bureau of Justice Statistics.

Kleber, Herbert D. 1992. "Federal Role in Substance Abuse Policy." In Joyce Lowinson, Pedro Ruiz, and Robert B. Millman, eds., *Substance Abuse: A Comprehensive Textbook.* Baltimore, MD: Williams & Wilkins.

Levine, Samuel M. 1974 (rev.). *Narcotics and Drug Abuse.* Cincinnati: The W.H. Anderson Company.

May, Gerald. 1988. *Addiction and Grace.* New York: Harper & Rowe.

Muffler, John, John G. Langrod, and David Larson. 1992. "There Is a Balm in Gilead: Religion and Substance Abuse Treatment." In Joyce Lowinson, Pedro Ruiz, and Robert B. Millman, eds., Substance Abuse: A Comprehensive Textbook. Baltimore, MD: Williams & Wilkins.

Musto, David. 1992. "Historical Perspectives on Alcohol and Drug Abuse." In Joyce Lowinson, Pedro Ruiz, and Robert B. Millman, eds., *Substance Abuse: A Comprehensive Textbook.* Baltimore, MD: Williams & Wilkins.

New York Times/CBS News Poll. 1986. *Source Book of Criminal Statistics.* New York.

Office for Substance Abuse Prevention (OSAP). 1991. *What You Can Do About Drug Use in America.* DHHS Pub. No. (ADM)91- 1572. Rockville, MD: U.S. Department of Health and Human Services.

O'Sullivan, Sean. 1988. "Religious and Community Organizations: An Untapped Resource?" Presentation at White House Conference for a Drug-Free America, March 1988. Washington, DC.

Petersen, Robert C. 1983. "Cocaine: The Lessons of History." In The American Council for Drug Education, *Cocaine: A Second Look.* Rockville, MD.

The Presbyterian Church (USA). 1986. *Alcohol Use and Abuse: The Social and Health Effects.* New York.

Sarvela, P.D., and E.J. McClendon. 1987. "Impact Evaluation of a Rural Youth Education Program." *Journal of Drug Education,* 213-31.

Sarvela, P.D., P.R. Newcomb, and D.F. Duncan. 1988. "Drinking and Driving Among Rural Youth." *Health Education Research,* 197-201.

Schwartz, Richard. 1990. "Rethinking the Failures of Prohibition." *U.S. Journal of Drug and Alcohol Abuse* Vol. 14, No. 8: 5.

State Alcoholism, Drug Abuse and Mental Health Reports (State ADM Reports). 1991. *Intergovernmental Health Policy Project* No. 7 (September). Washington, DC: George Washington University.

Strategy Council on Drug Abuse. 1979. *Federal Strategy for Drug Abuse and Drug Traffic Prevention.* GPO Pub. No. 052-003-00640-5. Washington, DC.

Szasz, Thomas. 1974. *Ceremonial Chemistry.* New York: Anchor Press.

United Church of Christ Executive Council. 1970. "The Crisis of Drug Abuse."

United States Catholic Conference. 1990. "New Slavery, New Freedom: A Pastoral Message on Substance Abuse." Washington, DC.

Wargo, M., et al. 1990. "The Extent of Substance Abuse in Rural Places." General Accounting Office Report to Congressional Requestors, *Rural Drug Abuse, Prevalence, Relation to Crime, and Programs.* Washington, DC.

Weinberg, Joseph. 1988. Keynote presentation at Interfaith Conference of Metropolitan Washington: Pastoral Reflection on Drugs and Violence. Washington, DC.

Wesson, Donald R., David E. Smith, and Richard B. Seymour. 1992. "Sedative-Hypnotics and Tricylics." In Joyce Lowinson, Pedro Ruiz, and Robert B. Millman, eds., *Substance Abuse: A Comprehensive Textbook.* Baltimore, MD: Williams & Wilkins.

White House Conference for a Drug Free America. 1988. *Final Report.* Washington, DC.

Williams, Trevor. 1947. *Drugs from Plants.* London: A.L. Atkinson, Ltd.

