A MANUAL FOR PREVENTION SPECIALISTS

People of Faith
Partners in Prevention

Engaging the Faith Community in Substance Abuse Prevention

INTERFAITH CENTER FOR HEALTH ISSUES

The People of Faith, Partners in Prevention manual was designed to assist substance abuse prevention specialists to engage the faith community in substance abuse prevention.

The People of Faith, Partners in Prevention manual was written by Roger Svendsen, Associate Director for the Interfaith Center for Health Issues. The author wishes to acknowledge the significant contribution of Trish Merrill and Drew Brooks, Rush Center of the Johnson Institute, Jerry Jaker, Tom Griffin, Sally Mandler, Dawn Cedergren, Irene Lindgren and Tanya Prahl, of the Minnesota Institute of Public Health, and Reverend Gordon Grimm, Center City, Minnesota.

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Author's Note

It is my hope that substance abuse prevention specialists and others who work with any faith, spiritual, or religious groups or organizations will find these materials informative and useful. Tremendous diversity of spiritual expression exists in contemporary society. Faced with the difficult task of using language that, by its nature, tends to be exclusive, yet striving to be inclusive, I use broad definitions for terms in this document such as: faith community, religious organizations, spiritual groups, congregations and pastoral. Wherever I use those terms, I hope you will substitute whatever language is appropriate for your spiritual and/or religious experience or group.

Roger Svendsen

Contents

1 Introduction

3 Rationale for the Role of the Faith Community in the Prevention of Substance Abuse Problems

9 Substance Use and Abuse Problems Among People of Faith

13 Religion, Spirituality and Health

21 The Role of the Faith Community in Substance Abuse Prevention

27 Faith Groups' Beliefs about Substance Use and Abuse

45 Helping Members Establish Guidelines for Healthy, Safe and Appropriate Choices about the Use and Nonuse of Substances

55 Preparing Young People to Make Adult Choices

59 If Someone's Alcohol, Tobacco or Other Drug Use is of Concern, What Can Be Done?

63 Can the Faith Community Influence Social Norms

65 Conclusion

Additional Materials

71 Alcohol Concentration Worksheet

73 How to Have Fun Without Alcohol

75 Faith Partners and the Congregational Team Ministry

79 The Congregational Team Ministry Project Findings

87 A Congregational Checklist for Assessing Substance Abuse Prevention and Recovery Needs

89 Examples of Past and Current Efforts

91 Key Elements That Make a Congregational Plan Work

93 Links to Faith-based Organizations

95 The Faith Community and Substance Abuse Prevention and Recovery

97 The Faith Community and Alcohol, Tobacco and Illicit Drug Use

99 Substance Use Situations

101 Setting Guidelines for Substance Use and Non-use

105 Personal Guidelines for Use and Non-use

107 Family Guidelines for Use and Non-use

109 Citations

Introduction

The National Survey on Drug Use & Health published by the Substance Abuse & Mental Health Services Administration (SAMHSA) found that in 2002, about 8 million youth (33%) aged 12-17 attended religious services 25 times or more in the past year. More than 19 million youth (78%) reported that religious beliefs are a very important part of their lives, and 17 million (69%) reported that religious beliefs influence how they make decisions (SAMHSA, 2004).

Much of what community members learn about alcohol, tobacco and other drug use is conveyed through what the faith community says or does not say about it.

Substance abuse is a significant challenge within the faith community, not only for leaders involved in spiritual and pastoral care, but for all congregational members as well. Much of what community members learn about alcohol, tobacco and other drug use is conveyed through what the faith community says or does not say about it.

Faith-based organizations, because of their concern for their members and communities, have a long history of dealing with a wide range of substance abuse issues. Indeed, some believe that the treatment field, for example, has deep roots in America's churches. From the Interfaith Prevention Project in California, to Faith Partners in Texas, to projects in the rural South, congregations all over the country have developed formal substance abuse prevention programs (Merrill, 1999). Often, their activities have been linked with local coalitions comprised of other faith and community groups, including federally funded projects. Of all congregations in the U.S., 35 percent participate in coalitions with other organizations to address substance abuse in their community (Saxon-Harrold et al. 2000).

Prevention professionals solidified links with faith communities because they recognize the importance of faith and spirituality as deterrents to substance abuse. Faith institutions have the potential to touch a broader range of the community than other sectors because they reach people of all ages, economic levels and ethnicities. Joseph Califano, President and Chairman of the National Center on Addiction and Substance Abuse (CASA), comments that, "America has a unique and powerful tradition of religious commitment: 95 percent of our people believe in God and 92 percent are affiliated with a specific religion. Our nation is richly endowed with an astonishing array of churches and cathedrals, synagogues, Islamic centers and mosques, Hindu and Buddhist temples" (CASA, 2001).

The involvement of faith organizations in substance abuse prevention is important because:

- The presence of faith groups lends credibility
- Faith groups touch people of all ages, economic levels, and ethnicities and are able to mobilize them

- Members provide a sense of community to one another and accept that they have responsibilities to each other, their faith and themselves
- Members look to and respect the opinions and guidance of their faith leaders
- Faith groups exist in nearly every community
- Clergy and laity recognize substance abuse as an important issue among family members in their congregation
- There is support from congregational members
- They provide opportunities to work with families who might otherwise not be involved in prevention
- Religious beliefs and spirituality are protective factors in the prevention and treatment of substance abuse and in maintaining recovery

Whether in the suburbs or in the inner city, the drug problem provides an opportunity for the faith community to grapple with the great needs which face us. The fabric of many of our communities, prosperous and poor both, is being severly tested. Spiritual belief and moral vision are in want. The time is ripe for churches and synagogues to act, to re-assert their traditional role in the community.

—Dr. Herbert D. Kleber, MD Former Deputy Director for Demand Reduction, Office of National Drug Control Policy

Whether attempting to prevent or respond to existing problems, the role of the faith community in establishing values and guidelines and promoting moral and spiritual growth as well as spiritual healing cannot be overemphasized.

Although an environment of faith, support and mutual responsibility is ideal for dealing with substance abuse problems (that affect nearly everyone in our society), research indicates that the leadership of many congregations and religious organizations feels ill-equipped to deal with such problems.

These materials will assist you in your work with congregational leaders and leaders of religious organizations. During the course of your reading and this training, you will:

- identify the role of the faith community in substance abuse prevention
- identify the role of substance abuse professionals in working with the faith community on substance abuse prevention
- identify opportunities and barriers to faith community involvement
- learn about a model for developing a Congregational Team Approach to Substance Abuse
- learn about ways the faith community can work cooperatively with other community sectors to prevent substance abuse

Rationale for the Role of the Faith Community in the Prevention of Substance Abuse Problems

Faith Community Role

Current prevention research emphasizes the importance of multiple efforts by many sectors of the community, targeting people of various ages, addressing both individuals and the broader community environment, and sustaining efforts over time. In order to understand the impact of any specific prevention strategy (such as prevention within the faith community), it is prudent to consider it within the broader context of prevention efforts in the community at large.

Prevention strategies that show the greatest promise focus on change at multiple levels, including the family, social groups, local communities and broader society. These approaches advocate changing the broader environment across the whole population and are not simply targeted to those deemed to be at highest risk for substance use and related problems. This current perspective (i.e., that prevention effectiveness requires multiple efforts tailored to the needs, resources and readiness of different sectors of the community) suggests that the expected impact of any single prevention program is likely to be modest and, from a research standpoint, difficult to isolate.

The Larger Community

The following pie chart identifies a number of community sectors, each of which plays a unique and important role. Please note, however: community sectors are rarely found in equal pieces, working together as illustrated in this chart. Many communities are missing some components. In addition, some components are larger than others, and often they are disconnected. To maximize the potential benefits of prevention efforts, it is important to identify all the potential sectors within a community and begin the process of working together toward a shared goal.

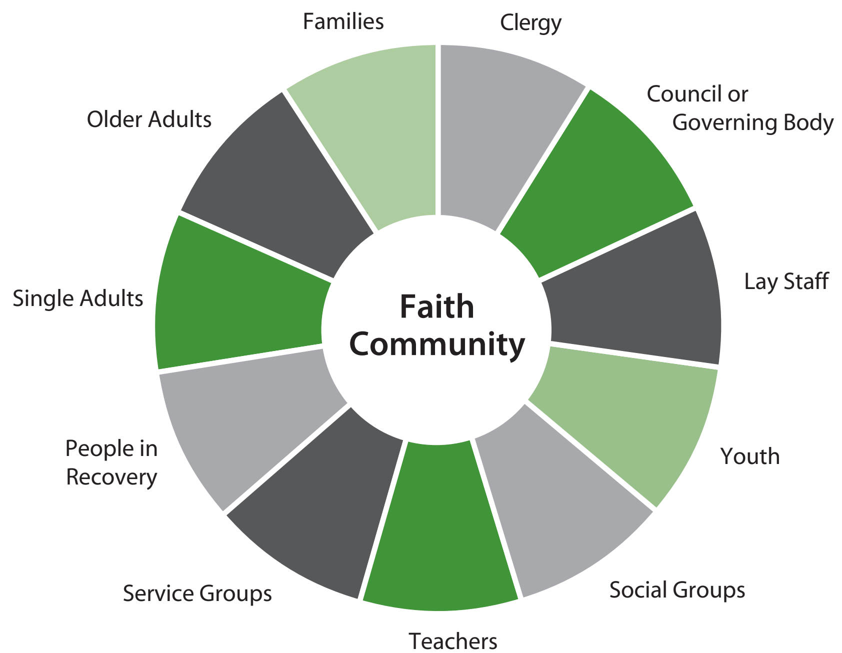
Religious groups and the government are the only two institutions that follow people from the cradle to the grave. As a result, the religious community has the potential to be the most significant force in the whole field of chemical health.

—Reverend Phil Hansen

Substance use results from the intersection of social influences (such as public policy, family, friends, availability, religious beliefs and traditions, and social norms) with personal factors (such as personality traits and biological or genetic characteristics). Planning efforts to prevent substance use and related problems must thus consider all social and personal factors in order to increase the likelihood that any given prevention program will be effective.

There is a similar need to involve multiple groups and individuals within the congregation. The faith community pie chart on the following page identifies a number of important individuals or groups within the congregation that have a role in planning and conducting an effective substance abuse prevention and recovery program

"A broad community approach to substance abuse prevention will hopefully facilitate both a meaningful dialogue and a better understanding of the role of faith, spirituality, and the importance of faith-based programs. The field (prevention) may need to adopt different paradigms in working with religious groups and institutions. Further, in assessing the value of faith-based approaches, a valuable point of departure might be a careful consideration of the medical research on faith, spirituality, religion and health." (Eduardo Hernandez-Alarcon, 2001.)



When the faith community is a nurturing, supportive community within which alcohol and other drug use issues and spiritual needs are addressed, problems can be identified and responded to, as well as prevented.

Those who report religious beliefs and involvement in religious activities also report lower rates of substance use. Whether the measure is attendance at worship services, importance of religion, parents' religiousness, participation in religious-based youth programs, frequency of devotional behavior such as prayer or scripture reading, or belief in life after death, the rule seems to be that any measure of religious sentiment or activity will be inversely related to substance use. This basic relationship has been reported among adolescents, college students, adults, males, females, African-Americans, Hispanics and among the population as a whole within each census region of the United States and Canada.

Clearly, the faith community can, and often already does, play an important role with regard to preventing substance abuse. It can:

- Provide assistance to congregational members and staff troubled by alcohol, tobacco or other drug use problems
- Help members develop personal guidelines for safe, legal and appropriate choices about substance use and nonuse
- Develop a framework for integrating and sustaining prevention and recovery strategies
- Help members understand the spiritual dimensions of substance abuse problems and prevention

- Work with other institutions and organizations within the community to design and implement community-based prevention efforts

As communities engage in the process of forming cross-sector partnerships to support youth and families (refer to the pie chart on page 5), religious institutions and their leadership need to be visible, present and active.

Community initiatives targeted at substance abuse prevention are enhanced when religious institutions support the initiative and also mobilize their own resources. Religious leaders should always be included in gatherings of community leaders. Coordinating prevention efforts with the faith community will reach audiences that otherwise would have been excluded.

No entity in American society is in a more strategic position to assist in affecting positive, planned social change in substance use and attitudes around its use than the faith community. When the faith community is a nurturing, supportive one within which alcohol and other drug use issues are addressed in concert with spiritual needs, substance abuse can be prevented and problems can be identified and responded to. Within such a context, the faith community can establish an appropriate and essential role in response to the immensely important and complex problem of preventing substance abuse problems.

Defining Terms

As we begin to examine the relationship between religion and spirituality and health, it is helpful to define the difference between religion and spirituality.

Dr. Kenneth R. Pelletier, Director of the Complementary and Alternative Medicine Program at the National Institutes of Health, writes in his book, *The Best Alternative Medicine: What Works? What Doesn't*, that spirituality is, "an inner sense of something greater than oneself, a recognition of a meaning to existence," while religion is, "the outward expression of spiritual impulses, in the form of specific religion or practice." (CSAT, 2001.)

The National Center on Addiction and Substance Abuse defines religion as being, "characterized by a set of particular beliefs about God or a higher power shared by a group of individuals, and the practices, rituals and forms of governance that define how those beliefs are expressed. Spirituality, on the other hand, is a deeply personal and individualized response to God, a higher power or an animating force in the world. One does not have to engage in religious rituals, belong to a church or even believe in God to be spiritual." (CASA, 2001.)

It is also helpful to define faith-based and science-based programs. Bill Bailey, former Director of the Indiana Prevention Resource Center provides the following descriptions:

Faith-based programs are programs supported by congregations and other faith communities. While it is likely that such programs are compatible with the shared values and service mission of the sponsoring organization, the programs may or may not be related to the religious doctrines of the sponsoring faith organization. A food pantry sponsored by a church, for example, likely will have no direct link to the church doctrine, but will simply be related to the church's mission to serve the citizens of its home community.

Evidence-based programs are approaches that have been developed and evaluated using scientific processes. These programs are grounded in a clear theoretical foundation and have been carefully implemented and evaluated. The evaluation findings have been subjected to critical review by other researchers and the program has been replicated in a variety of settings. Programs and approaches that are evidence-based have produced desired results in a number of different settings.

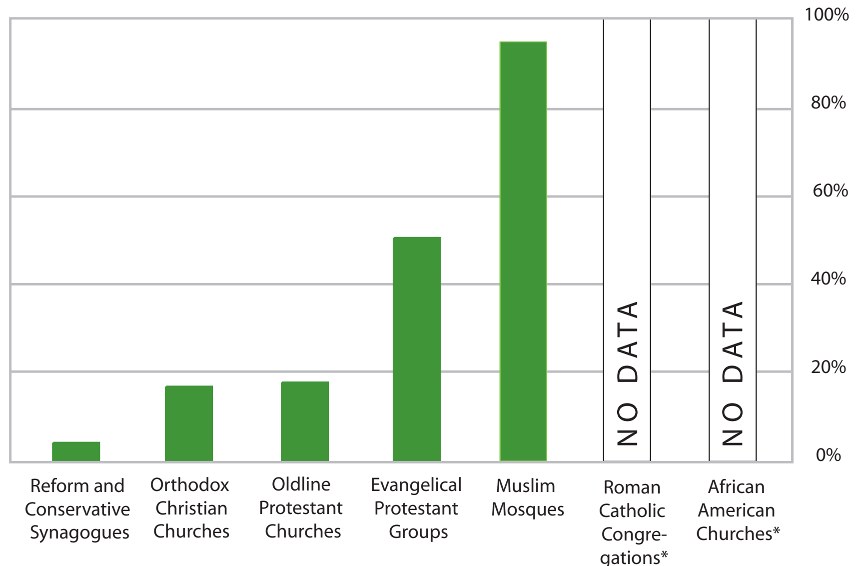
If a church selects an evidence-based prevention program for implementation in a church-sponsored afterschool program, then the resulting program is both faith-based and evidence-based. The two concepts are NOT mutually exclusive (Bailey, 2001).

Substance Use and Abuse Problems Among People of Faith

Substance use and abuse problems can be found among clergy and non-clergy alike, regardless of faith tradition or denomination. It is safe to assume that nearly everyone in our society has been affected either directly or indirectly by substance abuse.

The Faith Communities Today publication "Interfaith Facts" compares the beliefs, practices and vitality across Jewish, Christian and Muslim congregations in America. As the following table illustrates, the emphasis on abstinence from alcohol use varies among different faith groups.

ABSTINENCE FROM ALCOHOL



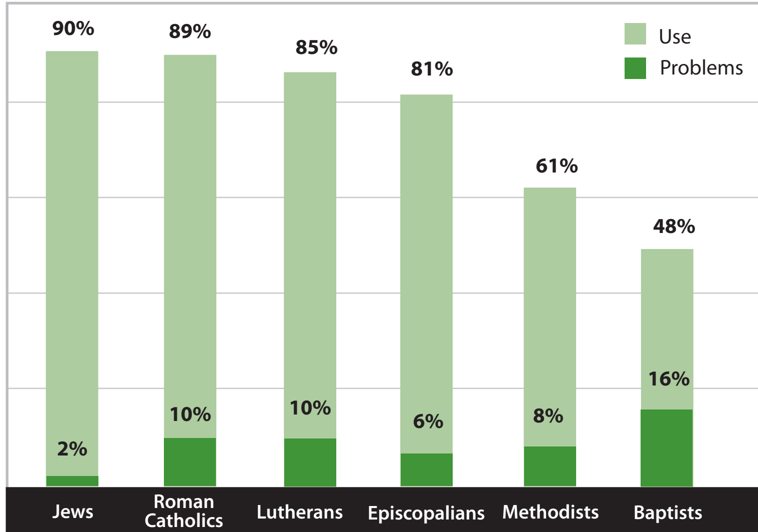
*Roman Catholic researchers omitted the question on abstinence because that is a well-known teaching of that church and African American researchers omitted this question because it was necessary for them to limit the number of questions.

SOURCE: HARTFORD SEMINARY, 2003

A study by Harold Mulford in the early 1960s compared the level of drinking problems among several major faith groups. The study found that 90 percent of Jews and 89 percent of Roman Catholics use alcohol, compared with 85 percent of Lutherans, 81 percent of Episcopalians, 61 percent of Methodists, and 48 percent of Baptists. Correspondingly, Roman Catholics and Lutherans each report a 10 percent rate of problem drinking among those who use alcohol. Among Episcopalians, the rate of problem

drinking is 6 percent, among Methodists 8 percent, among Jews 2 percent, and among Baptists 16 percent (Mulford, 1964).

DRINKING AND DRINKING PROBLEMS

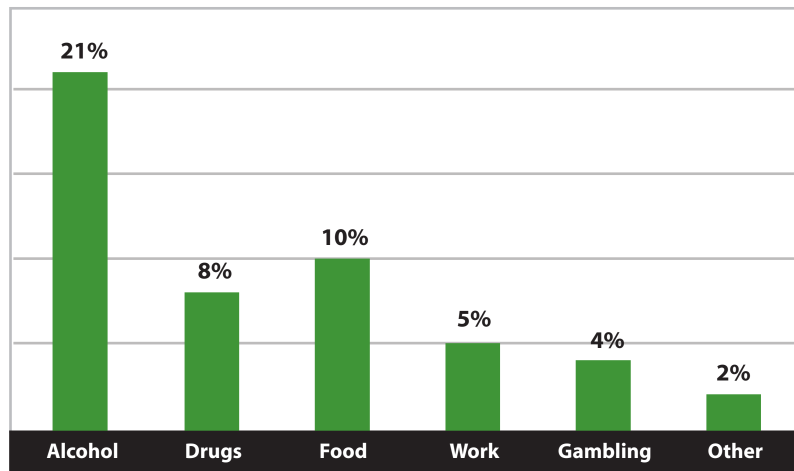


SOURCE: MULFORD 1964

A survey of 4,510 members in 23 Minnesota and Texas congregations by the Central Center for the Application of Prevention Technology (CAPT) and Faith Partners over a three year period from 1999-2002 found that:

- Over 21 percent of respondents reported a family member with an alcohol problem in addition to other problems
- Over 17 percent reported a family member in recovery from an addiction problem
- Over 4 percent were in recovery themselves

PERCENT REPORTING A FAMILY MEMBER WHO HAS A PROBLEM WITH…



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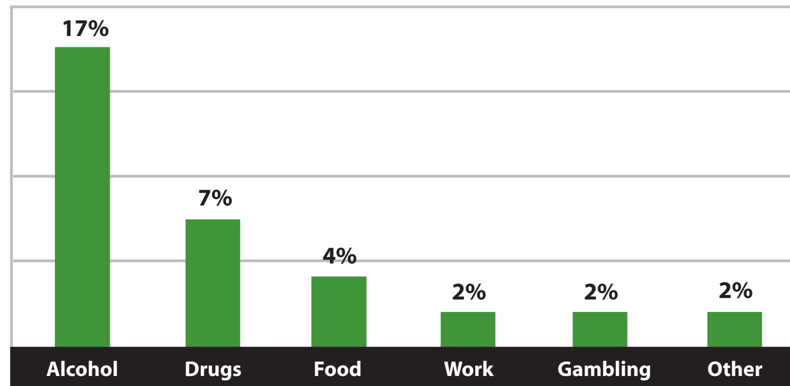
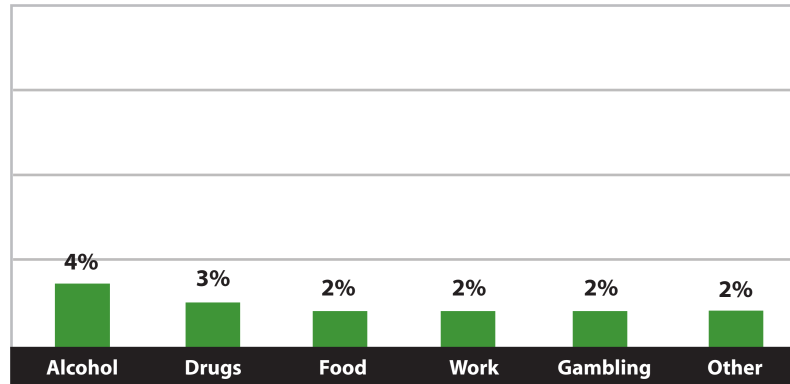
Congregational Team Approach (2003), CCAPT

PERCENT REPORTING A FAMILY MEMBER WHO IS IN RECOVERY FROM…



Congregational Team Approach (2003), CCAPT

PERCENT REPORTING THAT THEY ARE IN RECOVERY FROM…



Congregational Team Approach (2003), CCAPT

A 2001 national survey of clergy found that:

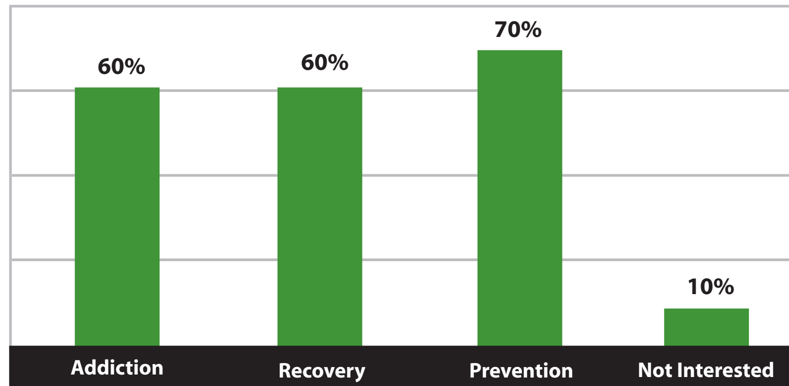
- 94 percent considered substance abuse to be an important issue they face
- 38 percent reported alcohol abuse in half or more of the family problems they confront (CASAM 2001)

Clearly, the misuse of alcohol, and the non-ceremonial use of tobacco, and the use of illicit drugs are significant problems that cut across age, racial, geographic, gender, cultural, religious, social and economic backgrounds.