Winick, Charles. 1992. "Epidemiology of Alcohol and Drug Abuse." In Joyce Lowinson, Pedro Ruiz, and Robert B. Millman, eds., *Substance Abuse: A Comprehensive Textbook.* Baltimore, MD: Williams & Wilkins.

· APPENDIX F ·

ADDITIONAL REFERENCES, WORKS CONSULTED, AND RESOURCES

READINGS

Addiction Research Foundation. 1987. *Drugs and Drug Abuse: A Reference Text.* Toronto, Canada.

Alcoholics Anonymous World Services, Inc. 1979. *A Clergyman Asks About Alcoholics Anonymous.* New York.

____. 1974. *Alcoholics Anonymous: Twelve steps and twelve traditions.* New York.

Anderson, James D., and Ezra Earl Jones. 1978. *The Management of Ministry.* New York: Harper and Row.

Apthorp, Stephen P. 1990. *Alcohol and Substance Abuse: A Handbook for Clergy and Congregations.* Second Edition. Harrisburg, PA: Morehouse Publishing.

Barber, Bernard. 1989. *Drugs in Society.* New York: Russell Sage Foundation.

Beattie, Melody. 1986. *Codependent No More.* San Francisco: Harper and Row.

Benowitz, Neal L. 1990. "Clinical Pharmacology of Inhaled Drugs of Abuse: Implications in Understanding Nicotine Dependence." In *Research Findings on Smoking of Abused Substances.* Research Monograph Series 99. Rockville, MD: National Institute on Drug Abuse.

Bissel, LeClaire. 1982. *Some Perspectives on Alcoholism.* Minneapolis: Johnson Institute.

Blizzard, Samuel W. 1956. "The Minister's Dilemma." *The Christian Century,* 15 April.

Booth, L. 1984. "The gauntlet of spirituality." *Alcoholism Treatment Quarterly* Vol. 1, No. 1: 139-41.

Botvin, G.J., and S. Tortu. 1988. "Preventing Substance Abuse Through Life Skills Training." In R. Price, E.L. Cowen, R.P. Lorion, and J. Ramos-Mckay, eds., *Fourteen Ounces of Prevention: A Casebook for Providers.* Washington, DC: American Psychological Association.

Braude, M.C., and H.M. Chao. 1986. *Genetic and Biological Markers in Drug Abuse and Alcoholism.* Research Monograph Series 66, DHHS Pub. No. (ADM)86-1444. Rockville, MD: National Institute on Drug Abuse.

Brisbane, F.L., and M. Womble. 1992. *Working with African Americans - The Professional's Handbook.* Needham Heights, MA: Ginn Press.

____, eds. 1985. *Treatment of Black Alcoholics.* New York: Haworth Press.

Brown, Frieda, and Joan Tooley. 1989. "Alcoholism in the Black Community." In G.W. Lawson and A.W. Lawson, eds., *Alcoholism and Substance Abuse in Special Populations.* Rockville, MD: Aspen Publishers.

Callahan, Rachel, and Rea McDonnell. 1990. "Adult Children of Alcoholics: Ministers and the Ministries." The School of Sisters of Notre Dame and the Sisters of the Holy Cross.

Center for Substance Abuse Prevention. 1993. *Faith Communities.* DHHS Pub No. (ADM)93-1986. Rockville, MD: U.S. Department of Health and Human Services.

____. 1993. *Prevention Strategies Based on Individual Risk Factors for Alcohol and Other Drug Abuse.* DHHS Pub. No. (ADM)93-1996. Rockville, MD: U.S. Department of Health and Human Services.

Claussen, Russell G. 1982. *Alcohol and Other Drugs,* New York: United Church Press.

Clinebell, Howard J., Jr. 1968. *The Pastor and Drug Dependency.* New York: Council Press.

_____. 1990. *Understanding and Counseling the Alcoholic - Through Religion and Psychology.* Nashville: Abingdon Press.

Cone, James H. 1970. *A Black Theology of Liberation.* Philadelphia: Lippincott.

Conley, Paul C., and Andrew A. Sorenson. 1971. *The Staggering Steeple.* Philadelphia: Pilgrim Press.