Congregational Readiness for Prevention and Recovery

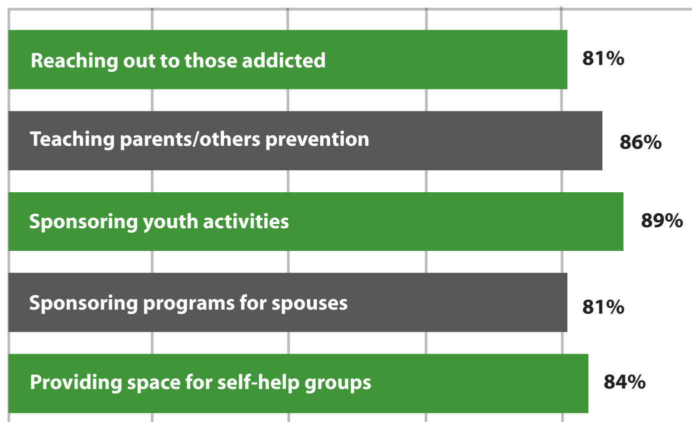
In addition to finding substance abuse problems among their members, the study of Minnesota and Texas congregations found overwhelming support for their congregation's involvement in prevention and recovery activities.

PERCENT WHO WOULD SUPPORT OUR CONGREGATION OFFERING EDUCATION PROGRAM AND RAISING AWARENESS ABOUT…



Source: CSAP's CCAPT (2003)

PERCENT WHO WOULD SUPPORT OUR CONGREGATION



Source: CSAP's CCAPT (2003)

Religion, Spirituality and Health

The spiritual connection between alcohol/drugs and healing/health is age-old. Shamans and other religious figures have delivererd health care for as long as human societies have existed. Wine and tobacco have been, and still are, integral to many religious rituals. In fact, throughout history, much of what communities learn about alcohol, tobacco and drugs is conveyed through what spiritual leaders say—or do not say.

It has only been within the past 200 to 300 years that physical disease has been understood outside of religious or spiritual terms, giving rise to the belief that healing is primarily, if not solely, a physical phenomenon. In that context, it's not surprising that our recent understanding of substance addiction as a disease has come with a reliance on medical models of treatment.

Fortunately, today we are seeing a resurgence of interest in the relationship between health and religion and spirituality. In 1990 for example, fewer than five medical schools in the United States offered courses on religion, spirituality and medicine. Today, nearly 80 of the 126 U.S. medical schools either require or offer such a course (Koenig et al., 2001). What is the appeal and scientific basis for such a revival?

In 1990 for example, fewer than five medical schools in the United States offered courses on religion, spirituality and medicine. Today, nearly 80 of the 126 U.S. medical schools either require or offer such a course (Koenig et al., 2001).

This renewed interest is due in part to mounting evidence from various empirical studies about the use of religion as a coping strategy associated with better psychological adjustment and better health outcomes. Although much more research needs to be done to determine whether religious practices actually cause better health, the findings to date are impressive (CSAT, 2001).

A considerable body of literature on the relationship between personal religiousness, spirituality and substance use has emerged since the mid-1970s. Among the more recent studies that examine this relationship are:

- *A Congregational Team Approach to Substance Abuse Prevention*. CSAP's Central Center for the Application of Prevention Technology (CAPT), Faith Partners and The Johnson Institute, 2003.

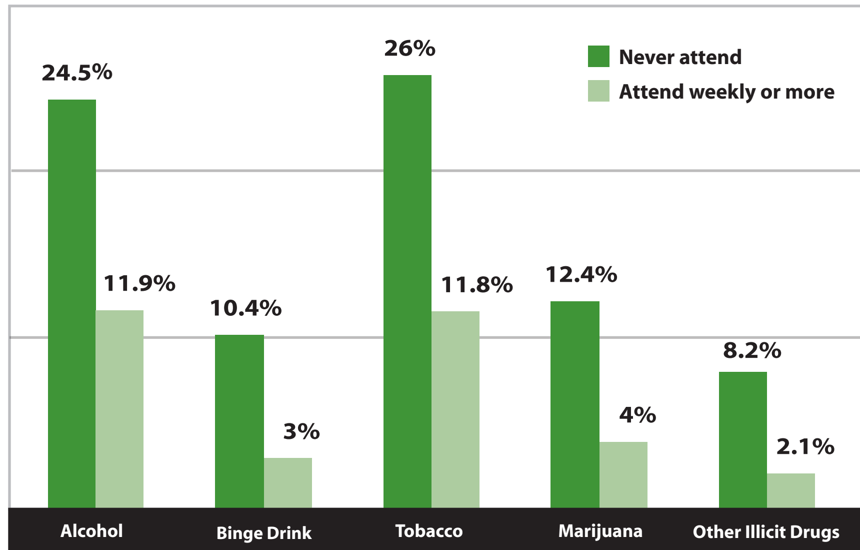
- *Handbook of Religion and Health*, by Harold G. Koenig, Michael E. McCullough and David B. Larson, Oxford University Prevention, 2001.
- *Healing Places: How Faith Institutions Can Effectively Address Chemical Dependency*, by Johnny Allem and Trish Merrill, The Rush Center of the Johnson Institute, 2004.
- *Religious Beliefs and Substance Use Among Youth*. The National Survey on Drug Use and Health Report. Office of Applied Studies, Substance Abuse and Mental Health Administration (SAMHSA), Washington, DC, 2004.
- *Religious Effects on Health Outcomes: A Literature Review*. Prepared by Logicon/ROW Sciences for the Center for Substance Abuse Treatment's (CSAT) Faith and Community Partners Initiative, National Focus Group Meeting. Washington, DC, 2001.
- *So Help Me God: Substance Abuse, Religion and Spirituality*. The Center on Addiction and Substance Abuse (CASA) at Columbia University, New York, NY, 2001.
- *Spirituality, Faith-based and Community Programs: Implications for Substance Abuse Prevention*, by Eduardo Hernandez-Alarcon. A report for the Division of State and Community Systems Development. Center for Substance Abuse Prevention (CSAP), Washington, DC, 2001.

Religion and Spirituality as a Protective Factor

Religion and spirituality can provide protection from substance use and abuse. According to Eduardo Hernandez-Alarcon, special expert for the Center for Substance Abuse Prevention (CSAP), "There is a substantial body of research that demonstrates positive relationships of spirituality and religiosity on physical and behavior health. These studies should interest substance abuse professionals both in the prevention and treatment fields because they document good health outcomes in areas related to alcohol abuse and drug use. This research indicates that faith and spirituality can decrease risk factors and enhance protective factors for the avoidance of substance abuse problems" (Hernandez-Alarcon, 2001).

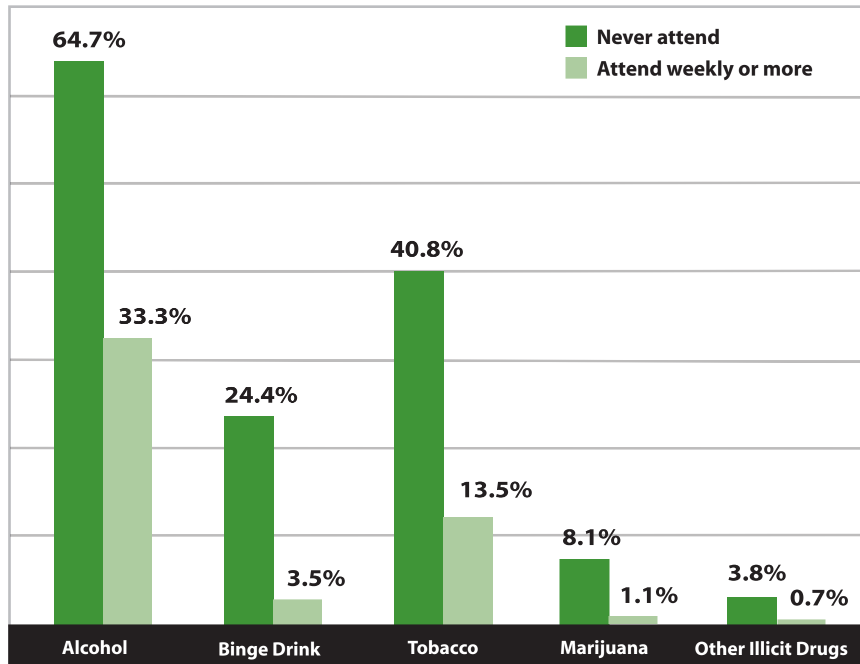
Additional evidence of spirituality and religiosity as a protective factor is found in CASA's analysis of National Household Survey data. These data reveal that among both adults and teens, those who attend religious services and feel that religion is important are less likely to use tobacco, alcohol, marijuana and other illicit drugs than those who do not attend religious services or do not feel that religion is important. See the four tables on the following pages for another representation of these data.

TEEN SUBSTANCE USE BY ATTENDANCE AT RELIGIOUS SERVICE



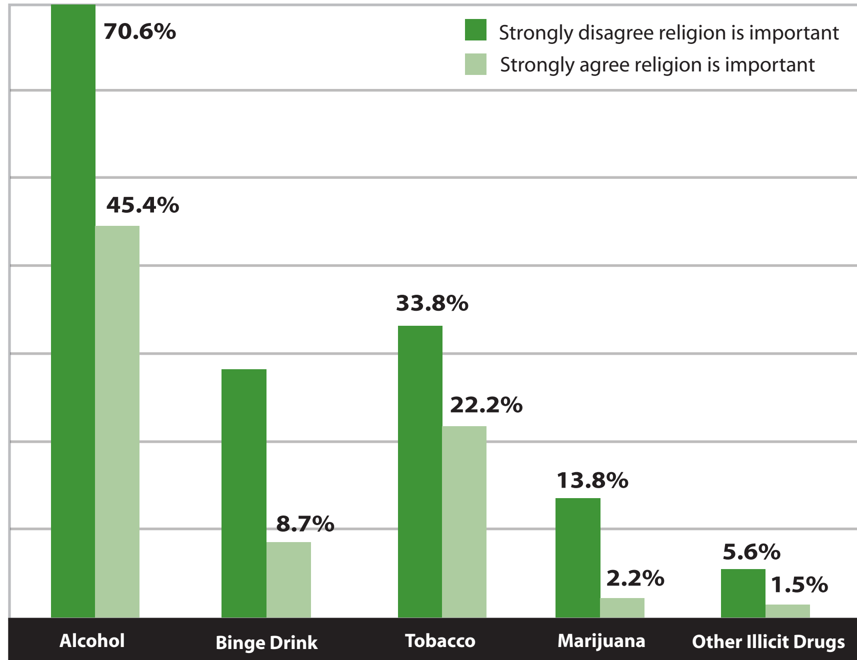
Source: NATIONAL HOUSEHOLD SURVEY, CASA (2001)

ADULT SUBSTANCE USE BY ATTENDANCE AT RELIGIOUS SERVICE



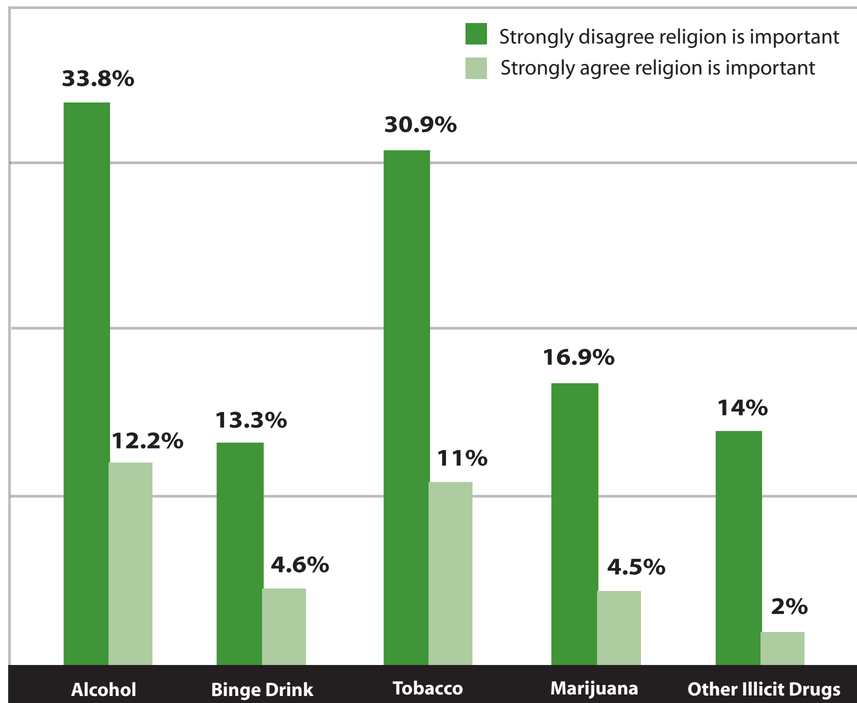
Source: NATIONAL HOUSEHOLD SURVEY, CASA (2001)

ADULT SUBSTANCE USE BY BELIEF IN IMPORTANCE OF RELIGION



Source: NATIONAL HOUSEHOLD SURVEY, CASA (2001)

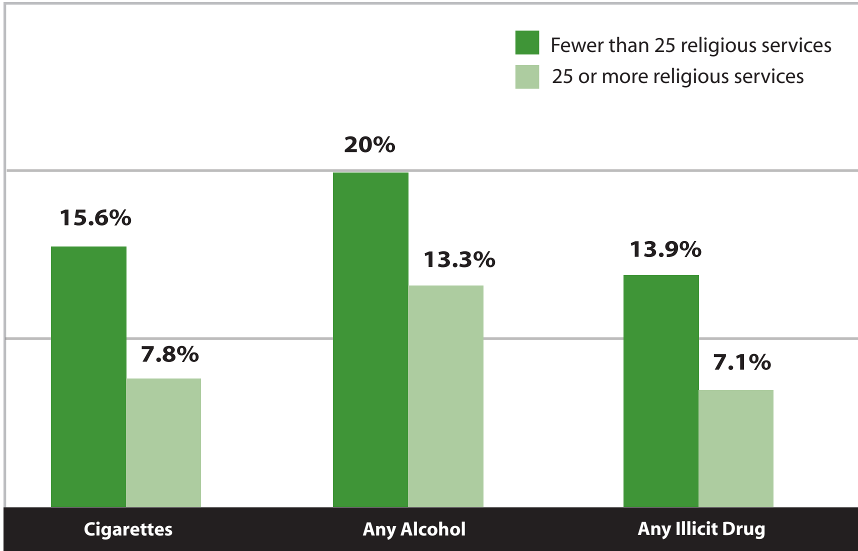
TEEN SUBSTANCE USE BY BELIEF IN IMPORTANCE OF RELIGION



Source: NATIONAL HOUSEHOLD SURVEY, CASA (2001)

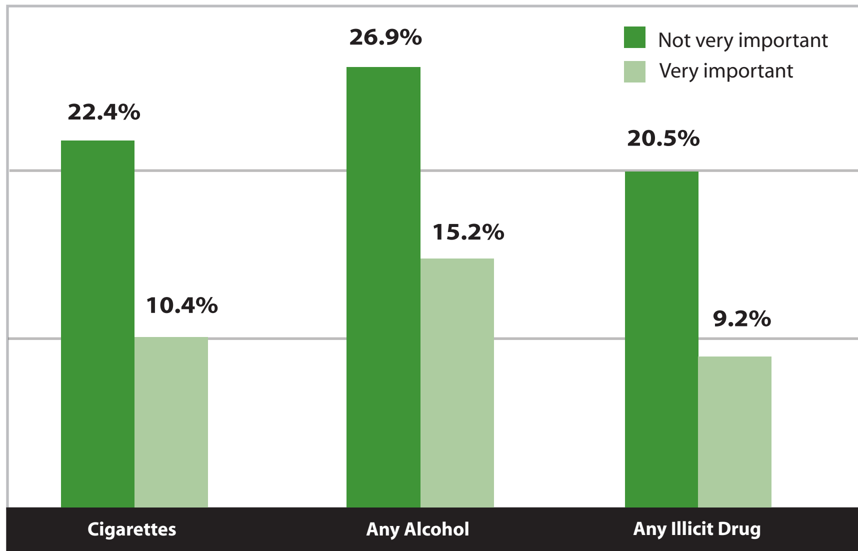
The following year's *National Survey on Drug Use and Health* (2002) found that youths aged 12–17 who attended religious services in the past year, reported that religious beliefs are a very important part of their lives. Also, those who reported that their religious beliefs influence how they make decisions were much less likely to have used cigarettes, alcohol or illicit drugs in the past month. These results are shown in the following three tables:

PERCENTAGES OF YOUTHS AGES 12 TO 17 REPORTING PAST MONTH SUBSTANCE USE BY PAST YEAR RELIGIOUS SERVICE ATTENDANCE: 2002



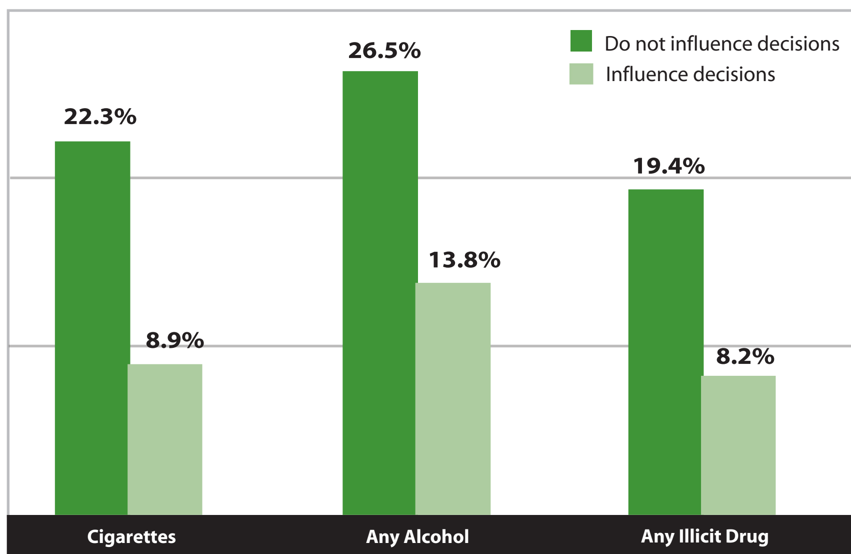
SOURCE: Substance Abuse & Mental Health Services Administration, 2004

PERCENTAGES OF YOUTHS AGES 12 TO 17 REPORTING PAST MONTH SUBSTANCE USE, BY WHETHER OR NOT RELIGIOUS BELIEFS ARE A VERY IMPORTANT PART OF THEIR LIVES: 2002



SOURCE: Substance Abuse & Mental Health Services Administration, 2004

PERCENTAGES OF YOUTHS AGES 12 TO 17 REPORTING PAST MONTH SUBSTANCE USE, BY WHETHER OR NOT RELIGIOUS BELIEFS INFLUENCE HOW THEY MAKE DECISIONS: 2002



SOURCE: Substance Abuse & Mental Health Services Administration, 2004

Beyond the link between belief in God, religious affiliation, spirituality and substance abuse, medical and social scientists have amassed a sizeable body of research demonstrating the beneficial effects of religion on a wide range of mental health measures, including depression, anxiety, coping with stress and personal well-being. Studies also have identified beneficial effects of religious and spiritual commitment of physical health, including life expentancy. Meditation, common in both religious and spiritual traditions, has been correlated with a variety of positive health outcomes. The benefit of religion seems to be linked to a nurturing and supportive religiousness rather than one that is "restrictive, negativistic and ritualistic" (CASA, 2001).

Ongoing prevention research continues to show that the faith community can be a critical link in the overall effort of substance abuse prevention. It also shows that religion and spirituality can provide protection from substance use and abuse, and that the faith community can reclaim an appropriate and essential role in responding to this immensely important and complex problem that historically has been left almost entirely to the secular world.

"The faith community is in a powerful position to effect changes in attitudes toward the use of illicit drugs, alcohol and tobacco. People of faith—including young people and their parents--often look to their religioius roots

and their fellow believers when grappling with life's problems. The values that religious communities promote and maintain are a solid foundation on which effective prevention programs can be built.

While the challenges of youth development are both immense and complex, the faith community is unusual in its ability to instill deep, lasting changes in people's lives. It's a unique environment, in part because it consists of people of different ages. In fact, many congregations are a 'sleeping giant' of possibilities for the creation of a 'community of caring' for youth.

Today our lives are often structured so that adults in the workforce spend most of their waking hours with other adults while young people are engaged in activities with youth their own age. Relgious communities offer one of the few places where large groups of unrelated adults and young people gather together. Weekly worship, Sabbath or prayer offer chances for encounters between ages—giving young people the chance to talk with not only adult congregation members but also those 'near' peers who are just slightly older." (ONDCP, 2003.)

The Role of the Faith Community in Substance Abuse Prevention

The faith community has two clear roles in dealing with substance abuse problems: prevention and recovery.

Prevention - As the word suggests, focuses on people who currently do not have identifiable alcohol, tobacco or other drug use problems. The objectives of prevention are to:

- Support abstinence as a safe, healthy and acceptable decision
- Delay the onset of first and experimental use of alcohol, tobacco and other drugs by young people
- Prevent the illegal use of alcohol and any use of tobacco (outside of ceremonial use by American Indians), any use of illicit drugs, or misuse of prescription drugs
- Prevent low-risk patterns of use from becoming high risk
- Reduce current high-risk patterns of use

"Health promotion at its essence is the action of God that makes us whole as individual persons and joins us together in community."

—Reverend Harold Hinrichs

The following are among the strategies faith communities can use to facilitate prevention efforts:

- Provide members with information to assist them in making healthy decisions about use and nonuse.

  While information alone is not likely to prevent problems, it is an important part of a comprehensive prevention effort. People of all ages need accurate information about alcohol, tobacco and other drugs and their effects. They also need to be exposed to individuals who model appropriate use and nonuse. Equally important is that people learn of their faith tradition's beliefs and teachings about alcohol, tobacco and other drug use.

- Teach members to identify and counteract social influences that encourage alcohol, tobacco or other drug use.

  Help people recognize the power of advertising, as well as the influence of friends or co-workers.

- Encourage and support alcohol, tobacco and other drug-free activities and events for members.

These activities go beyond physical skills, heavily stressing personal, social and spiritual dynamics.

- Provide members with instruction and practice in personal and social skills that resist pressures to use alcohol, tobacco and other drugs.
- Establish guidelines for safe, healthy and appropriate behavior for members within the congregation, their families, social institutions and the community.

    Congregations can provide opportunities for members of all ages to discuss and develop guidelines for legal and appropriate use and nonuse of alcohol and other drugs.

- Support prevention efforts within the broader community.

Recovery - Faith communities must also be prepared to address the issue of recovery. Because faith community leaders are involved in spiritual and pastoral care, it is easy to see their role in responding to individuals and families who are experiencing substance abuse problems. However, all faith community members can play a helpful role. Referrals, support groups, social action and community involvement are some examples of activities that help support individuals through recovery.

The objective is to create a safe, caring environment where members or other persons served by the congregation can share their concerns. The role of the congregation regarding recovery is to develop a system to:

- Create a safe environment where members can share concerns
- Communicate to members that there is hope and help for substance abuse problems
- Identify members needing assistance
- Respond or intervene in a positive, helpful and confidential way
- Match member needs to appropriate congregational or community resources
- Support the member and the member's family throughout the process of recovery

While some clergy and lay professionals are trained to assess and diagnose substance abuse and provide therapy or treatment, most faith communities rely on the resources of the larger community for these services. Congregations that have a thoughtful plan in place find it easier to respond, refer and support members and their families before, during and after treatment. Examples of how faith communities can show their willingness to help persons in recovery include:

- Hosting Alcoholics Anonymous, Al-Anon, and other 12 Step meetings
- Offering creative programs that support recovery and nurture spiritual healing and growth
- Planning a special day of prayer and educational activities
- Acknowledging and celebrating recovery from substance abuse in a visible way such as a "Recovery Sunday"

Faith communities have the opportunity and responsibility to themselves and society to exercise considerable influence over their members' use of alcohol, tobacco and other drugs. They can do this by forging comprehensive systems for dealing with issues of substance use and abuse and by developing programs that respond to the needs of their members.

Ministries of Recovery by Trish Merrill

Why do we need ministries of recovery for alcoholics, addicts and their families? One reason: they are there, in the midst of every congregation—lonely, frightened, uncertain and ashamed. Some may know they need help and don't know where to turn. Others have yet to name their affliction but know that something's wrong somewhere, in their own behavior or that of a spouse, parent, sibling or friend.

Unfortunately, many are not aware that chemical dependency is a disease—a serious, progressive illness that requires intervention and treatment. Recovery requires abstaining to halt the progression of the disease, surrendering to a Higher Power, and working with others to deal with the power of the dependency. With that understanding, clergy, with the support of congregational members, can provide appropriate pastoral care, referral information and support for healing. A ministry of recovery can offer people real hope.

Many congregations are also home to alcoholics, addicts and family members already working toward recovery. People often separate their recovery from their involvement in a congregation, keeping quiet out of a fear of being judged. A ministry of recovery offers them an opportunity to share their experience, strength and hope without shame, for the benefit of themselves, those who still suffer and for the good of the larger body. It presents those in recovery with both a unique opportunity for service and the chance to pursue their own healing with the support of their congregational family.

There's another reason for congregations to undertake ministries of recovery. Talking openly about alcohol and drug addictions offers a context

for talking about other addictions. It brings all members of a congregation to a gradual awareness that it's not 'us versus them'. We are more alike than different, addicts all, looking for meaning, searching for God, and endowing false idols with power over our lives. As the saying goes, "A church should be a hospital for sinners not a museum for saints."

People turn to clergy for help when they hurt. They would likely turn to clergy more often with their alcohol and drug-related problems if they knew their clergy and the congregation were sensitive to these problems and could respond to their needs.

A ministry of recovery offers a congregation an opportunity to rejuvenate its spiritual life by talking openly about the hardship of daily living, asking out loud, "Why am I here? What is the meaning of my life?" and struggling with the answers publicly. In so doing, a congregation offers its members support in their frailties and thus, the tools for preventing addictions in the first place.

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Barriers to Faith Community Involvement

Despite numerous opportunities for involvement, the faith community has been slow to assume a visible, active and unified response to substance abuse problems. A study of substance abuse, religion and spirituality found that:

- More than 94 percent of clergy recognize substance abuse as an important issue in their congregations
- 36.5 percent of clergy reported preaching a sermon on substance abuse more than once a year
- 22.4 percent say they never preach on the subject (CASA, 2001)

"It is not the malicious acts that will do us in but the appalling silence and indifference of good people."

—Martin Luther King, Jr.

The same study found that only 12.5 percent of clergy had completed any course work related to substance abuse while in seminary.

Jeannette Johnson, Director of the Research Center on Children and Youth at the State University of New York in Buffalo talks of a "wall of silence" that still stands between the faith community and people with alcohol and drug abuse and dependence, preventing faith communities from availing themselves of opportunities to help. (Substance Abuse and Mental Health Services Administration, 2004.)

Individual leaders may help develop intervention, treatment and aftercare programs, but little has been done to develop prevention programs in

congregations or prepare members to make decisions about substance use and nonuse. In a 1990 national study of Protestant congregations:

- More than half of the respondents felt that their congregations did not do a good job of helping members avoid alcohol or drug abuse
- Only 20 percent of the congregations incorporated content on alcohol and other drug use into their religious education programs (Search Institute, 1990)

A 'wall of silence' still stands between the faith community and people with alcohol and drug abuse and dependence, preventing faith communities from availing themselves of opportunities to help.

—Jeannette Johnson, 2004

Instead, the faith community most often turns over this responsibility to schools, government, law enforcement or health care providers, contributing to what has been referred to as a "conspiracy of silence" on the issue.
A number of factors contribute to this lack of unity in addressing alcohol and other drug use issues including:

Lack of agreement about the use and nonuse of alcohol. Historically, many members of the Christian and some other faith communities considered the use of alcohol to be a moral weakness, sin or personal inadequacy. For them, the only option was total abstinence. For others, in Jewish communities for example, using alcohol was accepted or actively promoted as part of the celebration of life, and any concern over problematic use of alcohol was confused with opposition to any drinking. Because enough members of faith communities identified the use of alcohol as a moral problem, they often became perceived as being highly judgmental. This resulted in confusion, inconsistency and ultimately a lack of involvement. (See Faith Group's Beliefs About Substance Use and Abuse beginning on page 27.)

"People just don't talk about drinking. They either do or they don't! But generally they don't discuss it, and those who do certainly do not discuss it with those who don't, and vice versa. There is a curious conspiracy of silence around the question of why, where, when, whether or how much."

—Bishop Roger Blanchard, 1979

The development of the understanding of chemical dependency as a disease. Ironically, the development of the understanding of alcoholism and drug dependency as a disease also contributed to the lack of involvement by the faith community. While reducing the stigma associated with alcoholism and drug dependency made it easier for persons to seek help, this focus on a medical model placed substance abuse beyond the direct concern and attention of many within the faith community. Yet, even within a medical model, the majority of treatment programs acknowledge the importance of the spiritual dimension. Alcoholics Anonymous and other spiritually-based 12-step programs are widely recognized as effective. However, the role of the faith community in relation to these programs and other community-based programs has yet to be defined. The result is that the faith community has had limited involvement in assisting persons afflicted with or affected by a disease with a significant spiritual dimension.

As the saying goes, a church should be a hospital for sinners, not a museum for saints.

Many congregations have not formally acknowledged the need to address substance abuse. This reluctance to take action can be a result of any number of factors including:

- The lack of education or preparation of clergy in seminary or field placement regarding the issue (the CASA study referenced earlier found that only 12.5 percent of clergy had completed any course work related to substance abuse as part of their clergy training)
- The demands on clergy and congregational leaders for involvement in competing initiatives or programs
- The stigma associated with alcoholism and drug dependency
- The ambiguity or lack of guidelines of many clergy and congregational leaders for their own use of alcohol
- Having had a negative experience when trying to help a family with substance abuse problems
- A genuine lack of awareness about substance abuse
- A lack of information on workable models for congregational response
- A perception that there is little support among congregational members to actively address substance use and abuse

While this historical lack of involvement is real, the fact remains that no institution offers a religious and moral heritage that acknowledges a person's self-worth so well as the church, synagogue, temple or mosque. With its emphasis on spiritual healing and growth, the faith community offers love and support, a chance to move from guilt to reconciliation, to build and strengthen relationships and renew one's trust in the future. All these factors support the need for the faith community to overcome barriers and to assume an active role in addressing substance use.

Faith Groups' Beliefs About Substance Use and Abuse

In order to guide efforts to prevent alcoholism and alcohol use problems, numerous efforts were made over the past century to answer the question, "What do we believe about substance use and abuse?" Reviewing some of these efforts can be helpful to prevention professionals working with the faith community.

In 1979, Bishop Roger Blanchard of the North Conway Institute wrote *A Plea for National Unity and Policy on Responsible Decisions About Alcohol.* In this, he discussed the silence, ambivalence and lack of action around the use of alcohol as follows:

> All too often, however, when we look beyond the care of alcoholics to those who are habitally drunk, those who have serious drinking problems, those who may very well have problems in the future, we find silence, ambivalence and a lack of action in any way commensurate with the gravity of the situation.

In his book, Bishop quotes Dr. Thomas Price who said:

> People just don't talk about drinking. They either do or they don't! But generally they don't discuss it, and those who do certainly do not discuss it with those who don't, and vice versa. There is a curious conspiracy of silence around the question of why, where, when, whether or how much.
>
> Bishop continues his analysis: "A curious conspiracy of silence" about drinking—apart from concern for the alcoholic—as though everyone else has a license to drink even as he wills!
>
> Why do you think this silence persists? Could it be that we are still suffering from a grievous hangover from the years of Prohibition, resulting in ambivalence about helping those who have an alcohol problem, but are not alcoholics? And we do nothing!
>
> Could it be that having been nurtured and weaned on the preaching of total abstinence from alcohol, we now avoid the issue, fearful that in order to be responsible we must either promote abstinence or nothing at all? So we do nothing!
>
> And, continuing this line of thought, could it be that given our disillusionment with the Prohibition experiment and apparently unaware or ignorant of any valid alternatives that could prevent, reduce and insofar as possible eliminate problem drinking, we do nothing?
>
> Or could it be that living in an age of complete permissiveness, we hesitate to appear critical of another's drinking habits lest he question ours, and do nothing?

How else do you account for the apathy, complacence and non-involvement on the part of almost all denominations at national or regional levels in positive programs reaching out to all those who abuse alcohol?

A recent survey of 15 so-called mainline churches revealed that only one has a department or division concerned exclusively with alcohol and other drugs. I know that many of you represent local efforts within your communion or community. And, to be sure, a number of denominations do include a portfolio for alcohol and drug-abuse among a number of other concerns heaped on one person seeking to fulfill the judgment, "Inasmuch as ye do it unto the least of these, my brethren, ye do it unto men." (Matthew 25:40)

This silence, this condoning of abuse by inactivity, is tragic because it means that we are left without any realistic standards of behavior concerning the use and non-use of alcohol for a very high percentage of our people.

In *Alcohol, Alcoholism and Social Drinking,* in 1958 the question of "Should a Person Drink or Not" is addressed. The following point of view was presented.

There is a point of view held by many Christians, which stands unequivocally against any use of beverage alcohol by any Christian. This stand against all drinking, even so-called moderate drinking, is summed up in the words of Henry Ward Beecher who said, "To speak about a moderate use of alcohol is like speaking of a moderate use of the plague." This absolute "temperance" point of view has been supported by a segment of Protestantism which began condemning all use of beverage alcohol in the late 18th Century, often defending its views with incorrect biblical exegesis in an attempt to force Holy Scripture into agreement with it. "Grape juice" is read into the Scripture, for example, instead of the plain words for "wine."

Other Christians have come out on a different side of this issue, however, and by far the majority of Christians have done so in the past and still do in the present. These people more nearly represent a traditional point of view of Christian ethics, a point of view which declares itself just as clearly against all abuses of beverage alcohol but which does not insist that the only remedy for this abuse is total abstinence for all Christian people at all times. This is the prevailing tradition of the Episcopal Church. We do not underestimate the disastrous consequences that arise from the misuse of alcohol. We agree with the worst pictures painted by reasonable men of the havoc that misuse of alcohol can cause, but ultimately we believe that each Christian man must make the decision himself as to whether or not he will drink alcoholic beverages. He should make his decision in the light of all the facts he can gather about

the nature of alcohol and its effects upon man and his relationships today, with awareness of the theological principles we have briefly summarized, and for reasons that are compatible with Holy Scripture.

When he makes his decision he should be well aware of the following excellent reasons in favor of total abstinence:

1. He may believe that his drinking is an offense to others who have been or may be hurt by alcohol, in accordance with St. Paul's advice to the Corinthians and Romans (I Corinthians 8 and Romans 14:21).
2. He may be an alcoholic or he may have some other illness that requires total abstinence.
3. He may believe that alcohol is a luxury that should be foregone.
4. He may want to exercise a discipline of fasting for a time, or permanently, as an act of devotion.
5. He may not like alcoholic beverages or his whole way of life may have never included it.
6. He may abstain for good occupational reasons, to insure optimum physical, mental and emotional efficiency.

In adopting total abstinence as a way of life for these or other reasons, however, a Christian must beware of insisting, either explicitly or by self-righteous demeanor, that he is following "a better way" and is thereby setting an example for other men to follow. Total abstinence is not necessarily "a better way" except for him and for the reasons he has chosen it, although the temptation for certain conscientious men to think otherwise is always great.

In 1952, C.S. Lewis wrote about alcohol use when discussing the Cardinal Virtues in his book *Mere Christianity*. In it, Lewis wrote:

Temperance is, unfortunately, one of those words that has changed its meaning. It now usually means teetotalism. But in the days when the second Cardinal Virtue was christened 'Temperance,' it meant nothing of the sort. Temperance referred not specially to drink, but to all pleasures; and it meant not abstaining, but going the right length and no further. It is a mistake to think that Christians ought all to be teetotalers; Mohammedanism, not Christianity, is the teetotal religion. Of course it may be the duty of a particular Christian, or of any Christian, at a particular time, to abstain from strong drink, either because he is the sort of man who cannot drink at all without drinking too much, or because he is with people who are inclined to drunkenness and must not encourage them by drinking himself. But the whole point is that he is abstaining, for a good reason, from something which he does not condemn and which he likes to see other people enjoying. One of the marks of a certain type of bad man is that he cannot give up a thing himself without wanting every one else to give it up. That is not the Christian way. An

individual Christian may see fit to give up all sorts of things for special reasons—marriage, or meat, or beer, or the cinema; but the moment he starts saying the things are bad in themselves, or looking down his nose at other people who do use them, he has taken the wrong turn."

***A Report of the Task Force on Alcohol Problems* conducted by the National Council of Churches of Christ in the USA in 1973 described the attitudes of churches at that time when it stated:**

Those church members traditionally oriented to abstinence have been most active, but their efforts have been handicapped by their apparent uncompromising opposition to all drinking. It seems to be the image of disapproval projected by these members, not their practice of abstinence as such, which has limited their effectiveness in such areas as ministry to alcoholics and their families and the stimulation of public discussion of alcohol use. This condemnatory image may well have enhanced the problem by reinforcing the stigma attached to alcoholism.

Those members without a doctrinaire position on abstinence have been reluctant to deal with any alcohol problems, except extreme uncontrolled drinking, for fear they would be perceived as opposed to all drinking. This non-involvement and seeming unconcern has limited the effectiveness of these members also.

The resulting polarization of attitudes has led to the same patterns of denial and neglect of alcohol problems by churches that are seen in the larger society. In this polarized situation uncritical attitudes toward alcohol and indiscriminate drinking practices have arisen and exaggerated claims about the unambiguous benefits of alcohol have flourished.

In 1977, the North Conway Institute, in cooperation with the Education Commission of the States published *Responsible Decisions About Alcohol: A Report to the Churches* at its 23rd Annual Assembly in Boston. The conclusion of the task force reads as follows:

Only two decisions exist that will result in the reduction of the incidence of alcohol-related problems. The first decision that can be reached is that the individual may choose not to drink.

A responsible decision for abstinence should be just that—a decision. There are some who do not use alcohol, yet they have never made a conscious decision about alcohol. They may follow a family custom or merely adopt the lifestyle of those in their circle of friends. These people may have difficulty when they leave their families to attend college, serve in the military or otherwise depart from an abstinence-oriented environment.

Although fear of alcohol problems may be involved in a responsible decision to abstain, fear is seldom a sufficient motivation. A responsible decision for alcohol nonuse involves more positive than negative reasons.

Responsible abstinence should involve conscious decision making, not merely a drifting or a "following of the crowd." The decision not to drink may be based on a wide range of reasons. Some people opt for abstinence for personal reasons; they may not care for either the taste or the effects of alcohol. Others may choose to abstain from alcohol for religious reasons. Still others may feel it important to establish an example of abstinence for people whose alcohol use might be harmful.

Cultural, social and family patterns may also become major reasons why some choose not to drink. When this is the case, a responsible abstinence decision would recognize which factors were influential in helping the individual to make a decision not to drink. People may choose not to drink prior to situations requiring the use of maximum physical and mental capabilities.

The task force also recognizes that certain individuals are so sensitive to the use of alcohol that the most responsible decision they can reach is to abstain from its use. This is particularly true for those individuals whose reaction to alcohol results in alcoholism.

Regardless of what reasons are involved, those who choose not to drink alcohol should do so freely without pressure or duress. Further, they should not attempt to impose that decision or the values surrounding the decision on others. A willingness to work with others who may not share the same views with relation to alcohol use and nonuse should characterize the responsible abstainer. Indeed, responsible abstinence should go beyond the willingness to work with others. It should extend into social situations that bring together persons with a wide range of attitudes and practices relating to alcohol use and nonuse.

The second decision which exists is that the individual may choose to drink responsibly. Assuring that all Americans arrive at one of these two important decisions is no easy task and will require much of the same kind of approach that our nation has adopted in implementing national policy regarding the educational opportunities offered our young. The task force is not suggesting that the same level of massive resources be set aside to deal with this problem. Rather, the task force recommends establishing a national policy that integrates all of the factors affecting our daily lives as the technique most likely to reduce the problems America is confronted with regarding the use or nonuse of alcohol.

Walter Brueggeman and Paul S. Minear examine Old and New Testament observations in *The Bible and Alcohol and Drugs: A Study Guide for the United Church of Christ Commission for Racial Justice Program to Combat Drug Abuse*. Excerpts from the study guide follow:

Enhancing Covenantal Faithfulness

Brueggeman writes that:

The Old Testament affirms that creation, as an expression of God's faithfulness, is to be enjoyed. Thus a life of responsible faithfulness is in deep touch with all of God's creation, eager to share fully in its good gifts.

The fruit of the vine is not singled out for special attention, but is most often listed among other gifts richly to be enjoyed. The Old Testament comes out of a culture in which wine was accepted as a normal part of life. There are no hang-ups about enjoying the goodness of life, and surely no distinction which can be maintained about fermented and unfermented grape juice. Brueggeman then cites several Old Testament texts and in summary says:

In these texts there is no hint of regret or censure. A life of fidelity embracing God's gifts is one which knows peaks of joy. Wine is regarded not as an artificial stimulant, but as an embrace of a normal gift. There is no need of special permit, no notion that it is out of the ordinary or unacceptable, no limiting sanction, because wine was responsibly utilized in the community of covenantal faithfulness.