Cook, Paddy. 1991. *Drugs and Pregnancy: It's Not Worth the Risk.* Rockville, MD: American Council for Drug Education.

Crowley, T.J. 1988. "Learning and Unlearning Drug Abuse in the Real World: Clinical Treatment and Public Policy." In B. Ray, ed., *Learning Factors in Substance Abuse.* Research Monograph Series 84, DHHS Pub. No. (ADM)88-1576. Rockville, MD: National Institute on Drug Abuse.

Dole, V.P. 1988. "Implications of Methadone Maintenance for Theories of Narcotic Addiction." *Journal of the American Medical Association* Vol. 260, No. 20: 3025-29.

Ernster, Virginia, et al. 1990. "Smokeless Tobacco Use and Health Effects Among Baseball Players." *Journal of the American Medical Association* Vol. 264, No. 2 (July 11): 218-24.

Gary, L.E. 1982. *Religion and Mental Health in an Urban Black Community.* Washington, DC: Howard University, Institute for Urban Affairs and Research.

Greaves, Wayne. 1991. "Drugs and AIDS." In *Drugs Close to Home,* a special supplement of MESSAGE Magazine (ISSN 0026-0231). Hagerstown, MD: Review and Herald Publishing Association.

Hancock, David C. 1980. *Alcohol and the Church.* Minneapolis: Prevention of Alcohol Problems.

Hawkins, J.D., D.M. Lishner, J.M. Jenson, and R. Catalano. 1987. "Delinquents and drugs: What the evidence suggests about prevention and treatment programming." In B. Brown and A. Mills, eds., *Youth at Risk for Substance Abuse.* Rockville, MD: Alcohol, Drug Abuse and Mental Health Administration.

Hewitt, T. Furnman. 1988. *A Biblical Perspective on the Use and Abuse of Alcohol and Other Drugs.* Raleigh, NC: Department of Human Resources.

Hilton, Betty. 1989. "Parent Power: Keeping Our Kids Drug Free" Washington, DC: B'nai B'rith International.

Institute on Black Chemical Abuse. 1988. *Alcohol and Drug Abuse in Black America: A Guide for Community Action.* Minneapolis.

James, W. 1920. *The Varieties of Religious Experience.* New York: Longmans, Green and Company.

Jellinek, E.M. 1960. *The Disease Concept of Alcoholism.* New Brunswick: Hillhouse Press.

Jones, Dionne. 1976. "The Black Church: A Community Resource." Conference paper. Washington, DC: Howard University, Institute for Urban Affairs and Research.

Kelsey, M.T. 1983. *Companions of the Inner Way: The Art of Spiritual Guidance.* New York: Crossroad Publishing Company.

Kellerman, Joseph L. 1958. *Alcoholism: A Guide for the Clergy.* New York: National Council on Alcoholism.

Kleber, Herbert D., and Frank H. Gawin. 1987. "Cocaine Abuse: A Review of Current and Experimental Treatments." In John Grabowski, ed., *Cocaine: Pharmacology, Effects, and Treatment of Abuse.* Research Monograph Series 50, DHHS Pub. No. (ADM)87-1326. Rockville, MD: National Institute on Drug Abuse.

Koop, C. Everett. 1988. *The Health Consequences of Smoking: Nicotine Addiction, 8.* Washington, DC: U.S. Government Printing Office.

Leonard, Linda Schierse. 1989. *Witness to the Fire: Creativity and the Veil of Addiction.* Boston: Shambhala Publications, Inc.

Lettieri, D.J., et al., eds. 1980. *Theories on Drug Abuse: Selected Contemporary Perspectives.* Research Monograph Series 30, DHHS Pub. No. (ADM)80-967. Rockville, MD: National Institute on Drug Abuse.

Lusane, Clarence. 1991. *Pipe Dream Blues.* Boston: South End Press.

MacNutt, F. 1981. *The Prayer That Heals - Praying for Healing in the Family.* Notre Dame, IN: Ave Maria Press.

McAlpine, C. 1981. *Alone with God - A Manual of Biblical Meditations.* Minneapolis: Bethany Fellowship, Inc.

Menninger, Karl. 1973. *Whatever Became of Sin?* New York: Hawthorne Books.

Miller, Gary J. 1992. *Drugs and the Law: Detection, Recognition and Investigation.* Altamont Springs, FL: Gould Publications.

Moore, R.L., ed. 1988. *Carl Jung and Christian Spirituality.* Mahwah, NJ: Paulist Press.

Musto, David. 1973. *The American Disease.* New Haven, CT: Yale University Press.

National Drug Abuse Center for Training and Resource Development. 1978. *Drugs in Perspective.* DHHS Pub. No. (NDAC-TRD)79-015P. Rockville, MD: U.S. Department of Health and Human Services.

National Institute on Drug Abuse. 1987. *Drug Abuse and Drug Abuse Research: The Second Triennial Report to Congress from the Secretary of Health and Human Services.* DHHS Pub. No.(ADM)87-1486. Rockville, MD.

_____. 1991. *Drug Abuse and Drug Abuse Research: The Third Triennial Report to Congress From the Secretary, Department of Health and Human Services.* DHHS Pub. No. (ADM)91-1704. Rockville, MD.

_____. 1993. Epidemiologic Trends In Drug Abuse, NIH Pub. No. 93-3645. Rockville, MD.

O'Brien, Charles, P. 1988. "Treatment Strategies for Alcohol and Other Drug Abuse." Presentation made June 23, 1988. In *NIDA Capsules.* Rockville, MD: National Institute on Drug Abuse.

Office on Smoking and Health. 1989. *Reducing the Health Consequences of Smoking: 25 Years of Progress.* A Report of the Surgeon General. Washington, DC: U.S. Government Printing Office.

Office for Substance Abuse Prevention. 1991. *Prevention Plus III.* By Jean Ann Linney and Abraham Wandersman. DHHS Pub. No. (ADM)91-1817. Rockville, MD: U.S. Department of Health and Human Services.

Peterson, E.H. 1979. *A Year with the Psalms.* Waco, TX: Work Books.

Petersen, Robert C. 1991. *Childhood and Adolescent Drug Abuse: A Physician's Guide To Office Practice.* Rockville MD: The American Council for Drug Education.

Petrakis, P.L. 1985. *Alcoholism: An Inherited Disease.* DHHS Pub. No. (ADM)85-1985. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Pickens, R.W., and D.S. Svikis, eds. 1988. *Biological Vulnerability to Drug Abuse.* Research Monograph Series 89, DHHS Pub. No. (ADM)88-1590. Rockville, MD: National Institute on Drug Abuse.

Ray, O., and C. Ksir. 1987. *Drugs, Society, and Human Behavior.* St. Louis: Times Mirror/ Mosby College Publishing.

A Report of the Surgeon General. 1964. DHHS Pub. No. CDC 90-8416. Washington, DC: U.S. Government Printing Office.

Restak, R.M. 1988. "Addiction." In *The Mind.* Bantam Books: New York.

Ricaurte, G.A., et al. 1988. "MDMA Selectively Damages Central Serotonergic Neurons in the Primate." *Journal of the American Medical Association* Vol. 260: 51-55.

Ruiz, Pedra and John G. Langrod. 1992. "Substance Abuse Among Hispanic-Americans: Current Issues and Future Perspectives." In Joyce Lowinson, Pedro Ruiz, and Robert B. Millman, eds., *Substance Abuse: A Comprehensive Textbook.* Baltimore, MD: Williams & Wilkins.

Rule, S. 1984. "Church is at the center of life for a family proud of tradition." *New York Times,* September 20.

Scanlon, M. 1974. *Inner Healing.* New York: Paulist Press.

Secretary's Task Force on Black and Minority Health. 1987. *Volume 7: Chemical Dependency and Diabetes.* Washington, DC: U.S. Department of Health and Human Services.

Sheppard, Charles W., George R. Gay, and David E. Smith. 1972. "The Changing Patterns of Heroin Addiction in the Haight- Ashbury Subculture." *Journal of Psychedelic Drugs* Vol. 3, No. 2 (Spring): 22-30.