Detracting from Covenantal Faithfulness

Brueggeman then follows with:

But the Old Testament knows that God's gifts are not only filled with potential delight; they are also fraught with danger. The danger of wine is that it diminishes the covenant-keeping capacity of persons and seduces them to act in unfaithful and destructive ways. Thus Amnon is rendered vulnerable by manipulation of wine (II Sam. 13:23-33). The use of wine often places people in danger, not because they themselves are destructive, but because they are unprotected and inordinately vulnerable to being used and exploited by others (see also Esther 1:10-12). The warnings however do not suggest wine is intrinsically bad, but that it works havoc in the community. The teaching is not absolute or doctrinaire, but is based on the observation of the power of wine to cause destruction, to diminish persons and to jeopardize community.

The Old Testament, out of hard experience, warns against the dangers. On the one hand, the warning is a common sense approach used by the writer of Proverbs, who has observed the problem on a practical basis.

New Testament Perspectives

Minear writes:

It may be that for many readers my treatment of New Testament perspectives has been too indirect to be of immediate use in wrestling with the urgent problems created by increasing use of alcohol and drugs. You want something more definite and practical, some dependable guidelines. Although I believe that the greatest contribution the New

Testament can make is by releasing among us a new powerful sense of vocation, I am also aware of the need for more specific directives. How, after all, did the leaders of the early church regard alcohol? To this I would answer: they neither discouraged nor prohibited the drinking of wine, if this was compatible with a Christian's own conscience as an expression of freedom/self-control, of hospitality/self-government, and of honesty/joy, those basic fruits of life in the family of Christ. How did they view drunkenness? It was generally, if not universally, discouraged as incompatible with those fruits and as a sign of rejection of life in that family. Drugs? Of modern drugs there is no mention. Of some drugs, what has been said of alcohol could be repeated. Of other drugs, what was said of drunkenness must be said. But the decisive appeal must always be to the nature of the Gospel and to the vocation of every Christian and every congregation.

The following is taken from the 1986 publication *Alcohol Use and Abuse: The Social and Health Effects, Reports and Recommendation by the Presbyterian Church*.

The Biblical Witness

Christians look to the Bible for reflection and help regarding social issues. Covenant community is a dominant theme throughout Scripture. God calls people together, establishes the covenant, and promises to be their God (Exodus 19:4-6a). The people, in turn, are to keep the covenant, follow the guidance of God, and be a light to the nations (Isaiah 42:6). The theme of covenant community is sustained through the Cross and Resurrection as we are called to be the body of Christ (I Corinthians 12:12-30). Therefore, the Scriptures speak to us as individuals, as a covenant community, and as the whole human society.

The great realities of covenant, liberation, sin and redemption, grace and shalom that dominate the Bible as a whole are the ground and context for both our understanding and our response to alcohol and its effects. Within those great realities, however, we need to examine briefly the specific biblical witness in regard to alcoholic beverages.

1. Wine is a commonly used alcoholic beverage. The Psalmist expresses joy that he has "wine to gladden the heart." (Psalms 104:15). Jesus himself drank wine, in contrast to John the Baptist, for his enemies accuse him of being a drunkard (Matthew 11:18-19). And on one occasion Jesus moved quickly to rescue the host at a wedding feast from the embarrassment of running out of wine by changing water into wine (John 2:1-11). Wine, of course, became a central part of the celebration of the Last Supper (Matthew 26:27).
2. But drunkenness is condemned in both the Old Testament and the New Testament. A classic description is found in Proverbs 23:29-35.

   "Who has woe? Who has sorrow?"

Who has strife? Who has complaining?
Who has wounds without cause?
Who has redness of eyes?
Those who tarry long over wine,
Those who go to try mixed wine.
Do not look at wine when it is red,
When it sparkles in the cup
and goes down smoothly.
At the last it bites like a serpent
and stings like an adder.
Your eyes will see strange things,
and your mind utter perverse things.
You will be like one who lies down
in the midst of the sea
like one who lies on the top of a mast.
"They struck me," you will say,
but I was not hurt;
"They beat me, but I did not feel it.
"When shall I awake?
"I will seek another drink."

3. Intoxication takes away understanding (Hosea 4:11), creates embarrassment and scandal among religious leaders (Isaiah 28:7), becomes the center of one's life (Isaiah 5:11, 22), and is something to avoid (Proverbs 31:4; 20:1; 23:21). Jesus condemns drunkenness (Luke 21:34) and Paul frequently puts drunkenness in the category of those "works of the flesh" that pull people away from a Christ-centered life (Galatians 5:21; I Corinthians 6:10, 11:17-22, and 5:11; Ephesians 5:18; Romans 13:11-14).
4. It is the overt conduct of intoxicated people that is condemned in the Bible. While scant attention is given to the reasons or motivation for excessive drinking, by inference it is judged to be self-centered and self-gratifying. It comes at the expense of a wholesome relationship to God and to neighbor. It destroys Shalom.
5. Leaders are singled out for special admonitions against intemperance. Kings ("shepherds") are criticized for wanting to fill themselves with wine and strong drink (Isaiah 56:11-12; Hosea 7:5). Priests and prophets who "reel" and "stagger" because of wine are condemned (Isaiah 28:7). Priests are not to drink while on duty in the Sanctuary (Leviticus 10:8-9; Ezekiel 44:21), and bishops are not to be intemperate (I Timothy 3:3; Titus 1:7).
6. Nowhere in the Bible is abstinence advocated as a general rule. However, there is mention of particular groups where it was practiced. We have noted above that priests are not to take intoxicating drinks

while officiating at shrines (Leviticus 10:8-9; Ezekiel 44:21). Nazarites are forbidden to drink intoxicants (Numbers 6:2-4, 20; and Judges 13:5-7). There are Rechabites who do not drink (Jeremiah 35), and John the Baptist did not drink (Matthew 11:18), but all of these are marked exceptions to the general pattern of common use of wine.

In summary, then, in today's terms, the Bible accepts the use of alcohol as a common practice, recognizes abstinence as a positive option, calls for moderation, and severely condemns excessive drinking.

In a position paper on *The Role of the Church in the Prevention, Intervention and Treatment of Alcoholism and Addiction* written by Patricia Merrill in 1982 for the Texas Council of Churches, the following biblical perspective on alcohol as well as the drug problem is offered:

In searching the scriptures, Dr. T. Furman Hewitt, in *A Biblical Perspective on the Use and Abuse of Alcohol and Other Drugs*, reflects that most of the 220 references to wine and strong drink in the Old Testament speak matter-of-factly of the beverage as a staple in the average person's diet along with wheat and oil. Wine was considered a gift of God, yet there are clear warnings against drunkenness. The New Testament clearly reflects the Old Testament's affirmation of the drinking of wine as a normal, accepted activity while at the same time warning of its potential misuse. Abstinence is not demanded, but drunkenness is condemned.

Hewitt points out differences that make it difficult to compare the ancient world and our world today. Wine was customarily diluted with water in the ancient world. Today, distilled spirits have an alcoholic concentration three to five times higher than undiluted wine. Also, people traveled by foot or by donkey in the ancient world. Today, our society is highly urbanized and mechanized, requiring good and accurate judgment and quick reaction time. These differences and others make it impossible for us to find the answers to the question of alcohol and drug use in the Bible in a proof-text fashion.

Paul wrote that we were not to pass judgment on our brothers and sisters, for both those who eat and those who abstain from eating certain foods were to do so in honor of their Lord. The believer is called to walk that ill-defined but narrow and necessary line between personal freedom and responsibility to the neighbor. Our struggle is to ask what it means to be a loving servant in the twentieth century.

Hewitt, recognizing there are no easy answers, recommends that individuals and institutions commit themselves to study the complex issues surrounding the use of alcohol and other drugs and attempt to make decisions that are responsive to God as Creator, Judge and Redeemer. As Creator, God has declared the elements of this world to be good within the limits of their own makeup and functions; therefore, a substance cannot be easily dismissed as evil in itself. As Judge, God calls us to repent of our mishandling of his creation, our humanity, and our

freedom. As Redeemer, God reaches out in a consistent loving way to those who seemingly least deserve his compassion.

The Drug Problem

Although churches have not been united in addressing the use and abuse of alcohol, they are undoubtedly together, although not vocal, in opposition to drug abuse, if that is defined as the use of illegal drugs. The issue is not that simple, however, since there is a growing trend toward depending on a variety of drugs—both legal and illegal—as a solution to everyday problems.

According to Dr. Herbert Ratner, editor of *Child and Family Magazine*, "We Americans are the most over-medicated, over-operated, over-inoculated people in the world. We have been brainwashed into believing that there is a pill, nostrum, or potion which will remedy any trouble, be it headache, insomnia, fatigue, depression, loneliness, anxiety, tension, flat feet, or body odor… And we have effectively taught this to our children."

The incidence of substance abuse knows no racial, cultural, or socioeconomic boundaries. Whether it be children sniffing glue, youth smoking pot, young adults injecting heroin, celebrities sniffing cocaine, housewives ingesting pills, businessmen consuming large amounts of alcohol, older people abusing over-the-counter or prescription medication or doctors overprescribing drugs, the addictive process is at work, and damage to individuals and families frequently occurs.

The question of alcohol and other drug use is more complex than simply use versus nonuse. Rev. John Keller, Chief Clinical Officer, Parkside Medical Services, Lutheran General Health Care Systems in Park Ridge, Illinois, is quoted from his introductory address to the American Lutheran Church Chemical Health Conference in Roger Svendsen's 1986 book *Chemical Health: A Planning Guide for Congregations*. Keller said:

Chemical health means that there is such a thing as healthy use as well as nonuse. But it means more than that. It means alcoholic beverages are affirmed as part of God's creation—God's goodness and good gifts to use—and that drinking alcoholic beverages is affirmed as part of life's enhancement and enjoyment."

The Reverend Thomas E. Price provided a bit of humor when he wrote the following in "Responsible Decisions About Alcohol: A Report to the Churches" in 1977:

"Underlying the controversy is the deep division in this country over the subject of alcohol. Alcohol is not a neutral substance. Unlike tea or aspirin, we do not view it dispassionately. Alcohol is a meaningful substance. The use or nonuse of alcohol means something—good or bad, right or wrong. Whether you use or don't use alcohol says something about your self-identity. We do not take alcohol for granted!

Nowhere in the confusion over the use of alcohol more apparent then in the following speech attributed to a Southern Congressman who received a letter from a constituent demanding to know, HOW DO YOU STAND ON WHISKEY?

Knowing that his constituency was divided on this volatile subject, the Congressman framed his reply as follows:"

"I had not intended to discuss this controversial matter at this time. However, I have never shunned a controversy and I will take a stand on ANY issue at ANY time. You ask me how I stand on whiskey. Here is how I stand:

"If, by whiskey, you mean the devil's brew, the poison scourge, the bloody monster that defiles innocence, dethrones reason, destroys the home, creates MISERY and POVERTY—yea, literally takes bread from the mouths of little children—If you mean the evil drink that topples Christian man and woman from the pinnacles of righteous and GRACIOUS living into the bottomless pit of DEGRADATION, DESPAIR, SHAME, HELPLESSNESS, AND HOPELESSNESS—then I am against it with all my power!

"BUT," the letter went on, "if when you say whiskey, you mean the OIL OF CONVERSATION, the philosophic wine, THE ELIXIR OF LIFE, the ale that is consumed when GOOD FELLOWS GET TOGETHER, that puts a SONG IN THEIR HEARTS and LAUGHTER ON THEIR LIPS, and the warm glow of contentment in their eyes—If you mean Christmas Cheer, the stimulating sip that puts a little spring into the step of an elderly gentleman on a frosty morning—If you mean the drink that ENABLES MAN TO MAGNIFY HIS JOY AND HAPPINESS, and to FORGET, if only for a little while, life's great tragedies, and HEARTBREAKS AND SORROW—If you mean that drink, the sale of which pours into our treasuries untold MILLIONS of dollars that provide tender care for our LITTLE CRIPPLED CHILDREN, OUR BLIND, OUR DEAF, OUR DUMB, OUR PITIFUL, aged and infirm—to build HIGHWAYS, and HOSPITALS, and SCHOOLS—then certainly I am in FAVOR of it. This is my stand.

AND I WILL NOT COMPROMISE."

Several years ago in Minnesota, the Governor's Interfaith Task Force on Chemical Health, made up of representatives of the Catholic, Protestant and Jewish faiths, recognized the need to examine the theological basis for choices about alcohol and other drug use and nonuse in our society. The task force prepared a *Statement of Values and Intent* as a formal statement of its beliefs with regard to alcohol and other drug use and the role of the religious community. The Task Force intended for the *Statement of Values and Intent* to serve as a starting point for discussion in local congregations. The following is a result of their discussion and careful efforts to draft an interfaith position from which other churches and synagogues could begin:

A common and basic teaching of many religious traditions is that human beings are made in the image and likeness of God. This likeness is to be found in the operation of one's intellect and will. Misuse of chemicals clouds and diminishes the proper use of these God-like functions.

We believe that all of God's creation is "good." The intention and purpose of acknowledging God's creation as "good" is that people might live in purposeful harmony with all of life. We are accountable to God, to our community and to society to care for ourselves and for each other.

We need to develop a workable understanding of lifelong health development. Health, as a concept, has a common derivative to "holy," "whole," "heal" and several related terms. We are created as whole persons who are individually named and known by God. Our personhood is a combination of body, spirit, feelings and ideas with God-given right and authority to express ourselves to each other in care and service. We are called to love God and our neighbors with all our heart, soul, mind and strength. The misuse of God's good gifts can impair our ability to fulfill this calling.

Our religious traditions assume that we have the power and freedom to make individual decisions about the use and nonuse of all God's gifts, including chemicals. As with all of God's creations, chemicals are neither good nor bad but the way they are used determines their potential benefits or risks. For example, wine is used in celebration rituals within many worshipping communities of Jews and Christians, but at the same time, is regularly misused by problem drinkers.

The wise and healthful use of chemicals in all of life becomes each person's responsibility. Chemical health is a state of spiritual, physical, emotional and social well-being that exists as a result of a lifestyle which includes responsible decisions about chemical use and nonuse.

We live in a drug-oriented society which promotes the concept of "instant relief or gratification" which is inconsistent with the experience of lifelong growth, composed of natural highs and lows. Stress, suffering, grief, and physical, spiritual and emotional pain are realities that cannot be avoided. While there are uses for some mood-altering drugs, never-

theless, to use alcohol and other drugs for the means of coping with life's everyday problems—to search for insight, for feelings of worthwhileness, for love, for creativity, for self-realization—to search for these through chemicals is unrealistic, inappropriate and can lead to dependency or addiction. The inappropriate use of chemicals can deprive a person of the greatest opportunities for spiritual-human growth and deepening. Physical, spiritual and emotional pain, bravely and nobly borne, can often deepen one's compassion for other's sufferings. Indeed, the use of a drug, like alcohol, to handle life's problems can actually interfere with one's own ability to deal with them. The temporary euphoria it gives can sabotage attempts to deal with them more realistically. There are no shortcuts to honest, responsible living.

The basic issues involved in the promotion of chemical health and the prevention of chemical use problems are uniquely within the religious community's area of special expertise; namely, the meaning of life, the search for God and reality, and the need for honest, responsible living. The religious community can provide the milieu of caring persons within which authentic acceptance and reconciliation are possible, and within which each person's self-worth is acknowledged and nurtured.

The following is an excerpt from *A Précis On Chemical Health* authorized by participants of the American Lutheran Church Chemical Health Conference in 1983 and subsequently adopted by the church council for comment and counsel throughout the American Lutheran Church.

II. We Believe:

a. That the Christian is called to respond to God in faith, love, and obedience. Response assumes the careful use of creation's gifts. In Christ we have freedom to use all the gifts of creation which can include a careful and responsible use of legal substances. Enhancement and enjoyment of life are parameters; impairments of life, ours and others, constitute perimeters. When dealing with the traumas and stress of life, latitude to use prescribed mood-altering substances therapeutically must be deemed reasonable and of value.

b. That to use legal mood-altering substances in any way that violates our creatureliness (createdness) or subverts our ultimate trust in God, is both disobedience and idolatry. In a wide variety of situations, adults and youth distort, disrupt, and destroy their own humanity and relationships with others by inappropriate use of mood-altering substances. But these people and those who live with addiction are not more sinful or different than others. All such behaviors and conditions manifest the common human condition of estrangement. Like all God's people, they need to assume responsibility for recovery and newness of life as they hear of the help and hope that is available for them within and outside the services of the church.

In 1993, the Presbyterian Church in The USA issued *Substance Abuse: A Handbook for Young People.* Its introduction reads as follows:

> Jesus' first miracle was to turn water into wine for the celebration of love at a wedding in Cana. The image of happy people sipping champagne at a wedding reception is one image of the goodness of which wine can be a part. This type of use of alcohol is called "problem-free" drinking.
>
> Unfortunately, though, every good thing can be misused. Scripture does not condemn wine, but it is critical of drunkenness. As Jesus puts it, "Be careful not to let yourselves become occupied with too much feasting and drinking and with the worries of this life…" (Luke 21:34a, TEV)
>
> Jesus warns us to "be careful." Being careful means, for each of us, finding the delicate balance point of responsible behavior in relation to the use of drugs and alcohol. The way people drink, the decisions they make about drugs and alcohol, reflect what they believe. In this handbook we will talk about faith, feelings, and those decisions.

A Roman Catholic perspective is provided by Father John Ford, writing in 1961 about spiritual athletes in his book *What About Your Drinking?*

> *Spiritual Athletes.* We have to exercise ourselves spiritually, like athletes training for a contest, in order to practice virtue. St. Ignatius, in his little book of the *Spiritual Exercises*, begins with his famous *Principle and Foundation:* "Man was created to praise, reverence, and serve God, Our Lord, and thereby save his soul. And the other things on the face of the earth were created for man's sake, and to help him in the following out of the end for which he was created. Hence it follows that man should make use of creatures so far as they help him toward this end, and should withdraw from them so far as they are a hindrance to him in regard of that end."
>
> Beverage alcohol is one of those "other things on the face of the earth," a creature which man should make use of so far as it helps him, and withdraw from so far as it hinders him in his journey back to God. It is not one of those things that is in itself forbidden to the liberty of our free will, such as stealing or lying.
>
> Alcohol is neither morally good nor morally bad; it is morally indifferent, or morally neutral in itself. But since it is a creature extremely attractive to sense appetite, it is dangerous.

Barbara Binder Kadden in a *Family Shabbat Table Talk* on the website of the Union for Reform Judaism discusses Judaism's mixed messages about alcohol (downloaded June 1, 2006 from http://urj.org/PrintItem/index.cfm?id=2152&type=Articles).

> Ezekiel warned the priests not to drink in the inner courtyard of the Temple in Jerusalem. Furthermore, Ezekiel warned, never drink when leading the rites and the rituals associated with the Temple service.

Nadav and Abihu, sons of the first High priest, Aaron, died a sudden and mysterious death when they brought an "alien fire" as a sacrifice (Leviticus 10:1). In the verses following this tragic event, the Torah commands the priests: "Drink no wine or other intoxicant, you or your sons with you, when you enter the Tent of Meeting, that you may not die—it is a law for all time throughout the ages (Leviticus 10:8). Because these verses immediately follow the section on the deaths of Nadav and Abihu, some commentators have suggested that these men were inebriated and thus made an inappropriate sacrifice leading to their deaths.

The priests were not commanded to abstain completely from intoxicants, but they had to abstain when they were to carry out their duties. This law is repeated by Ezekiel. What the Torah and Ezekiel did, was to establish boundaries for appropriate behavior.

Interestingly, wine is also described in celebratory terms in the biblical text: "Wine gladdens *Adonai* and men" (Judges 9:13); "Wine cheers the heart of humankind" (Psalms 104:15); "They make a banquet for revelry; wine makes life merry…" (Ecclesiastes 10:19)

Jews begin Sabbath and holiday celebrations with a blessing over wine—the *Kiddush* as a symbol of joy and gladness. Many other significant moments in the life cycle include the blessing and drinking of wine.

Rabi Huna asserted that drinking wine helps to open the heart to reasoning. (Talmud, *Baba Batra* 12b) and wine in moderation whets the appetite and is beneficial to health (Talmud Berachot 35b).

Beyond the story of Nadav and Abihu, there is further biblical evidence that wine and other intoxicants should be handled carefully. One of the most pointed examples of the potential danger of wine comes from the book of Proverbs 23:29-35:

"Who cries, 'Woe!' who, 'Alas!';
Who has quarrels, who complaints;
Who has wounds without cause;
Who has bleary eyes?
Those whom wine keeps till the small ours,
Those who gather to drain cups.
Do not ogle that red wine
As it lends its color to the cup,
As it flows on smoothly;
In the end, it bites like a snake;
It spits like a serpent.
Your eyes will see strange sights;
Your heart will speak distorted things.
You will be like one lying in bed on high seas,
They struck me, but I felt no hurt;
They beat me, but I was unaware;
As often as I awake,
I go after it [a drink] again."

From the Talmud we learn that it was a positive injunction to get drunk enough on Purim so that one could not distinguish between "Blessed be Mordechai" and "Cursed be Haman." Later rabbinic authorities pointed out that this Talmudic attitude was not to be taken literally (*Encyclopedia Judaica* Vol. 6, p.239)

What do we learn? Alcohol is not inherently evil substance. It is the human element, what we as individuals do with alcohol, that makes all the difference.

The Islamic perspective on alcohol and drug use is very clear. Physician and editor Shakid Athar provides the Islamic perspective (downloaded onJune 1, 2006 from www. islam-usa.com/im21.html).

The objectives of Islamic divine laws are the protection of faith (belief in one God), life (abortion, suicide, homicide), property (ownership) and the mind (intoxicants). Normally in the brain there is an inhibitory control which tells us not to engage in shameful or wrongful acts. Any suppressant drug including alcohol will suppress this nerve pathways and take away such restraint. Ability to make a judgment, to protect the body or honor, a quality for humans is taken away under the influence of drugs.