Shoemaker, Samuel M. *What the Church Has to Learn from Alcoholics Anonymous.* Clarkston, GA: National Episcopal Coalition on Alcohol and Drugs.

Springle, Pat. 1990. *Rapha's Twelve-Step Program for Overcoming Codependency.* Houston and Dallas: Rapha Publishing, Word, Inc.

Stoll, R.S. 1979. "Guidelines for spiritual assessment." *American Journal of Nursing* Vol. 25 (September): 1574-77.

Substance Abuse and Mental Health Services Administration. 1993. Preliminary estimates from the 1992 National Household Survey On Drug Abuse. Rockville, MD.

Svendsen, Roger. 1987. *Chemical Health: A Planning Guide for Congregations.* Center City, MN: Hazelden Educational Materials.

Tobler, N. 1986. "Meta-analysis of 143 adolescent drug problems: Quantitative outcome results of program participants compared to a control or comparison group." *Journal of Drug Issues* Vol. 16: 537-67.

U.S. Customs Service. 1988 (rev.). *Narcotic Identification Manual.* Washington, DC: U.S. Government Printing Office.

Vaughan, Clark. 1982. *Addictive Drinking: The Road to Recovery for Problem Drinkers and Those Who Love Them.* New York: Viking Press.

Whitfield, C.L. 1984. "Stress management and spirituality during recovery: A transpersonal approach, Part I: Becoming." *Alcoholism Treatment Quarterly* Vol. 1, No. 1: 3-54.

Woody, George E., and John Cacciola. 1992. "Diagnosis and Classification: DSM-III-R and ICD-10." In Joyce Lowinson, Pedro Ruiz, and Robert B. Millman, eds., *Substance Abuse: A Comprehensive Textbook.* Baltimore, MD: Williams & Wilkins.

Program Resources for Substance Abuse Ministries

The following materials are available from the National Pan-Methodist Coalition on Substance Abuse, c/o St. John's A.M.E. Zion Church, Tuskegee, AL.

"Revival of Hope: A Church Guide for Community Action on Drug Concerns" (basic leadership component). Twenty-minute video and viewer's guide illustrating current effective models of ministry.

"Making a Difference: A Church Guide on Alcohol and Other Drug Concerns" (assessment, awareness, action strategies).

Pan-Methodist Social Witness Resource Book (social witness/outreach ministries throughout the country).

"Resources to Be Our Neighbor's Neighbor" (drug abuse resources).

"Revival of Hope: Adults Making a Difference" (curriculum).

"Revival of Hope: Youth Making a Difference" (curriculum).

"Revival of Hope: Children Making a Difference" (curriculum).

· APPENDIX G ·

RESOURCES

Addiction Research Foundation
33 Russell Street
Toronto, Canada M5S 2S1
1-800-661-1111

Adult Children of Alcoholics
Central Services Board
P.O. Box 3216
Torrance, CA 90505
(213) 534-1815

Aerosol Education Bureau
1001 Connecticut Avenue, NW, Suite 1120
Washington, DC 20036

Al-Anon/Alateen Family
Group Headquarters
P.O. Box 862, Midtown Station
New York, NY 10018
(212) 302-7240; 1-800-334-2666

Alcoholics Anonymous
World Service Office
475 Riverside Drive
New York, NY 10115
(212) 870-3400

American Cancer Society
1599 Clifton Road, NE
Atlanta, GA 30329-4251
1-800-ACS-2345

American Council for Drug Education
204 Monroe Street, Suite 110
Rockville, MD 20850
(301) 294-0600; 1-800-488-DRUG (3784)

American Heart Association
7272 Greenville Avenue
Dallas, TX 75231
1-800-242-8721

American Lung Association
1740 Broadway
New York, NY 10019
(212) 315-8700

Andrews University
Institute of Alcoholism and Drug Dependency
Berrien Springs, MI 49104

Atlanta Masjid of Al-Islam
560 Fayetteville Road
Atlanta, GA 30316
(404) 378-1600

Bethel A.M.E. Church
1300 Druid Hill Avenue
Baltimore, MD 21217

B'nai B'rith International
1640 Rhode Island Avenue, NW
Washington, DC 20036
(202) 857-6582

Catholic Charities, USA
1731 King Street, Suite 200
Alexandria, VA 22314
(703) 549-1390, ext. 29

Child and Adolescent Service System Program
(CASSP) Technical Assistance Center
Georgetown University Child Development Center
3800 Reservoir Road, NW
Washington, DC 20007

Children of Alcoholics Foundation
200 Park Avenue
New York, NY 10166
(212) 949-1404

Christian Civic Foundation
Drug, Alcohol, Tobacco Education (DATE)
3426 Bridgeland Drive
Bridgeton, MO 63044
(314) 739-5944

Cocanon Family GroupsP.O. Box 64742-66
Los Angeles, CA 90064
(213) 859-2206

Congress of National Black Churches, Inc.
National Anti-Drug Campaign
1225 I Street, NW, Suite 750
Washington, DC 20005-3914
(202) 371-1091

Cork Institute on Black Alcohol and
Other Drug Abuse
Morehouse School of Medicine
720 Westview Drive, SW
Atlanta, GA 30310-1495
(404) 753-1780

DELMARVA Rural Ministries, Inc.
26 Wyoming Avenue
Dover, DE 19901

Families Anonymous, Inc.
P.O. Box 528
Van Nuys, CA 91408
(818) 989-7841

Families in Action
2296 Henderson Mill Road, Suite 204
Atlanta, GA 30345
(404) 934-6364

Florida Drug-Free Communities Project
Religious Leaders Response to Substance Abuse
9401 Biscayne Boulevard
Miami Shores, FL 33138

General Board of Church and Society of the United Methodist Church
100 Maryland Avenue, NE
Washington, DC 20002
(202) 488-5653

Glide Church
330 Ellis Street
San Francisco, CA 94102
(415) 563-8576

Hazelden Educational Materials
P.O. Box 176
Center City, MN 55012
1-800-328-9000

Howard University School of Divinity Clearinghouse
1400 Shepherd Street, NE
Washington, DC 20017
(202) 806-0500

Institute for Advanced Study of Black Family Life
155 Philbert Street, Suite 202
Oakland, CA 94607
(415) 871-7878

Institute on Black Chemical Abuse
2614 Nicollet Avenue
Minneapolis, MN 55408
(612) 871-7878

International Affairs Office
Church of Jesus Christ of Latter Day Saints
529 14th Street, NW, Suite 900
Washington, DC 20045
(202) 662-7480

International Commission for the Prevention of Alcoholism (ICPA)
12501 Old Columbia Pike
Silver Spring, MD 20904
(301) 680-6719

International Institute for Inhalant Abuse
799 East Hampden Avenue, Suite 500
Englewood, CO 80110
1-800-832-5090

Jewish Alcoholic and Chemically Dependent Persons and Significant Others
426 West 58th Street
New York, NY 10019
(212) 397-4197

Johnson Institute
7205 Ohms Lane
Minneapolis, MN 55439-2159
1-800-231-5165

Just Say No Foundation
1777 N. California Boulevard, Room 200
Walnut Creek, CA 94596
(415) 939-6666

Lutheran Church-Missouri Synod
Board for Social Ministry Services
1333 South Kirkwood Road
St. Louis, MO 63122
(314) 965-9000

Midwest Christian Counseling Center
Plaza Parkway Building, Suite 403
4620 J.C. Nichols Parkway
Kansas City, MO 64112

Minnesota Prevention Resource Center
Health Promotion Resources Division
Minnesota Institute of Public Health
2829 Verndale Avenue
Anoka, MN 55303

Mothers Against Drunk Driving
Central Office
669 Airport Freeway, Suite 310
Hurst, TX 76053
(817) 268-6233

Nar-Anon Family Group
San Pedro, CA
(310) 547-5800

Narcotics Anonymous
World Service Office
P.O. Box 9999
Van Nuys, CA 91409
(818) 780-3951