There are two main features of Islamic prohibitions:

a) Islam stops the wrong at the inception and not at the end. There is nothing like safe drinking age, or safe drugs to get high. Most of the teenage alcoholics don't buy the alcohol from the store but get it at home. Islam makes equal laws for both children and parents by prohibiting completely (total abstinence), but the West does not. It is for this reason, the West has been crippled to handle the problem of drugs and alcohol, because it has made duel standards.

b) Islam blocks all the avenues to the wrong. Therefore not only illicit sex is prohibited, but casual mixing of sexes freely is prohibited, but obscenity and pornography is prohibited, and in the same context, not only drinking wine is prohibited, but making it, selling it, keeping it, or even growing grapes for the sole purpose of selling it to winery for making wine is prohibited by the Prophet (PBUH). Some 1400 years ago, Allah (swt), our creator and sustainer, who cares for us, sent down following revelation in the following order, mentioned in Quran.

Al Baqarah 2:219: "They ask you concerning wine and gambling." Say: "In them there is great sin, and some profit, for men, but sin is greater than the profit."

Al-Nisa 4:43: "O you who believe! Approach not prayers, with a mind befogged, until you can understand all that you say."

Al-Ma'idah 5:93: "O you who believe! Intoxicants and gambling, (dedication of) stones, and (divinations by) arrows, are an abomination of Satan's handiwork: Avoid such (abomination) that you may prosper."

Al-Ma'idah 5:93: "Satan's plan is to sow enmity and hatred among

you with intoxicants and gambling, and to hinder you from the remembrance of Allah and from prayer. Will you not then give up."

The above verses came over period of years and when the last verse came, Muslims threw away all the wine into the streets and stopped completely in whatever state they were in, and streets of Medina were flowing with wine.

Sayings of Prophet Mohammed (PBUH) and about wine and other intoxicants.

1. "Every intoxicant is khamr, and every khamr is haram (unlawful)" reported by Muslim.
2. "Of that which intoxicates in a large amount, a small amount is haram" (Ahmad, Abu-Daud and Al-Tirrnizi).
3. "Khamar (intoxicants) is the mother of all evils." Reported in Bukhari.

Two concluding comments seem appropriate at this point. The first:

In 1966, the Ecumenical Council on Alcohol Programs of Greater Boston published a statement, signed by 16 ecclesiastical leaders representing Protestant, Roman Catholic and Jewish groups in New England. It states:

We believe that we may all unite on the ground of the virtue of sobriety. This can be practiced in two ways. One is by total abstinence from beverage alcohol for religious motives. The other is by true moderation in the use of alcohol, also for religious motives. On this common ground the virtue of sobriety may be practiced both by abstainers as well as by those who drink moderately.

And the second:

Reverend A. Philip Parham, who comments in *The Chuch and Alcohol: A Resource Manual* published by the San Antonio Council on Alcoholism:

Today our situation demands cooperation among all Christians who can join together on the principle of sobriety and responsibility, and still embrace moderation and abstinence. Not all use is misuse; not all drinking is drugging, not all consumption is excessive. Perhaps the mild, occasional, moderate drinkers in the church can become mutual companions with abstaining Christians and together join in attacking the inappropriate and harmful misuse of all mood-altering chemicals in our society. Then both can work together to build a safer, saner and more wholesome land. The conflict between wet and dry Christians began in the 19th century, and hopefully it can be resolved in the 20th.

Helping Members Establish Guidelines for Healthy, Safe and Appropriate Choices about the Use and Nonuse of Substances

The environment and social norms of a community influence choices people make about alcohol, tobacco and other drugs. What the faith community does or does not say about substance use and nonuse has a powerful influence on its members and on the entire community. Religious organizations in a community can help create norms that discourage problem use. Unfortunately, most congregations have rarely gone beyond an admonition to abstain, blanket permission to use, or total silence on the issue. The following information is designed to assist congregations and individual members as they grapple with their own beliefs about what constitutes safe, appropriate and healthy decisions about use and nonuse.

"By failing to affirm alcoholic beverages and drinking alcoholic beverages within this context of chemical health, we live with the fact that the most neglected group in our church and society is not the nondrinkers, but the drinkers—the majority. For them the church and society will have no approval or guidelines as to what is healthy drinking versus unhealthy, appropriate versus inappropriate, acceptable versus unacceptable, integrated versus nonintegrated."

—Rev. John Keller, 1986

In our congregations and in our homes, we can help one another think about this issue. What should the role of alcohol be in family, religious or social events? How can young people learn to make responsible decisions about whether or not to drink? How can we be of assistance to those whose lives have been affected by alcohol and other drug use problems? How can we encourage people who use alcohol to drink moderately and respect those who choose not to drink? How can we prevent the illegal use of alcohol and any use of tobacco (outside of ceremonial use by American Indians), or use of illicit drugs by people of all ages? How can we help all members use their prescription medications wisely and safely? What is the congregation's role in all this? What are our roles and responsibilities as a congregational member?

Who sets guidelines for substance use in our country? Schools? Parents? The alcohol beverage industry? Businesses? The criminal justice system? The medical community? While each of these sectors plays a significant role, the faith community has often been overlooked as an obvious catalyst for forming these guidelines. Even though a significant number of faith community members drink alcoholic beverages, most congregations have not examined beliefs about appropriate or inappropriate alcohol and other drug use. They have not developed a set of guidelines for people of all ages to follow when considering first, whether or not to use alcohol and other drugs, and second, how to use in a safe, appropriate and legal manner if the decision is to use.

Before most faith groups and congregations can respond to substance use and abuse issues, the relationship between substance use and religious doctrine must be reflected upon and understood. In order for any group to develop an effective prevention program, it must first answer the question, "What do we believe about substance use and abuse?" Once answered, they will have the foundation for whatever prevention, or recovery efforts they undertake.

Setting Personal Guidelines About Alcohol, Tobacco and Other Drug Use

In today's culture, there exist two accepted, yet competing, realities about alcohol and drugs. One is that alcohol and other drugs can be used in healthful ways. Alcohol can be drunk in moderation, heightening physical pleasure, and it can be used for social and spiritual communion. Drugs can promote and restore health to the body and mind. The other reality is that healthy use, by personal choice or physical disposition, can become addictive, immoderate, health-destroying alcohol and/or other drug abuse.

Preserving the first reality while protecting against the second is an enormous endeavor that touches and involves every aspect of our world community: political, medical, judicial, social, familial, personal, and increasingly, spiritual.

"Our religious traditions assume that we have the power and freedom to make individual decisions about the use and nonuse of all God's gifts, including chemicals. As with all of God's creations, chemicals are neither good nor bad, but the way they are used determines their potential benefits or risks. "

—Governor's Interfaith Task Force on Chemical Health

Hardly a day goes by that the newspapers and television don't include stories about the "war on drugs," meth houses, teenage drinking, drunk driving, fetal alcohol syndrome, athletes using steroids, drinking games among college students, lives torn apart by alcohol use, as well as medications that can save lives. The list goes on. Legal as well as illegal drugs are part of life in our society.

There are a number of terms used to describe various ways people use alcohol, tobacco and other drugs including: substance abuse, chemical misuse, drug abuse, social drinking, addiction, responsible use, teetotaling, alcoholism and chemical dependency. Add to this the fact that the words substance, chemical and drug are often used interchangeably and it is easy to understand how people get confused.

Many drugs have the potential to improve our health and enrich our lives. They protect us from disease, guard against infection, speed recovery from injury, comfort the terminally ill, and even serve as part of the celebration of religious, social and other special events. Examples of healthy behavior include:

- Appropriate use of prescribed medications
- Occasional, moderate and legal use of alcohol

- Abstinence from alcohol use for personal, religious or health reasons
- Abstinence from any use of tobacco outside of ceremonial use by American Indians
- Abstinence from illicit drug use

Alcohol is neither morally good nor morally bad; it is morally indifferent, or morally neutral in itself. But since it is a creature extremely attractive to sense appetite, it is dangerous.

—Father John Ford, 1961

The abuse of alcohol, tobacco and other drugs has the potential to cause serious health, legal, economic, emotional and spiritual problems. People can experience a variety of problems resulting from inappropriate use of these substances, only one of which is addiction. Examples of substance abuse problems include:

- Impaired or intoxicated driving
- Interpersonal, family, group or congregational tension due to abuse
- Underage drinking and other legal problems
- Chemical dependency
- Harm to a developing fetus

Since substances can both improve our health and cause serious problems, it is essential that everyone sets their own personal guidelines to assist them in making safe, healthy, legal and appropriate choices about the use and nonuse of alcohol, tobacco and other drugs. The guidelines can also serve as the basis for early intervention when use is illegal, unhealthy or risky.

Alcohol: A Special Topic—Black and White, or Shades of Gray?

Alcohol is an example of a substance around which there is a great deal of confusion and few generally accepted guidelines for its use. There is no consensus about the use or nonuse of alcohol. Historically, many members of congregations have considered the use of alcohol as a sign of moral weakness, sin or personal inadequacy. For them, the only option was total abstinence. For others, the use of alcohol was actively promoted as part of the celebration of life. For them, any concern over the problematic use of alcohol was confused with opposition to any drinking. By identifying the use of alcohol as a moral problem, religious organizations have often been seen as overly judgmental.

We know that a significant number of people choose to abstain from any alcohol use. There are others who experience alcohol-related problems. Some are alcoholic; others occasionally use alcohol in risky and dangerous ways. Yet, there is a large percentage of people who are neither abstainers nor problem/dependent drinkers. These people choose to use alcohol legally, occasionally, moderately and safely. By failing to affirm the safe, legal and appropriate use of alcoholic beverages, we have historically created two

groups in our society, users and nonusers, and we have driven a wedge between them.

One result of this wedge has been the labeling of individuals and their behavior. Nonusers have been referred to as dry, winners, saints, healthy and/or moral. Meanwhile, users have been referred to as wet, sinners, losers, sick and/or immoral. While these labels sometimes appropriately describe behavior associated with problematic or dependent use of alcohol or describe some behavior associated with nonuse, they do not describe the behavior of a moderate, occasional and appropriate user. Such alcohol use does not necessarily make them bad or immoral, nor does their nonuse necessarily make them saints, healthy or winners. These labels actually serve as obstacles to discussing the appropriate use and nonuse of alcohol in our society. They interfere with developing clear guidelines for appropriate behavior and providing an objective basis for intervening when someone's behavior is risky, unhealthy or inappropriate.

What is needed is an approach that removes the wedge between users and nonusers. Such an approach would regroup nonusers with moderate, appropriate, occasional users and identify a clear set of guidelines for what is risky, illegal, inappropriate, unhealthy and possibly dependent. People who follow these guidelines may choose to abstain from alcohol or choose to use it legally, occasionally, moderately and safely. All of these people are demonstrating healthy behavior regarding alcohol.

Suggestions for Setting Personal Guidelines

The decision to use alcohol or not is a personal choice. Each of us, at any age, is responsible for the consequences of our decisions. Choices about using or abstaining from alcohol based on a clear set of guidelines will enhance health and reduce the risk of experiencing a wide range of alcohol-related problems. These guidelines need to be set prior to drinking and adhered to carefully.

The following suggestions are based on current scientific information and common sense. They can be used to help people make healthy, safe and appropriate choices about the use and non-use of alcohol, tobacco and other drugs.

1. **To use or not use alcohol is a personal choice for which each person is accountable.**
   No one should feel pressured to drink or made to feel uneasy or embarrassed because of a personal choice. Many people will choose to use alcohol safely, moderately and appropriately. Others will simply have no desire to experience the effects of alcohol. Those with a family

Standard Drink

One 5 oz. glass of wine

One 1.5 oz. shot of liquor

One 9 oz. wine cooler

One 12 oz. beer

All these drinks contain the same amount of alcohol.

history of chemical dependency or alcoholism may choose not to risk any use of alcohol. The bottom line is that no one should feel that he/she has to drink to be accepted.

2. **Alcohol use is not essential for enjoying family, recreational or social events.**
   The real value of parties, recreational and other social activities is being with friends and taking time out from the pressures of work and school. Drinking alcohol should not be seen as a necessary component or the sole reason for having fun and being with friends, but as an enjoyable complement to such get-togethers. Actually, focusing on alcohol use as the main reason for getting together results in intoxicated people who get sick, can't carry on a conversation and generally aren't much fun to be with after awhile.

3. **Use of alcohol that leads to impairment or intoxication is unhealthy, risky and should be avoided and discouraged.**
   Getting drunk is not a condition to be admired, laughed at or taken lightly. Rude, destructive or just plain foolish behavior triggered by alcohol use is socially unacceptable and may indicate an alcohol use problem. Drinking games often result in drunkenness and can present serious risks for those involved. Driving after drinking to the point of impairment is always illegal and dangerous.

4. **There are times when it is important to abstain from alcohol or other drug use.** Examples include:
   - When it is inconsistent with religious beliefs
   - When recovering from chemical dependency
   - When the alcohol or other drug use is illegal
   - When pregnant or nursing
   - When operating equipment—motor vehicles, motorcycles, boats, tools, firearms, etc.
   - When swimming, skiing, climbing, or doing other risky physical activities
   - When at work or studying
   - When performing in athletics or fine arts
   - When taking certain medications

Each of these situations presents specific risks and are times when alcohol use should be avoided. As caring friends, we can help each other choose not to use during such times.

5. **There are personal limits of moderation for anyone who chooses to use alcohol.**
   It is essential that everyone who chooses to drink alcohol knows his/her personal limit of moderation. It is important that each person set a limit before having any alcohol, as judgment can be affected after even a small amount of alcohol intake. Generally, alcohol is eliminated from the body at the rate of just less than one standard drink per hour, or .015 AC level. However, a variety of other factors may also influence the level of alcohol retained:

   - **Gender.** Because of differences in body composition and chemistry, males and females are affected differently by alcohol. Men generally have more muscle and women more fatty tissue per pound. Fatty tissue has a smaller blood supply than muscle tissue, so more of the alcohol goes into the bloodstream. The result is that when a man and woman of equal weight drink equal amounts of alcohol, the AC level will be higher in the woman than in the man.
   - **Body weight.** Total body weight and the ratio of body fat to muscle affect the AC level. Lower weight and/or a higher ratio of fat to muscle result in a higher AC level.
   - **Time.** The number of hours you have been drinking affects your AC level. Unless you drink less than one standard drink per hour, your AC level will continue to increase over time. The body slowly eliminates the alcohol as follows: oxidation by the liver (95 percent), breath (2 percent), urine (2 percent), and perspiration (1 percent). The liver's rate of oxidation is constant and cannot be increased by drinking coffee, physical activity, or cold showers.
   - **Strength and quantity of drinks.** It does not matter what kind of alcohol you drink—what counts is how much. The table to the left highlights the fact that a 5 oz. glass of wine, a mixed drink with 1.5 oz. of rum, whiskey, gin, vodka, etc., a 9 oz. wine cooler, and a 12 oz. beer all contain the same amount of alcohol. It is very important to be aware that beer is served in glasses containing more than 12 ounces and that mixed drinks often contain more than 1-1/2 oz. of hard liquor.
   - **Food intake.** Drinking on an empty stomach can have a greater effect on judgment and behavior than expected. At the same time, although a full stomach will slow down the absorption of alcohol, it is much less important than most people believe.
   - **Age.** Age is rarely considered in a discussion of AC levels, yet it is very important since the human body becomes less tolerant

with aging. This is due to a gradual change or slowing down of the metabolic rate. The ratio of body fat to muscle also increases with age. The effect of these factors is that the same amount of alcohol intake per body weight consumed by older people can result in higher AC levels, and the effects may last longer. Age is also a factor for young people. Research shows that adolescents are involved in fatal crashes at significantly lower AC levels than those found in adults. Young people are just developing many adult skills, including driving, and these skills can be negatively affected at lower AC levels than in adults.

- **Mood.** Although one's mood does not directly affect the AC level, the effects of alcohol can be greater than expected when a person is tired, stressed out, angry, lonely or dealing with any other strong emotion.

(An Alcohol Concentration Worksheet is provided on page 71-72.)

0 - 1 - 3

0 - 1 - 3 Weekends

0 = Zero Alcohol
Especially if you're…
- under 21,
- driving,
- chemically dependent,
- pregnant

1 = One drink per hour sets the pace for moderate drinking

3 = No more than three drinks per day and never daily

6. **There are ways to minimize health and safety risks when serving alcohol.** Examples include:
   - Do not serve alcohol to underage youth
   - Emphasize friendship, conversation and other activities rather than drinking alcohol
   - Offer a variety of attractive nonalcoholic drinks that are readily available
   - Provide a variety of foods
   - Serve all drinks to guests rather than having an open bar
   - Inform guests whether or not beverages such as punch contain alcohol
   - Stay alert and assume responsibility to help a guest who may have had too much to drink
   - Create an environment that allows guests to feel comfortable making a personal choice about alcohol use or nonuse

   (See "How to Have Fun Without Alcohol" on page 73.)

7. **Illegal use of drugs has specific health, legal, and ethical risks and are to be avoided and discouraged.** Examples of risk include:
   - ➤ Unpredictable dosage
   - ➤ Unpredictable purity
   - ➤ Can result in a criminal record

8. **Tobacco is a drug that has significant risks and should be avoided and discouraged** *(with the exception of ceremonial use of tobacco by American Indians)*.
   The relationship between tobacco use and increased risk of heart disease and a variety of cancers and lung diseases has been clearly demonstrated. Current research efforts are further identifying the risks of secondhand smoke for nonsmokers. Tobacco is also considered a gateway drug for young people.

9. **Medications should be used only as prescribed or according to directions and never mixed with alcohol.**
   Drugs, both prescription and over-the-counter, should be used only when needed, never shared and all labels and instructions should be read and followed carefully.

10. **Avoid situations where someone else's alcohol, tobacco or other drug use may put you at risk.** Examples include:
    - Not riding with an impaired or intoxicated driver.
    - Using seat belts at all times to protect both drinkers and nondrinkers against being injured or killed in an alcohol-related crash.
    - Exercising caution in unfamiliar environments.
    - Recognizing and avoiding high-risk sexual situations.
    - Recognizing safety risks caused by a co-worker's impairment

Commentary

In recent years, the alcohol industry has developed advertising with simple messages about moderation. "Know when to say when," and "Think when you drink" are examples of slogans that seem to encourage moderation when consuming alcohol. However, neither of these messages offer specific guidelines about the frequency or quantity of alcohol use. Other organizations such as the Enjoy Michigan Safety Coalition have developed campaigns that offer more specific advice about if, when, and how much alcohol fits the concept of moderation. The 0-1-3 campaign suggests specific times when alcohol should not be used, offers limits of how much alcohol to consume at any one time, and also suggests a maximum frequency of drinking. The federal government has published Dietary Guidelines for Americans, which recommends that if Americans choose to drink alcohol, they should do so in moderation. Moderation is defined as no more than one drink per day for women and no more than two drinks per day for men. Similar to guideline four, the U.S. Dietary Guidelines also suggest that some people should not drink at all.

Concise guidelines such as these offer clear guidance for the general public that, if followed, will reduce the risks of alcohol-related problems. Because these guidelines do not reflect individual differences in weight, age, time spent drinking and other factors, they are often not completely accepted or followed. Alcohol concentration (AC level) is the amount of alcohol in the blood in relation to other fluids in the body. The more alcohol in your blood, the greater the degree of impairment. Despite criticism from some prevention specialists, alcohol concentration charts can provide guidance about moderation for some people. The Alcohol Concentration Worksheet on pages 71 and 72 can be helpful to many people as they make personal decisions about the use or nonuse of alcohol.

Summary

Preventing alcohol, tobacco and other drug use problems can begin in very small ways by first examining your own attitudes and guidelines about use and nonuse. The guidelines suggested here can provide a framework within which to examine the use of alcohol, tobacco and other drugs and the use of alcohol as part of family and social events. The need for guidelines about alcohol, tobacco and other drug use is clear and the responsibility for establishing and following them is shared by all of us. We can affirm the right of adults to drink alcohol safely and wisely. We can share our concerns with those who drink, smoke or use other drugs illegally or inappropriately. We can support those who choose not to drink. We can be compassionate to those whose lives have been affected by alcoholism and other drug-related problems. And, we can encourage discussions about alcohol use and be role models for healthy and appropriate choices about whether, when and how much to drink.

Preparing Young People to Make Adult Choices

The decision whether or not to use alcohol or other drugs is an intensely personal one. However, people of all ages need to understand that the consequences of their personal decisions can have an important effect on others. We can make only two reasonable decisions regarding the use of alcohol and other drugs: not to use them at all, or to use them legally, safely and appropriately.

What Can We Say to Our Children?

What parents, congregational members and other significant adults say has a substantial effect on the choices young people make about the use and nonuse of alcohol and other drugs. Those who feel their parents will be very upset about their use are much more likely to abstain or use infrequently.

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Yet it is difficult for many parents to know what to say about the use or nonuse of alcohol when talking to their children. Even though over half the adults in this country drink alcoholic beverages, many of us don't know what to tell young people about alcohol and other drug use—even our own sons and daughters. Some fear that if they talk with them about alcohol it will somehow encourage them to drink. Other parents feel that if they drink alcohol, it is impossible for them to ask their children to abstain. Even when their use of alcohol is within guidelines for safe, appropriate use, many parents simply do not know how to discuss the issue with their children. The result is that many simply say nothing or limit their comments to, "Don't drink, it's against the law." By saying nothing, however, parents risk that their children will think that they approve of their drinking or that they don't care.

As parents and as a congregation we need to communicate our concern directly, clearly and frequently, from preschool through adulthood. It begins with an examination of our faith traditions' beliefs and teachings about alcohol, tobacco and other drugs. Three messages should come through, loud and clear:

- Abstinence is a safe and acceptable decision that many young people are choosing
- We do not want you to use alcohol before you are legally allowed to do so, and we do not want you to use tobacco or illicit drugs at all

- Abstinence can be a lifelong decision. However, when you are an adult and if you choose to use alcohol, we want you to know how to do so legally, safely and appropriately.

These three messages are clear, direct and can be communicated to our children simultaneously. Of course, congregations can clearly communicate these same messages in many ways and times.

How Do We Prepare Them?

Getting a driver's license and reaching the legal drinking age are often considered two of the major rites of passage from adolescence to adulthood. Both of these transition points are full of risks for young people. When we think about preparing our children for adult choices about the use of alcohol, it is helpful to compare how our society prepares young people to use alcohol responsibly with how we prepare them to drive.

To Become a Licensed Driver

Our society has established a sequence of events and set of guidelines for getting a driver's license. There is a minimum age in each state when a young person is legally able to drive. Classroom driver's education is offered by schools and private agencies to provide an understanding of laws and other information related to driving. Behind-the-wheel instruction is provided so that young people learn the skills necessary to drive. In addition, they are expected to practice driving with a licensed driver, usually a parent, during a period of preparation.

Then, before receiving a license, young people are required to take written and skills tests. When these tests are passed, the young person is given a license to drive and enters a world that has agreed on a set of guidelines for safe driving. Perhaps most importantly, those laws, training programs and procedures have received widespread acceptance and respect by adults and young people. In the interest of protecting the safety of individuals and the community, our society has agreed on this set of guidelines. There is even general agreement that when people break a traffic law they should suffer some consequence; i.e. a warning, a fine, or loss of driving privileges. Those charged with enforcing these laws attempt to do so consistently and parents rarely allow their unlicensed children to drive cars by themselves.

To Make Responsible Choices About Alcohol

Unfortunately, these same conditions do not exist for young people as they confront decisions regarding the use and nonuse of alcohol. Our society has never agreed on a set of guidelines for the use of alcohol. Although our legislators have established a minimum legal drinking age, our inability to support and enforce these laws often defeats their purpose. Young people

have no required course of instruction or testing prior to drinking, nor is there a mandatory time period during which they can watch appropriate drinking behavior. Continuing confusion about alcohol has made the instituting of education programs difficult in many communities. Most importantly, we have not yet achieved broad community acceptance of a specific set of guidelines for safe and appropriate alcohol use or nonuse. The only prerequisite for a license to drink is one's age.

We would never consider handing a young person car keys when he or she turns 16 without first providing training and guidelines for safe and appropriate use of a car. Just as important we must not automatically open the doors of drinking establishments to our children of legal drinking age without first providing training and guidance. While the choice of abstinence should always be supported, we cannot wait until young people reach the age of 21 to discuss with them guidelines for the legal, safe, healthy and appropriate use and nonuse of alcohol.

If Someone's Alcohol, Tobacco or Other Drug Use is of Concern, What Can Be Done?

The faith community can play an important role in preventing substance abuse and promoting health. It can also assume a significant role in responding to substance abuse problems. Regardless of their personal choices, most people will experience times when someone else may be using alcohol or other drugs in dangerous or unhealthy ways or we may know someone close to us who has experienced many problems because of drinking or drug use. When that happens, what is our role? What can we do when a friend, family or congregational member is drinking too much or at inappropriate times; using illegal drugs; sharing prescriptions; using tobacco; or acting in ways that cause concern? What can we say?

Regardless of their personal choices, most people will experience times when someone else may be using alcohol or other drugs in dangerous or unhealthy ways or we may know someone close to us who has experienced many problems because of drinking or drug use.

Our society is filled with messages that tell us to keep quiet when we see behaviors that concern us. Many remember a parent saying, "If you can't say something nice, then don't say anything at all." Or the message that "If you are going to live in a glass house, you had better not start throwing stones." Others remember religious traditions that say, "Judge not lest we be judged." Add to this, a feeling many people have that they simply don't know enough about problems such as alcoholism, drug addiction, gambling, etc. to know when to talk to someone and "What if I make a mistake and say something wrong?" Other people are simply reluctant to get involved in someone else's business.

The result is that far too often when people observe risky, illegal or inappropriate behavior, they say nothing. By saying nothing we risk that the young person or our peers will either think we approve of their behavior or that we don't care (or they are happy because we are saying nothing).

A Gallup survey found that 94 percent of Americans feel it is their responsibility to speak to a friend who has problems with alcohol, tobacco or other drugs. But only 38 percent said they felt "very confident or comfortable in speaking up to a friend about it." (Gallup & Newport, 1990)

We are Our Bothers and Sisters Keepers

It is clearly the right and responsibility of caring, concerned members of a congregation to discuss with loved ones behavior that concerns them. The difficulty arises in not knowing what to say. Perhaps the key to removing this barrier is simple and honest feedback. Telling the person directly what behavior you observed and your feelings or reactions to that behavior is the most appropriate response. Avoid diagnosing or labeling or using judgmental words. It is important not to complicate the conversation with inflammatory words or words that are easily challenged.

A simple, straightforward approach to letting someone know you are concerned can sound easier to do than it really is. Not everyone will be grateful that you shared your concern and we cannot predict what a person will say or do in response to what we say. Yet, we do have control over what we say, how we say it, and when and where we say it. Though there is no foolproof way to share concern with another person, the following *See It, Say It* six-step process has worked well for many people:

1. **I care.** Tell the person that you care about him/her.

   I love you very much.

   We have been friends for a long time and I value our friendship.

   You are my grandchild and I care about you. You are important to me.

   You are a valued member of this congregation.

2. **I see.** Tell the person exactly what he/she has done that concerns you. Alcohol or other drug use that is inconsistent with the guidelines for chemical health is clearly inappropriate. Be descriptive and factual.

   Last night you had eight beers in less than three hours and then drove home.

   Saturday night you came in two hours late and smelled of alcohol.

   You became so angry after drinking last night that when you screamed at me and waved your fists, I was sure you were going to hit me.

   You are three months pregnant and still using alcohol.

3. **I feel.** Tell the person how you feel.

   It scares me when I see you driving after you have been drinking.

   I feel sad when I think of the risk you are taking with your baby.

   I am afraid when I see you doing things that are clearly dangerous.

4. **Listen.** After you tell the person that you care, what you've seen and how you feel, it is important to be willing to listen to what he or she says. A variety of responses can be expected. Many people will say nothing. The person may not be prepared for this and will not be ready to talk with you. Some people may become angry and tell you it is none of your business. Others may thank you and say they will make changes in their behavior. Still others may share a problem with you that goes well beyond your ability to help.

5. **Tell the person what you would like to see him/her do.**

   I do not want you to drink alcohol at all until you are old enough to do so legally.

   I want you to make arrangements for someone else who is sober to drive if you have been drinking.

   I do not want you to drink at all while you are pregnant or nursing.

   I want you to talk with the clergy person or counselor at your place of worship.

6. **Tell the person what you are willing and able to do to help.** The response can range from simply being available as a good listener, to giving them information to read, to helping arrange a meeting with someone who can help. If the person chooses to say nothing, let him/her know that the door is open to discuss this at a future time.

   I'll always be here if you need a friend to talk to or just a hug.

   If you do this again, I will take away the car keys until we can talk to someone and find out what to do.

   I'll help you make an appointment to speak to a counselor or clergy person.

The best time and place to talk with someone about something this important is when you feel comfortable and where there is privacy. It is important to have adequate time when you won't be disturbed. Never have a serious discussion with someone when either of you is under the influence of alcohol or other drugs.

Sometimes this conversation will trigger thoughts and reflections in the person and that person will change his/her behavior. Often, though, the problem is not resolved immediately. There may be a need to have a second or third similar conversation. If the behavior does not change, you may discover that you are dealing with substantial denial and a serious problem. You may want to talk to your pastor, priest or rabbi, a counselor or someone in recovery to learn more about what you can do

and what resources are available in the congregation as well as in the community. Do not be discouraged. People who get treatment for alcoholism or drug dependence often share how important it was that friends and family members reached out to them in a time of need, even though they were unable to respond.

If it is determined that the person's problem is alcohol or drug dependence, you can receive a great deal of help and support for yourself by attending Al-Anon meetings and by learning as much as you can about this disease. It is important to understand that there are ways to help yourself, whether or not the alcoholic or drug dependent person gets help for the problem. It is especially important to note that most alcoholic or drug dependent persons seek out or are willing to receive help after the family members have received help and have changed the way they relate to that person.

Can the Faith Community Influence Social Norms?

Religious organizations have a unique opportunity to establish policy and guidelines to assist their members as they live in a world of constant choices regarding alcohol, tobacco and other drug use and nonuse. There appear to be two levels of policy with which religious organizations can be involved. The first level involves taking a clear, responsible and visible position regarding substance use and abuse issues. This often takes the form of a formal position statement or policy.

A vision without a task is but a dream. A task without a vision is drudgery. A vision and a task are the hope of the world.

—From a Church in Sussex, England, 1730

The first level of policy within religious organizations essentially paves the way for the second, which is the development of informal norms or guidelines concerning alcohol, tobacco and other drug use and nonuse. History has clearly indicated that the family, religious institutions and the government have been primarily responsible for the establishment of norms and guidelines for alcohol and other drug use and nonuse. More recently, the alcohol and pharmaceutical industries have assumed a dominant role in establishing social norms about alcohol and other drug use choices.

Through the involvement of the congregation and its members in family, community or its own events, there is an opportunity to establish a clear line between alcohol, tobacco and other drug use that is acceptable and that which is not. Those who work in social policy development believe that, the clearer this line, the less tendency for individuals to cross it. It should be noted that these informal norms or guidelines may vary from one faith group or religious denomination to another, as well as from one congregation to another. The issue is not simply a question of abstinence versus use, but rather, a question of how to make safe, legal and healthy decisions about use or nonuse.

Is a Congregational Position or Policy Statement Necessary or Helpful?

Before most congregations and religious groups can respond to substance use and abuse issues, the relationship between alcohol and other drug use and religious doctrine must be reflected upon, discussed and understood. Developing a position or policy statement about alcohol

and drugs is not just a matter of words. In order for a school to develop an effective drug education program, a company to develop an employee assistance program, a family to discuss substance use and nonuse, or a religious group to develop identification, intervention, prevention and recovery programs, it must first answer the question, “What do we believe about substance use, nonuse and abuse problems?”

You cannot plow a field by turning it over in your mind.

—Anonymous

Congregational councils and other governing bodies are encouraged to assume responsibility for developing a position or policy on the use and nonuse of alcohol and other drugs. This position or policy should provide direction for developing administrative procedures necessary to implement a comprehensive and realistic program of providing assistance to members experiencing substance abuse problems, conducting prevention and recovery programs, as well as provide the foundation for helping members set personal guidelines for the use and nonuse of alcohol and other substances. It is important that this position be based on the specific needs and concerns of each congregation and community.

A checklist for assessing substance abuse prevention and recovery needs that has been helpful to some congregations is available on page 87.

Conclusion

The prevention of alcohol and other drug use problems is a concern for everyone. All of us—individually and through the organizations with which we are affiliated—have a role to play in prevention efforts. The purpose of these materials has been to provide some suggested areas and ways for religious organizations and spiritual groups to look at their role in these prevention efforts and take active steps to contribute to society's alcohol and other drug use prevention efforts.

Individually and collectively, members of the community look to their faith community and its leaders for guidance and direction in many aspects of day-to-day life. Clergy, spiritual leaders and religious organizations are expected to provide spiritual guidance in all aspects of day-to-day living.

Religious organizations, clergy and spiritual leaders can take a leadership role in the prevention of alcohol and other drug use problems. This can be done through the roles of teacher, policymaker, counselor, guide and role model. More than being caregiver for members of our community who are in trouble, religious and spiritual leaders are in the unique position to influence the collective conscience of religious organizations. Religious organizations and leaders are in the position of influencing members' attitudes regarding the issues we are all confronted with as part of our daily life, including alcohol, tobacco and other drug use.

All of these elements combine to provide the faith community a unique opportunity to influence the community at large. This opportunity allows for the subtle changing and shaping of norms and behavior through education, policy development, counseling and support, as well as modeling appropriate behavior.

No one knows for sure why some people develop serious problems, why others use alcohol safely, occasionally and moderately, and why others abstain completely from using alcohol, tobacco or other drugs. But the following page describes four important ingredients in preventing substance abuse problems. In each, the faith community, together with family, school, workplace, health care systems and other community sectors all play an important role.

1. People of all ages need information about substances and their effects. They need the guidance and direction from their families and the faith community as they develop personal guidelines and values regarding alcohol and other drug use and nonuse. Most people learn how alcohol, tobacco and other drugs should be used from the example and influence of their parents, peers, other adults and school drug education programs. It is extremely important to add the influence of the faith community and its teachings. What religious organizations say or do not say about alcohol, tobacco and other drug use significantly affects the decisions people make.

2. People need to develop personal and social skills that will enable them to cope with the freedom and pressures that exist in our society, such as making decisions, being assertive, and communicating effectively with family and peers. Family discussions and religious education programs within congregations can provide ideal environments for people to learn and practice these skills that will be so important to them as they make choices about alcohol, tobacco and other drug use and nonuse throughout their lifetime.

3. People need to feel loved and cared for by their family, friends and God. They need to feel that support is available from others in order to help them make decisions about alcohol, tobacco and other drug use and nonuse. The family and the congregation are essential in providing the support necessary for each person to develop a sense of self-confidence and responsibility that will enable them to act on what they know and value.

4. People need safe and healthy environments in which to live, work and learn. The religious organizations in any community can support formal and informal social policies and norms that prevent or reduce alcohol, tobacco and other drug use problems.

Personal Responsibility

In addition to formal program efforts, we can each assume personal responsibility for prevention in more informal ways. The prevention of substance abuse problems is a cooperative responsibility shared by each of us. Prevention efforts are ongoing and require the participation of everyone. As caring, concerned, people of faith, we can become preventers in many ways through our families, schools, civic groups, informal social groups and political parties, as well as through our work in our congregations.

1. We can examine our own choices about alcohol, tobacco and other drug use and nonuse.

2. We can encourage our friends and colleagues to use alcohol and other drugs legally, safely and appropriately.

3. We can model behaviors we want our children and friends to follow.

4. We can listen and support each other in times of stress.

5. We can tell our children and others how we feel when they act inappropriately.

6. We can create an environment which allows for open and honest communication.

7. We can encourage and help our children to develop skills to make legal, safe and healthy choices.

8. We can encourage and provide opportunities for young people to make decisions.

9. We can provide opportunities and support for people who choose a substance-free lifestyle, as well as those who are in recovery from an alcohol or other drug use problem.

10. We can support and encourage our lawmakers to enact legislation which will reduce the likelihood of people developing or continuing chemical use problems.

We hope that these materials have been helpful in providing a framework for religious organizations and spiritual leaders to play an active role in the prevention of alcohol, tobacco and other drug use problems within their congregations and the community at large.

ADDITIONAL MATERIALS

Alcohol Concentration Worksheet

For those who choose to use alcohol, the Alcohol Concentration Worksheet can help establish limits of moderate and appropriate amounts of alcohol to drink. It is important to remember that, even at very low AC levels, some people will show evidence of decreased performance. There is ample evidence that many persons show impaired judgment at AC levels at or below .04. There is strong evidence that all persons show impaired behavior, including driving performance, at AC levels between .04 and .10.

To estimate your own personal limit to avoid future problems related to a drinking and driving violation, you can use the following steps to calculate the maximum number of drinks you can have at any time. Remember, in order for this limit to be helpful, you must decide what is low risk drinking before you begin drinking. Research has shown clearly that a person who has started to drink will underestimate his/her alcohol concentration (AC) level.

Step 1 Determine your weight __________.

Step 2 Using the appropriate AC Chart on page 72, find the column that is closest to your weight. If your weight is between two columns, use the lower weight column to insure that your calculations will be within limits that are legal and low risk.

Step 3 Read down the column you located in Step 2 that is closest to your weight until you find an AC level of .04. This is the highest AC level you can reach without showing significant impairment of body functions and skills that affect your driving and other behavior.

Step 4 To calculate your AC level subtract the time factor from the figure on the chart to obtain the approximate AC. For example, for a 160 lb. man who has had 4 drinks in two hours, take the figure .09 (from the chart for males) and subtract .03 (from the Time Factor Table) to obtain an AC of .06%

Body Weight: Calculations are for people with a normal body weight for their height, free of drugs or other affecting medication and neither unusually thin nor obese.

Driving: There are two ways to ensure that your AC level does not impair your ability to drive: (1) pace your drinks at a rate that never results in a cumulative AC level of greater than .04 or (2) allow enough time after drinking for the body to eliminate enough alcohol so that the AC level remaining is not greater than .04 before you drive.

The only low risk method is to pace your drinks so you never reach an AC level which will impair your driving. As stated earlier, judgment is one of the first areas impaired by alcohol and once you have exceeded a .04 AC level it becomes increasingly difficult to accurately assess your level of impairment.

If you drink enough alcohol to go beyond an AC level of .04 or higher, the best thing to do is not to drive and find another person to drive you or call a cab. If neither of those options is available, the following Time Factor Table will help you determine when enough alcohol will have been eliminated from your body to reduce your AC level to below .04.

This is extremely important because it is possible for a person who has consumed a large amount of alcohol to stop drinking late at night, sleep for several hours and still have an AC level high enough to significantly impair their driving the next morning.

Step 5 Now, using the following worksheet, calculate the maximum number of drinks you may be able to have over time without reaching an AC level of .04.

Alcohol Concentration Worksheet (continued)

1 Hour _______

2 Hours _______

3 Hours _______

4 Hours _______

5 Hours _______

TIME FACTOR TABLE

Hours since first drink	1	2	3	4	5	6	7	8
Subtract from AC level	.015	.030	.045	.060	.075	.090	.105	.120

ESTIMATING TABLE FOR MEN

body weight in pounds

Drinks	100	120	140	160	180	200	220	240	260
0	0	0	0	0	0	0	0	0	0
1	.04	.03	.03	.02	.02	.02	.02	.02	.01
2	.07	.06	.05	.05	.04	.04	.03	.03	.03
3	.11	.09	.08	.07	.06	.06	.05	.05	.04
4	.15	.12	.11	.09	.08	.07	.07	.06	.06
5	.19	.16	.13	.12	.10	.09	.08	.08	.07
6	.22	.19	.16	.14	.12	.11	.10	.09	.09
7	.26	.22	.19	.16	.15	.13	.12	.11	.10
8	.30	.25	.21	.19	.17	.15	.14	.12	.11

ESTIMATING TABLE FOR WOMEN

body weight in pounds

Drinks	100	120	140	160	180	200	220	240
0	0	0	0	0	0	0	0	0
1	.05	.04	.03	.03	.03	.02	.02	.02
2	.09	.08	.06	.06	.05	.05	.04	.04
3	.14	.11	.10	.09	.08	.07	.06	.06
4	.18	.15	.13	.11	.10	.09	.08	.08
5	.23	.19	.16	.14	.13	.11	.10	.09
6	.27	.23	.19	.17	.15	.14	.12	.11
7	.32	.27	.23	.20	.18	.16	.14	.13
8	.36	.30	.26	.23	.20	.18	.17	.15

How to Have Fun without Alcohol*

America is drinking less and enjoying itself more. We are all looking for ways to be responsible hosts. *Non-Alcoholic Party Drinks*, a 36-page recipe book with hosting tips, available from the Minnesota Institute of Public Health, offers the following advice: New drinking habits make good sense. Everyone feels, looks, and acts better. Our highways are safer, corporate behavior becomes more professional, and the "morning after" becomes a time to do, not to doze.

The following suggestions, lead to healthy, good times with no worries. They apply at work, home and in faith communities.

1. Focus your event on something fun and creative other than drinking, such as dancing, games or good conversation.

2. Always provide lots of nonalcoholic drinks (or mixers). Don't bury them in the back of the refrigerator and present them in as appealing a manner as beverages containing alcohol.

3. Prepare some snazzy snacks to go with the beverages. Go easy on the salty, thirst-provoking appetizers.

4. Provide a relaxed atmosphere for the nondrinker by making nonalcoholic drinks readily available, easily obtained and in plentiful supply. If it's a big event, place posters and banners around the room announcing the nonalcoholic beverages.

5. Toss together nonalcoholic drinks with as much flair as you would alcoholic beverages.

6. Tend bar yourself or have someone mix the drinks who's humorous yet responsible.

7. Permit each person to comfortably say "no" to an alcoholic drink. Even during a meal, don't assume everyone wants a glass of wine or other alcoholic beverage

8. When serving alcohol at a company function or private dinner party, limit your cocktail time to under an hour.

9. Assume responsibility for the safety of anyone who exhibits signs of intoxication. Find someone to drive an intoxicated guest home, or call a taxi. Offer overnight stays if necessary. Stay alert yourself so you can be a good judge of your guests' condition. They're your responsibility

10. Show concern, not amusement, for guests who've "had too much." This conveys that you are a responsible host and encourages others to know their limits.

*Adopted from *Non-Alcoholic Party Drinks*, published by the Minnesota Institute of Public Health, Mounds View, MN 2001.

Building a Faith Partners Team Ministry: A Congregational Approach to Addiction

Introduction

From birth to death, through times both joyous and filled with pain, congregations bear us up. Belonging to a congregation fills our need for community, gives us identity, and adds meaning to our lives. Faith communities offer us celebration and solace, spiritual growth, and moral direction.

With calls and cards, casseroles and cakes, congregations shepherd us through the many transitions of life, including illness. Yet members of congregations all across this country suffer in loneliness and shame the physical, spiritual, and emotional ravages of addictive behaviors—their own and those of others.

We at the Rush Center of Johnson Institute recognize the threat alcohol and other drug problems pose to the well-being of individuals and families in our congregations. We know faith communities can play a unique role in supporting recovery from addictions and in preventing both use and abuse.