National AIDS Clearinghouse
1-800-458-5231

National Association for Children of Alcoholics
31706 Coast Highway, Suite 201
South Laguna, CA 92677

National Association of African Americans for Positive Imagery
3536 North 16th Street
Philadelphia, PA 19140
(215) 225-5232

National Association of Black Substance Abuse Workers
P.O. Box 201, Hamilton Grange Station
New York, NY 10031
(212) 234-1660

National Association of State Alcohol and Drug Abuse Directors
444 North Capitol Street, NW, Suite 530
Washington, DC 20001
(202) 783-6868

National Black Alcoholism and Addictions Council, Inc.
1629 K Street, NW, Suite 802
Washington, DC 20006
(202) 296-2696

National Black Organizations Against Alcohol and Drug Use
22 Chapel Street
Brooklyn, NY 11201

National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600; 1-800-729-6686

National Cocaine Hotline
1-800-COCAINE

National Council on Alcoholism and Drug Dependence, Inc.
12 W. 21st Street
New York, NY 10010
(212) 206-6770; 1-800-NCA-CALL (2255)

National Episcopal Coalition on Alcohol and Drugs
876 Market Way
Clarksston, GA 30021
(404) 292-2610

National Federation of Parents for Drug Free Youth 9551 Big Bend
St. Louis, MO 63122
(314) 968-1322

National Institute on Drug Abuse (NIDA)
Drug Abuse Treatment and Referral Hotline
1-800-622-HELP (4357)

National Prevention Network
444 North Capitol Street, NW, Suite 530
Washington, DC 20001
(202) 783-6868

North Conway Institute
14 Beacon Street
Boston, MA 02108

Office On Smoking and Health
Centers for Disease Control and Prevention
4770 Buford Highway, NE, MS K-50
Atlanta, GA 30341-3724
(404) 488-5705

One Church—One Addict
American Alliance for Rights and Responsibilities
1725 K Street, NW
Washington, DC 20006
(202) 785-7844

Parents Resource Institute for Drug Education (PRIDE)
50 Hurt Plaza, Suite 210
Atlanta, GA 30303
(404) 577-4500

Presbyterian Church Office of Health Ministries
Social Justice and Peacemaking Unit
100 Witherspoon Street, Room 3060
Louisville, KY 40202
(502) 569-5793

Prevention of Alcohol Problems, Inc.
4616 Longfellow Avenue South
Minneapolis, MN 55407-3638
(612) 729-3047

Rational Recovery Systems
P.O. Box 800
Lotus, CA 95651
(916) 621-2667

Search Institute
122 W. Franklin Avenue, Suite 525
Minneapolis, MN 55404
(612) 870-9511

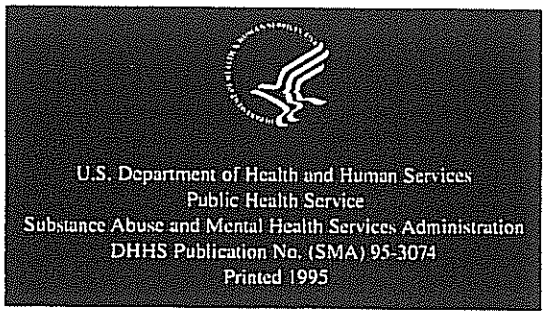
Solvent Abuse Foundation for Education
(SAFE)
750 17th Street NW, Suite 250
Washington, DC 20006
(202) 332-7233

Southern Christian Leadership Conference
Wings of Hope Anti-Drug Program
344 Auburn Avenue, NE
Atlanta, GA 30303
(404) 758-1517

St. Sabina Roman Catholic Church
1210 West 78th Place
Chicago, IL 60620
(312) 483-4300

Teen Challenge
National Office
1525 N. Campbell Avenue
Springfield, MO 65803

Urban Ministries, Inc.
1350 W. 103rd Street
Chicago, IL 60643



U.S. Department of Health and Human Services
Public Health Service
Substance Abuse and Mental Health Services Administration
DHHS Publication No. (SMA) 95-3074
Printed 1995