Faith Partners and Faith Communities

The Faith Partners Team Ministry Approach has worked for congregations from various faith traditions. Every congregation has members with expertise, life experience, and interest in providing alcohol and other drug awareness, education, referral assistance, and recovery support. Over 150 teams in four states represent many denominations: Baptist, Catholic, Congregational, Episcopal, Lutheran, Presbyterian, United Methodist, and Nondenominational Christian. Representatives of the Jewish and Muslim traditions are also adapting this approach to fit their tradition. We believe the basic issues involved in promotinghealth, in responding to those who suffer from addictions, and in preventing alcohol and other drug problems are issues within the religious community's area of special expertise.

Call to Action

The Rush Center of the Johnson Institute calls on clergy and congregational leaders to join with recovering people and members of the larger community to provide a special ministry to people who suffer the effects of alcohol and other drug addiction. They need pastoral care as well as expressions of divine love, which faith communities can offer.

We call on clergy and parents to join with other concerned adults to minister to the developmental needs of youth so that we might prevent their using alcohol or other

drugs. Congregations can nurture young people morally and spiritually by offering them support, teaching them life and social skills, and talking with them honestly about the choices they face.

We call on all adult members of faith communities to support these ministries of recovery and prevention. We call upon them to become intentional about their own use of alcohol and other drugs and model responsible behavior. We call upon members to increase their understanding of addiction, its family dynamics and the teachings of Twelve Step programs.There is something you can do to reduce alcohol and other drug use among young people and to support the recovery of those who suffer from their own addictions or those of others.

Vision and Promise

Our vision is of caring and hospitable congregations across the country supporting members in their struggles to free themselves of addictions. Our vision is of congregational families whose children live drug-free. We hope you will join us and we promise to help.

We will provide tools and guidance. We offer our best thinking based on our years of experience. We can help you establish a team in your congregation with materials based on the experiences of dozens of teams, with training and technical assistance, and by connecting you with a network of active addiction ministry teams.

Congregational Prevention and Addiction Ministry Teams

Current teams have undertaken numerous recovery/prevention activities, including:

- Teaching parents how to talk to their children about alcohol and other drugs;
- Taking people for assessments and helping them find treatment;
- Supporting family members;
- Bringing people in treatment to congregation for worship and study;
- Offering youth programs;
- Showing hospitality to Twelve Step programs;
- Starting scripture/Twelve Step study groups; and
- Tapping community resources to offer general educational programs.

Every team is different. How your ministry looks will depend on the needs of your congregation and community. It will also depend on your team's interests, gifts, and energy. There is no right way to do this.

What is important is getting started.

Unique and Effective Approach

We provide the tools, training, materials, and technical assistance to equip your congregation with a vital, comprehensive and sustainable lay ministry, the Faith Partners Team Ministry. Your congregation will be connected to a local, state and national network for help and ongoing support. This approach has been used in numerous congregations in several states and is unique in that:

- It builds on the strengths of the congregation by involving lay people with special expertise and a passion for this work;
- Clergy time, energy, and involvement are carefully utilized;
- Teams are trained in prevention, early intervention, referral assistance, and recovery support, choosing programs that meet the needs of the congregation;
- Teams network with other teams and utilize community resources, keeping their efforts focused on the congregation's mission;
- This effort is relevant to the whole congregation, young and old, individuals and families; and,
- This ministry cultivates a compassionate response to all human problems, creating long-lasting change that makes the congregation a safe and hospitable place.

Three Steps to an Effective Ministry

Though alcohol and other drug addiction affect every congregation conversations about alcohol and drug use, misuse and addiction are rare and uncomfortable. We believe an informed clergy, supported by committed and trained members of the congregation can serve by offering hope to those who suffer through a recovery support ministry and help to those who want to prevent problems through awareness, education and early intervention strategies. We also know that it takes a careful and thoughtful process to start an effective lay team ministry to address the whole congregation. To begin this congregational ministry we recommend an important three step process.

1. **Build Congregational Support – Order a Call to Action Kit**
   Build support for this ministry early. Use the Healing Places book, Faith Partners Journals, video and step-by-step guide to introduce this ministry to clergy, potential team leaders and congregational leadership. Identify clergy and congregational leaders for the leadership training. Send those ready and able to the leadership training. Readiness and support are critical to success.

2. **Equip the Leadership – Attend a Leadership Training**
   This workshop is a six-hour workshop for clergy, staff and lay members of congregations. Topics include the role of the congregation; scope of the ministry; important tips for clergy and team facilitators; and potential barriers to the ministry; and steps, tools, and strategies to assure success including ministry guides and on-going consultation.

3. **Develop the Ministry – Establish a Congregational Team**
   Attend the two-day team training for 3–10 team members, usually scheduled two to four months after leadership training, giving time to assess the needs of the congregation, identify opportunities for education and recruit team members. Team Training addresses specific prevention and recovery strategies; team functioning; connection to community resources and initial plan of action. Team training, ministry guides, a resource library, on-going consultation, and opportunities for networking are a part of this step.

"Healing Places for individuals and families touched by addiction are possible when congregations start the conversation, learn facts, avoid judgment, practice love, and offer support."

How to Participate

For more information or to register, contact Trish Merrill, Faith Partners at 512-451-9504, 1-888-451-9527 or trishmerrill@johnsoninstitute.org, or Roger Svendsen, Interfaith Center for Health Issues at 763-427-5310, 1-800-782-1878 or rsvendsen@miph.org.

The Congregational Team Ministry Project Findings

Introduction

The impetus for this project builds on the results of two previous efforts. The first is a five-year experience in Texas, by Faith Partners, in the early 1990s designed to assist congregations in 19 rural, suburban, and urban communities. It was found that lay people of all faith traditions were eager to learn more about alcohol, drugs and other addictions and that many were able to conduct some awareness activities in their congregations. However, most had difficulty putting together a ministry that would continue to provide prevention and education to all congregational members and to help those members afflicted or affected by substance abuse problems to find the help they needed. It was clear that more resources were needed specifically those providing technical assistance to congregations to develop the capacity to implement and sustain such a ministry.

The second effort was the work of the Minnesota Institute of Public Health (MIPH) and its Interfaith Center for Health Issues. Over the past 25 years MIPH assisted substance abuse professionals to engage and support the faith community in prevention and recovery. Through its Center for Substance Abuse Prevention (CSAP) Central Center for the Application of Prevention Technologies (CAPT) cooperative agreement initiated a three-year demonstration project to determine the effectiveness of a Congregational Team Ministry Approach to Substance Abuse Prevention.

The Project Overview

The partners in this project—Faith Partners, the Johnson Institute Foundation and the Center for Substance Abuse Prevention-funded Central Center for the Application of Prevention Technologies (CAPT)—were located at two sites: Austin, Texas and Minneapolis, Minnesota. These two sites were selected for the demonstration project. The executive director of Faith Partners and a senior prevention specialist from Central CAPT became the primary staff for this project.

The goals of this three-year demonstration project at the two sites were to:

- Improve systems of care for individuals and families suffering the effects of substance abuse—their own or others;
- Increase access to information, training and technical assistance for clergy, congregations, persons served by congregations and professionals in community-based organizations seeking to work with the faith community;
- Develop coordination and collaboration between the faith-based organizations, public health and community-based organizations addressing substance abuse; and,
- Develop the capacity of congregations to integrate and sustain ongoing efforts to provide prevention, education, access to treatment and recovery support services.

The primary strategy was to provide materials, training and technical assistance to initiate and sustain active substance abuse team ministries in 5–10 congregations each year. The goals are accomplished through the activities and ongoing presence of these teams. Each team would then conduct prevention and recovery activities for their congregation and connect with and utilize community resources.

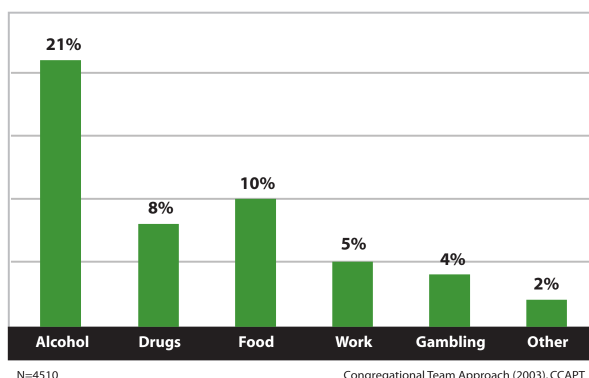
Congregational Need and Readiness

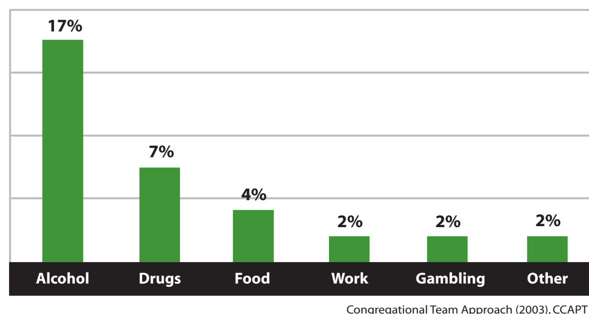
Methodology

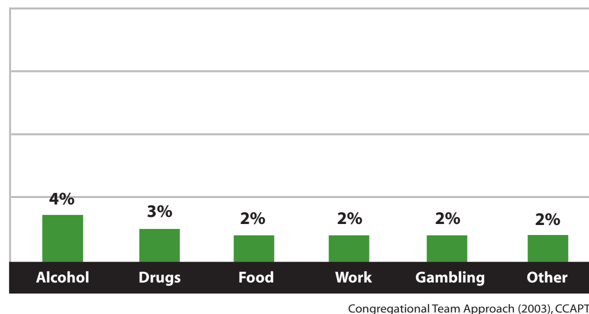
The Congregational Survey is a 14-item questionnaire, including demographics, that is most often administered during a worship service. This implementation approach has been shown to maximize the number of congregants completing the survey. The questionnaire was designed to help team leaders gauge interest, assess needs, determine programming directions, recruit team members and build support for the ministry.

Congregational Need for Prevention and Recovery
Survey results from 4,510 members in 23 Minnesota and Texas congregations over a three year period from 1999-2002 found that:

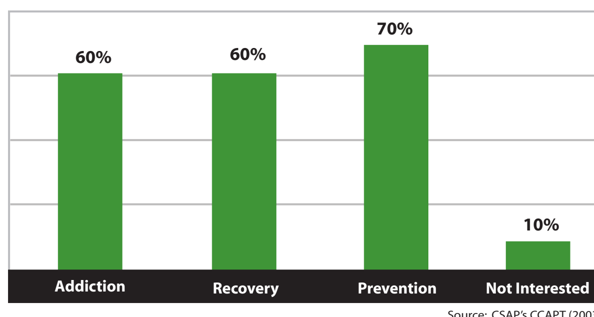
- Over 21 percent of respondents reported a family member with an alcohol problem in addition to other problems
- Over 17 percent reported a family member in recovery from an addiction problem
- Over 4 percent were in recovery themselves

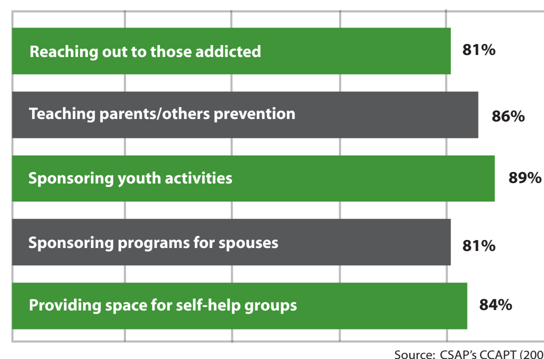






Congregational Readiness for Prevention and Recovery
In addition to finding substance abuse problems among their members, survey results from the study of Minnesota and Texas congregations found overwhelming support for their congregation's involvement in prevention and recovery activities.





Key Informant Interviews with Team Leaders

Methodology
Interviews were conducted with the leaders from 19 of the 23 participating congregations. Eight were located in Texas and 11 in Minnesota. The denominations represented include Lutheran, Catholic, Jewish, Baptist, Congregational, Methodist, Episcopal and Unity. Congregation size ranged from 250 to 10,000 with the average size being 2,750. The leaders that were contacted represented congregations that were mainly Caucasian, although African American, Hispanic and American Indian were included. All congregations have or had a core team. The core team is made up of a group of congregation members

who work together to implement this ministry. Team members often come from different backgrounds but come together to pursue similar interests, share experiences, explore talents and learn new skills in the area of substance abuse prevention. The average number of team members was 7 and ranged from 3 to 12 members. The ratio of male to female team members was fairly consistent across the sites with an average of 3 males and 4 females. Teams at a few of the sites did have significantly more women than men and vice versa. Team members' ages ranged from 16–86 across the sites with members in their 40s–60s being the most prevalent. The vast majority of teams met on a monthly basis and included team members who are in recovery. The core teams had fairly diverse representation: business, homemaker, legal, mental health, retired, arts, health care, government, management, high school student, college student, service, sales, education, parish nurse and members of the clergy. The majority of the congregations do have members outside of the core team that help with special events.

Implementation of the Team Ministry

The ways in which the 19 ministries were implemented varied depending upon congregation need and core team member abilities. There are several themes that appeared frequently as the team leaders described their ministries. These themes are outlined below:

1. Three implementation approaches were used either alone or in combination:

    - Prevention education—focused on presentations and literature distribution, which most often had a youth focus
    - Recovery and support—linked the 12-steps to the Bible and included opportunities for team and congregation members to participate in fellowship and recovery
    - Referral resource—compiled lists of 12-step meetings and treatment programs to share with members

2. Core team member recruitment varied from formal to informal. Some congregations put out a call for volunteers to work on a substance abuse ministry. While others led a structured information session and held interviews in order to get people involved.

3. Core team meetings varied from congregation to congregation and involved book reviews, discussions about how to best support a congregant's recovery and planning of events. Leaders were careful to note that team meetings were not a replacement for attending regular 12-step groups. Rather, they were an opportunity for action and fellowship regarding a topic all were concerned about.

4. Recovery worship services were an integral part of many of the ministries. Included in the service was the sharing of a personal recovery story, consecrating team members and generally increasing awareness of the substance abuse issue. In the words of one leader, "Having a Recovery Sunday is one way to have people sit up and take notice for a day." It should be noted that faiths with less flexibility in their liturgical schedule had a harder time incorporating a recovery worship service.

5. Many of the leaders felt it was important to include the sharing of a personal recovery story, especially if a respected member of the congregation was willing to share their journey. For many of the congregations this was the most successful part of their program because it allowed members of the congregation to see that people in recovery are the same as they are. Variations of this included one person presenting their story in sermon fashion or having a panel of those in recovery present during an adult forum and allowing congregation members to ask questions.

6. Many programs chose youth activities as their priority. Leaders often felt that parents were in denial and the only way to get them involved was to first involve youth. Work with youth varied included discussions about drug prevalence, zero tolerance and gangs to improvisational troupes and adapting the Peer Assistance Leadership

Program for use in a church setting. In some congregations a link was made between this initiative and the confirmation program. Some of the ministries took a slightly different approach and focused on the entire family, rather than just youth or parents. This emphasis had a wide scope of activity from helping family members recognize they need assistance to providing support to family members of those in treatment.

7. Leaders agreed that having youth core team members helped make their program more useful to the entire congregation.

8. Outreach is also being done to senior citizens. At one site, senior programs are currently being infused with topics on chemical dependency and the dangers of overusing and sharing prescription drugs. In addition, many of the sites are making connections within their community either through referrals or direct contact.

Key Factors for Successful Implementation of the Ministry

It became evident, during the conversations with the team leaders, that several key factors were involved in successful implementation of a substance abuse ministry. Those key factors are described below.

1. Overall program leadership was viewed by team leaders as one of the reasons for program success. The leadership that Trish Merrill, Director of Faith Partners; Roger Svendsen, Minnesota Institute of Public Health and Drew Brooks, Bloomington Minnesota Health Department, provided was invaluable. A few of this team's strengths that were cited by team leaders were the availability to provide consultation services, a willingness to listen when the going got tough and the ability to present complex material in an understandable manner. One team member wanted to be sure and say "thanks to Trish for putting 'feet' to her vision."

2. Strong core team leadership is critical. The programs that did not have strong leadership were less successful. This leadership manifests itself in several ways. The person must have some "clout" in the congregation in order to move the initiative forward. This person should also be dedicated to the project and be able to take charge and push the program forward. In the congregations that were not as successful, leadership was lacking or the leader was too involved in their personal recovery process that the core team turned into an AA-like support group.

3. Support of the clergy is essential to program success. Ministries whose pastor participates on the core team seem to better integrate this program into the congregation. Although this relationship is helpful, it is not essential. Pastors that show support by referring members of the congregation to the ministry, speak of the ministry during sermons and regularly check in with team leaders are also seen as a great benefit to the program.

4. Garnering support from the pastor and/or the church governing board is also helpful. A few of the team leaders attended the initial training and brought what they learned back to their church council to obtain buy-in before plunging ahead. In a few cases, the pastor attending the initial training with the team leader so he/she would be informed about the ministry.

5. Locating a member or members of the congregation in recovery that are willing to visibly support the program is another helpful tactic for moving the ministry forward. If the rest of the congregation sees that someone just like them is willing to participate, the congregational buy-in will be much more significant.

6. Outreach and marketing of the team ministry needs careful and thoughtful planning in order to maintain momentum and continued congregational involvement in the project. Although printing brochures and distributing it to various locations in the community can be a helpful way to increase awareness of the program, one team member reminds us to "remember the importance of word of mouth."

7. Thirteen of the 19 sites that participated in the key informant interviews completed the Congregational Survey. The survey helped these teams understand what the congregation already knew about addiction and recovery, what level of denial was present in their congregation and how much support the congregation had for implementing this ministry. In all cases, the survey was an important tool in developing activities and programs that would meet the congregation's needs.

Team Training and Follow-up

Team training occurs in a series of three steps. The first, half-day training was designed to introduce participants to information, strategies and faith-based materials that would increase a congregation's capacity to address substance abuse and is attended by clergy and core team leaders. During the first training, participants received a copy of the manual Building a Team Ministry. The congregational team training is step two. This 10-hour training was held on Friday evening and all-day Saturday and is attended by the entire ministry team. The goal of this training was to provide participants with the information, skills and resources to initiate and sustain an ongoing substance abuse prevention and recovery ministry in their congregation. The third training provided in-depth information and skills development in prevention programs for youth, parents and other adults. It was also a time to model recovery worship materials as well as enhance facilitator skills. The following describe the utility of the training process and materials.

- Many of the team leaders stated that the training manual was indispensable in the beginning of the program, but as the ministry grew the number of times the manual was used diminished. In these cases, the leaders did state that the manual still provided guidance for subjects the ministry has not yet addressed. During the high use stage the way the manual was used differed across congregations. Some went through it step by step while others passed it between team members and clergy for each to review individually. The manual was a great supplement to the initial team training and is cited as being "direct and concise," "very inclusive," and "well written." It covered more areas than most teams have needed, provided good background information and the activities were found to be useful.
- Team members are interested in practical, concrete reasons why the ministry would be helpful to their congregations. Ideas and strategies for practical application are a very necessary component of the team trainings. Team members are less interested in philosophical underpinnings of why a team ministry is a good idea.
- Increasing the amount of networking opportunities appears to be the biggest unmet need for existing and future ministries. Networking is important to this program because it offers the opportunity to hear successful program implementation strategies as well as learn about events that did not work. Networking that crosses cultural boundaries would also be valuable. In addition, the fellowship of meeting face-to-face was at the core of why this ministry was successful in many congregations. Although there seems to be a need for in-person gatherings, team members might find emailing and conference calls a better way to do this networking that will not cause increased time and scheduling constraints.

Barriers to Implementation

There were several barriers noted by team leaders that complicated or impeded implementation of the ministry. These barriers are listed below.

- Although most of the churches had the support of the pastor to implement this ministry, there were a few that found their clergy to be an obstacle to implementation. One team member commented that "our senior pastor and youth director have not been too interested, but this has just strengthened our resolve to show this is a good idea." Clergy transition has also affected implementation. A few teams had

not been very active because their pastor was new and they were waiting for him/her to get acquainted with the church before asking for involvement in this ministry. To the credit of these teams, they managed to keep the core team intact and the ministry operating at a minimal level so they would not be required to start over again.

- One of the biggest obstacles to implementing this program was congregational denial and fear that the ministry will judge those in recovery. In many cases the congregation was not willing to accept the fact that members were suffering from an addiction. Alcohol use was minimized by many members and even though they knew the ministry existed some "would not use it." For some, the community did not perceive this to be an important issue and the project was unable to get off the ground.
- Another obstacle to implementation was scheduling. This concern showed up in a variety of ways. Some team events were not planned well. In one instance a parent training was scheduled the same weekend as a major youth sporting event and many parents chose not to attend the training. Team leaders have also indicated they would like to attend more networking meetings with other congregational ministries, but these are often scheduled during the week. Many of the core team members work during the week and have found it challenging to attend because they are unable to take time off of work. This attendance is further complicated by location and the necessary travel time. On a more global scale, scheduling events is simply harder because of people's busy schedules.
- A few teams have found it challenging to keep members on the core team. One team had members drop off because they wanted to be part of a support group and another team found it hard to recruit members because the congregation thought you had to be in recovery to participate. Holding ongoing core team meetings has also proved hard. The scheduling issue, mentioned above, was part of the problem. Another team had a dedicated group of members but only two people showed up at a time and it was hard to make decisions or plan programs without the participation of the full group.
- Another big obstacle is time. Many of the team leaders acknowledged that getting this program up and running simply takes time—a commodity that was in often in short supply. There was the general thought that "people are supportive but do not have time to be ongoing participants." Core team leaders are also feeling the effects of these time constraints. Because some members have put boundaries around how much they are willing to do, the team leaders have needed to pick up the slack to ensure the program continues. Hence, burnout was rapidly approaching for some.

Summary

The team ministries have opened up the conversations about substance abuse simply by being present in the congregation. Talking and writing about the issue has been helpful in many congregations to dispel myths about substance use and encourage people to seek services.

There appear to be both team member and congregational benefits that go along with having this ministry operating in the congregation. For team members the opportunity to give back to the community significantly outweighs the effort put forth. Helping others was an integral part of this project and this ministry is a "socially acceptable way to carry the message as someone in recovery." Some team members felt that participating in this ministry also helped their personal recovery. For the congregation as a whole, this ministry was another option members of the congregation could seek out in times of need. It is another source of hope. It is also a marketing tool for new members. One team leader mentioned that she had a

new member come in and want to know if there were any local AA meetings. Because of this ministry, she was able to give him a brochure that listed all of the support groups in the area. This would not have been possible if it weren't for the organization that had occurred as a result of this ministry. Increased awareness about addiction is also a benefit for the congregation as a whole. This increased awareness comes in the form of prevention activities, advertisements for the ministry, and knowledge of local treatment services. Another congregational benefit is the fact that this ministry broke down barriers and diminished fears about addiction. The subject is now open for conversation.

The bottom line through all of this is that one size does not fit all. Each of these ministries has done what was needed to make this ministry work in their congregation. Be it a recovery, referral or education focus, each team worked hard to ensure that the team was helpful to their congregation. The few instances where teams were not successful were not due to a lack of passion or willingness to help. Most likely it was due to outside forces beyond the team members control, such as lack of clergy support or poor team leadership. Finally, it is evident from these interviews, that faith-based communities need leadership, direction and support for substance abuse prevention rather than monetary support.

A Congregational Checklist for Assessing Substance Abuse Prevention and Recovery Needs

The following are elements of a comprehensive congregational effort. The checklist is designed to assist individuals or planning groups to assess current efforts and plan future policies and programs. Which of the following are taking place within your congregation?

Elements	Yes	No	Action Needed	Person Responsible	Timeframe
1. A planning group of clergy, lay leaders, youth, parents, seniors and others develop and implement and maintain alcohol, tobacco and illicit drug use prevention and recovery programs.					
2. A substance abuse prevention and recovery team has been organized and trained to provide ongoing prevention and recovery services and programs within the congregation.					
3. Clergy and lay staff participate in/with other community groups in planning prevention and recovery programs.					
4. An alcohol, tobacco and other drug position/policy for the congregation exists.					
5. A tobacco-free policy exists.					
6. Collaboration occurs with other local faith groups regarding alcohol, tobacco and other drug issues.					
7. Procedures are in place to follow when a staff or congregational member seeks help for a personal problem or family problem.					
8. The congregation offers a support system for members returning to the congregational community after completing therapy or treatment.					

Checklist (continued)

Elements	Yes	No	Action Needed	Person Responsible	Timeframe
9. A special ministry to those affected by alcohol and other drug problems is provided.					
10. Clergy and lay leaders participate in continuing education and training in substance abuse problems prevention and recovery programs.					
11. Substance abuse prevention and recovery information are integrated into the congregation's ongoing education programs and publications.					
12. Recovery and prevention awareness events are conducted. Identify event(s): ______________________ ______________________					
13. A wide variety of alcohol, tobacco and other drug-free activities for youth are regularly scheduled with emphasis during the summer months. Identify activities: ______________________ ______________________					
14. A current listing of assessment, treatment and recovery resources available within the community is available to all members.					
15. Substance abuse prevention and recovery information is included in regular communications of the congregation such as worship service bulletins, newsletters, and literature racks.					
16. Meeting space for Alcoholics Anonymous, Al-Anon, A.C.O.A. or other support groups is available.					

Examples of Past and Current Efforts

An entire denomination sponsors a Recovery Sunday. Each year, a date is selected, and materials are provided for use within sermons, youth education, adult education and other appropriate areas of the church.

A congregation offers an educational program for parents and grandparents on a six step process for showing concern with a child or grandchild.

Another congregation annually integrates information on alcohol and other drug use as a part of their First Communion program for parents and their fifth grade children. This is an ideal time to focus parents on this issue at approximately the time when young people are beginning to make initial decisions about the use of tobacco, alcohol and other drugs. Participation of parents in this effort is nearly 100 percent, since attendance is expected by the congregation.

Alcohol and other drug use information is provided in a literature rack in the entryway of the house of worship. Materials are free and accessible to anyone.

A congregation has had great difficulty in getting parents and families to attend adult forums on alcohol and other drug use problems among youth. In response, the pastor integrated the information into the church's existing Confirmation program and required all ninth graders and their parents or guardians to attend a Saturday Confirmation program. The program involved everyone in talking, planning and learning about how to support each other and not get involved in inappropriate alcohol and other drug use. Attendance at the Saturday morning session was nearly 100 percent since it was required. Many parents and young people were unhappy to have to attend something on a weekend and were actually hostile at the beginning of the program. After being offered juice and other refreshments, asked to give each other a hug, and being involved in a relevant and active morning of learning together, nearly everyone who attended was grateful for the opportunity. It should be noted that, if this session had been voluntary, few families would have attended. By requiring attendance, this church used its tremendous opportunity to reach people through a captive audience.

Congregational facilities are used each week to hold AA, GA, Al-Anon, Gam Anon and Adult Children of Alcoholics meetings.

A local congregation sponsors and staffs an after school and summer time location for youth to gather, play and learn. The program meets the identified needs of many early and pre-adolescents who would likely be home alone and unsupervised if not involved in this kind of a program.

A congregation regularly includes information on substance abuse and prevention in its quarterly Health Newsletter.

A congregation integrates three, 1-1/2 hour sessions on alcohol, tobacco and other drug use into the religious education of their middle/junior high school age young people. All sessions are held on midweek evenings. **Session One** is for parents alone, and the content focuses on the importance of parents as role models, setting guidelines for alcohol and other drug use and nonuse, helping young people to remain alcohol, tobacco and drug free, how to talk to someone you are concerned about, and how to support each other. **Session Two** brings parents and children, other than their own, together to talk about alcohol, tobacco and other drug use, generation differences and what their faith has to say. **Session Three** brings parents and their own children together to talk about personal and family guidelines and expectations,

planning for future situations and how to be each other's keepers.

A congregation regularly provides information to all older adults on the safe and appropriate use of alcohol and prescription drugs.

A congregation requires all couples planning to be married to complete a guideline setting series of activities. The couple establishes family guidelines for the appropriate use and nonuse of alcohol and other drugs. The use of alcohol as a part of the wedding celebration is also discussed as part of the session, and guidelines are established if it is to be included.

The pastor of a congregation regularly integrates, when appropriate, content on the appropriate use and nonuse of alcohol and other drugs into the sermon. The pastor also integrates content on the successes of recovery and renewal through participation in treatment and therapy.

A congregation was confronted with a situation in which the city had an ordinance that prohibited the establishment of a bar or place that serves alcoholic beverages within 100 hundred yards of a church. This local congregation requested a permit to sell beer at its annual summer fest. When confronted by some city council members with what appeared to be hypocrisy or a double standard, a decision was made to review the congregation's policy on use of alcohol. The result of all of this was a major effort within an entire religious group to assist its congregations to establish guidelines for the appropriate use and nonuse of alcohol at church functions.

A congregation sends a booklet on setting guidelines for alcohol use to all of their members attending college.

Key Elements That Make a Congregational Plan Work

Clergy and Administrative Support
While much of what needs to be done in congregations can be accomplished by the laity, successful programs have the active personal support of the clergy.

Planning
Program planning includes: needs, readiness and resource assessments.

Trained Staff
Clergy and lay staff all have a need for general awareness and selected staff need specialized training for specific responsibilities.

Active Involvement of the Laity
Lay members of all ages need to be involved in planning and implementing program efforts. Many prevention and recovery efforts can be conducted by lay members. Congregational members are invaluable resources.

Coordination with Community Resources
Most congregations cannot provide all the services that members will need. Congregations will need to coordinate with and make use of the expertise and services available in the community. Utilization of community resources can also further protect the confidentiality of those seeking assistance.

Publicity
The congregation's programs need to be known by everyone. They should be highlighted in the congregational publications and referenced within the programs of the congregation.

Comprehensiveness
The program must address identification and referral, prevention and recovery support. All are equally important to a comprehensive response.

Integration within Existing Congregational Programs
Alcohol, tobacco and illicit drug concerns need to be integrated within existing congregation programs such as Confirmation, First Communion, Hebrew School, Sunday School, Marriage Preparation, Seniors, etc. If this integration does not take place, programs tend to last as long as an individual staff or lay member feels it is important or until it becomes unfashionable.

Links to Faith-based Organizations

Alcoholics Victorious
www.av.iugm.org
A directory of Alcoholics Victorious (AV) support groups, frequently asked questions, online bookstore and Christian Recovery Connection are just a few of the links available through the website of this organization that was founded in 1948.

Ark of Refuge
www.arkofrefuge.org
This site is designed as a tool for technical assistance information and links to assist faith-based communities in the fight against HIV/AIDS. The Ark of Refuge also provides capacity building and technical assistance to faith-based community-based organizations that are funded by the Centers for Disease Control. This includes training pastors and other faith-based leaders in substance abuse and other issues and needs of high-risk populations.

Christian Recovery Connection
http://crc.iugm.org/www.html
This directory page within the Alcoholics Victorious (see above) website can connect you to other Christian recovery sites from the 12-Step Cyber Café to the United Methodists in Recovery site. It also has links to a Spanish language site and other Internet resources.
Tip: This site offers a Christian Recovery Professionals E-mail Discussion List for added support.

Christian Recovery International
www.christianrecovery.com
Over 1,800 pages of information are included on this site. It also offers a Members Only area that provides a safe and loving atmosphere, private chat rooms, daily scheduled recovery meetings, e-mail groups, message boards, 12-Step Bible Study Groups and more.
Tip: Check out the Confident Kids part of this site to see youth-specific resources.

Christians in Recovery Resources Database
www.christians-in-recovery.com
This user-friendly database lists 2,000 Christian support groups.

Community of Hope
www.communityofhopedc.org
Community of Hope, a nonprofit organization serving Washington D.C.'s poor and homeless children and adults for over 20 years, runs a family health services clinic. One of its services is substance abuse early identification, referral and treatment.

Faithworks
www.axis1.org/FaithWorks.html
A joint effort of the faith community and the South Carolina Department of Alcohol and Other Drug Abuse Services, this initiative seeks to raise awareness of, and reduce the negative health, social and economic consequences stemming from the abuse of alcohol, tobacco and other drugs. Faithworks seeks to work with all members of the state's faith community. It includes, but is not limited to, the Christian, Jewish and Islamic faiths.
Tip: This site offers an example of a statewide faith-based prevention effort.

Gamaliel Foundation
www.gamaliel.org
The Gamaliel Foundation is an organizing institute committed to empowering communities and expanding democracy through faith-based community organizing. Its affiliates are congregations and other faith based organizations throughout the U.S. The foundation provides local community leaders with resources in the areas of staff recruitment and development, leadership training, strategic planning, issues of development and fundraising.

Interfaith Center for Health Issues
http://miph.org/interfaithcenter/
The Minnesota Institute of Public Health launched this center to provide useful resources to faith community leaders, then congregations and affiliated organizations so they can develop their roles as health advocates. The center provides training for substance abuse prevention professionals on working with the faith community.

Interfaith Health Program
www.ihpnet.org
The Interfaith Health Program was launched at the Carter Center and is housed at Georgia's Emory University Rollins School of Public Health where it has close ties to the University's schools of theology and nursing.
Tip: The site features a searchable database and includes practice models of working faith-based programs.

Jewish Alcoholics, Chemically Dependent Persons and Significant Others (JACS)
www.jacsweb.org
There are approximately 20 groups loosely affiliated with JACS throughout the U.S. and Canada. The site is for Jews and their families whose lives have been affected by substance abuse. It is also for rabbis and treatment professionals involved or concerned with addiction in the Jewish community.
Tip: Visitors to this site may subscribe to an e-mail discussion list.

Kiamsha
www.proinc.net/kiamsha
Kiamsha is an intergenerational organization in Washington, D.C. seeking to establish collaborative relationships among government, grassroots organizations, businesses and the faith community for the benefit of youth. Among Kaimsha's projects, is one with the Network of Freedom Youth Singers that promotes abstinence from alcohol and other drugs, premature sexual activity and violence.

Overcomers Ministry
http://overcomersministry.org
Overcomers Ministry was established in 1988 in the Phillips Neighborhood of Minneapolis as an outreach ministry to Native American Christians struggling with alcohol abuse. The website features information on the many activities the ministry sponsors as well as information about their outreach programs.

Rush Center of the Johnson Institute
www.johnsoninstitute.org
The mission of this organization is to engage and assist people of faith in the development of caring communities that promote prevention of alcohol, tobacco and other drug abuse and where recovery from addiction is valued and supported. The Faith Partners Service Center conducts regional workshops and training for establishing Faith Partner Teams in congregations and is a Central CAPT partner in offering faith-based prevention services in the Central CAPT region.

Teen Challenge
www.teenchallenge.com
A worldwide Christian network of speakers and support groups working with teens to educate them on the dangers of drugs. The organization offers residential programs, support groups (Turning Point) and a speaker's bureau. The site provides links to the Teen Challenge Curriculum and to centers throughout the world.

T.R.E.T.ment Faith Counselor Leasing Services
www.restcounseling.com
T.R.E.T.ment (Training, Research, Education and Therapy) certifies ministers and lay people to become faith-based counselors specializing in Rational Emotive Spiritual Therapy (R.E.S.T.). This therapy involves combination of spiritual, Christian intervention and medical treatment to deal with substance abuse and related issues. The website offers its services to churches and organizations in need of highly trained and certified, spiritually based faith counselors.

The Faith Community and Substance Abuse Prevention and Recovery

Instructions: Circle the response that most clearly indicates the way you feel about each item. You will be asked to share your responses in a small group discussion when everyone has completed the exercise.

SA = Strongly Agree **A = Agree** **U = Undecided** **D = Disagree** **SD = Strongly Disagree**

1. Substance abuse prevention is a primary concern for the faith community.	SA	A	U	D	SD
2. The basic issues in the prevention and treatment of substance abuse problems are spiritual.	SA	A	U	D	SD
3. Most prevention specialists are comfortable working with faith groups.	SA	A	U	D	SD
4. The faith community, as well as the broader community, has communicated with a clear, consistent message regarding the use and nonuse of alcohol, tobacco and other drugs.	SA	A	U	D	SD
5. The faith community has the expertise necessary to play a primary role in responding to society's problems with substance abuse.	SA	A	U	D	SD
6. Science and faith simply don't mix.	SA	A	U	D	SD
7. It is possible for one key person within a congregation to initiate the creation of a successful effort to address alcohol, tobacco and other drug use problems.	SA	A	U	D	SD
8. It will take significant funding for faith groups to initiate prevention and recovery programs within their congregations.	SA	A	U	D	SD
9. The effectiveness of prevention efforts can be significantly enhanced when multiple community sectors work together.	SA	A	U	D	SD
10. The faith community can engage audiences that are outside the reach of many prevention efforts.	SA	A	U	D	SD

The Faith Community and Alcohol, Tobacco and Illicit Drug Use

Instructions: Circle the response that most clearly indicates the way you feel about each item. You will be asked to share your responses in a small group discussion when everyone has completed the exercise.

SA = Strongly Agree A = Agree N = No strong feelings D = Disagree SD = Strongly Disagree

	Statement					
1.	The basic issues in the treatment and prevention of alcohol and other drug use problems are spiritual.	SA	A	N	D	SD
2.	As with all of God's creations, drugs are neither good nor bad; the way individuals use them determines their potential benefits or risks.	SA	A	N	D	SD
3.	Our religious tradition directs us to abstain from all alcohol and other drug use.	SA	A	N	D	SD
4.	We live in a drug-oriented society which promotes the concept of instant relief or gratification.	SA	A	N	D	SD
5.	The faith community, as well as the broader community, has communicated a clear, consistent message regarding alcohol, tobacco and other drug use.	SA	A	N	D	SD
6.	How an individual feels about himself/herself affects the way he or she behaves with alcohol and other drugs.	SA	A	N	D	SD
7.	Prevention efforts should focus primarily on youth.	SA	A	N	D	SD
8.	The faith community has the expertise necessary to play a primary role in substance abuse prevention and recovery.	SA	A	N	D	SD
9.	Parents and family, as well as the extended congregational family, have a potential, major influence on one another's attitudes, knowledge and behavior around substance use and abuse.	SA	A	N	D	SD

Substance Use Situations

A number of situations that involve actual or intended use of alcohol, tobacco and other drugs are described below. For each situation, choose from the words provided that you feel best describe the use, using no more than three words per situation. You will be asked to share your responses in a small group when everyone has completed this exercise.

Healthy	**Wise**	**Legal**	**Appropriate**	**Moral**	**Low-Risk**	**Responsible**	**Necessary**
Unhealthy	**Foolish**	**Illegal**	**Inappropriate**	**Immoral**	**High-Risk**	**Irresponsible**	**Unnecessary**

1. A person drinks one or two beers each evening to help to get to sleep. ________________
2. Parents allow a 16-year-old to have a glass of wine with the family at home. ________________
3. Medication is taken to help deal with the grief and emotion "when getting over" the death of a spouse. ________________
4. A person enjoys watching the late evening news and having a drink before going to bed. ________________
5. Champagne is served as part of a wedding celebration. ________________
6. A resident of an older citizens "high rise" regularly has a drink or two as a practice developed over a lifetime. ________________
7. A person has a bottle of beer after mowing the lawn on a hot afternoon. ________________
8. Wine is served to school age young people as part of a religious ceremony. ________________
9. A terminally ill person is given morphine to relieve the pain caused by cancer. ________________
10. During a council meeting, one of the members begins smoking, without asking nonsmokers if it bothers them. ________________
11. Two softball players on a church team share a 12-pack after a close loss. ________________
12. A woman continues to have a daily glass or two of wine after she becomes pregnant. ________________
13. A member of the clergy has a glass of wine with members of the congregation at a social event. ________________
14. Parents make beer available for everyone attending their child's high school graduation party. ________________
15. To conclude their date, a couple returns to his place for a few drinks. ________________

After completing this exercise, discuss the following questions:

1. Was it easy to choose words that describe each situation?
2. What were the criteria or guidelines you used to decide whether the use was appropriate, inappropriate, etc.?

Setting Guidelines for Substance Use and Non-use

As individuals, parents and families, our risk for developing a substance abuse problem is directly related to our ability to establish and follow guidelines for safe, legal and appropriate use or nonuse of alcohol and other drugs. Listed below are some suggestions for setting both personal and group guidelines. Please read through the information in **bold** type and then you will be asked to discuss the questions in a small group.

1. **To use or not use alcohol is a personal choice for which each person is accountable.**
   No one should feel pressured to drink or made to feel uneasy or embarrassed because of a personal choice. Many people will choose to use alcohol safely, moderately and appropriately. Others will simply have no desire to experience the effects of alcohol. Some people with a family history of chemical dependency or alcoholism may choose not to risk ay use of alcohol. The bottom line is that no one should feel that he/she has to drink to be accepted.
   a. *In what kinds of situations do adults feel pressure to use or not use alcohol?*
   b. *Is the pressure any different for young people?*
   c. *What factors influence your personal choices about alcohol use?*
   d. *How might a family history of alcoholism influence personal choice?*

2. **Alcohol use is not essential for enjoying family or social events.**
   The real value of parties and other social activities is being with friends and taking time out from the pressures of work and school. Drinking alcohol should not be seen as a necessary component for having fun and being with friends, but as an enjoyable complement to other activities, not the only reason for socializing. Actually, focusing on alcohol use as the main reason for getting together results in intoxicated people who get sick, can't carry on a conversation, and generally aren't much fun to be with after a while.
   a. *Are there events where it seems that alcohol is essential?*
   b. *Do you believe that most people agree with this guideline? Why or why not?*
   c. *Should drinking be the primary activity at certain social events?*
   d. *How do you feel in situations where drinking is the primary activity?*
   e. *Is alcohol appropriate as part of a wedding celebration?*

3. **Use of alcohol that leads to impairment or intoxication is unhealthy, risky and should be avoided.**
   Getting drunk is not a condition to be admired, laughed at or taken lightly. Rude, destructive or just plain foolish behavior triggered by alcohol use is socially unacceptable. It may also indicate an alcohol use problem. Drinking games often result in drunkenness and can present serious risks for those involved. Driving after drinking to the point of impairment is always illegal and dangerous.
   a. *What level of drinking is socially acceptable? Is drunkenness ever socially acceptable?*
   b. *Are there circumstances in which excessive drinking is tolerated in your community?*
   c. *Do you think people generally agree with this standard?*
   d. *Should drunkenness be considered irresponsible? Indicative of personal problems? A normal part of life? Humorous?*
   e. *Is there anything wrong with laughing at people who are drunk?*

4. **There are times when it is important for everyone to abstain from alcohol or other drug use.**
   Examples include:
   - When it is inconsistent with religious beliefs.
   - When recovering from chemical dependency.
   - When the alcohol or other drug use is illegal.
   - When pregnant or nursing.
   - When operating equipment–motor vehicles, motorcycles, boats, tools, firearms, etc.
   - When swimming, skiing, climbing, or doing other risky physical activities.
   - When at work or studying.
   - When performing in athletics or fine arts.
   - When taking certain medications.

   a. *What effects of alcohol make this guideline important?*

   b. *Do you agree that people should abstain at these times?*

   c. *At what times does your Faith tell you to abstain?*

   d. *What would you say to someone who is pregnant and drinking? Pregnant and smoking? Using steroids? Swimming and drinking? Smoking marijuana while studying? Drinking and ready to drive? Under the legal age?*

   e. *Are there other times when it is important to abstain?*

5. **There are personal limits of moderation for everyone who chooses to use alcohol.**
   Factors that influence the effects of alcohol include:
   - Body weight.
   - Strength and number of drinks. A 12 oz. bottle of beer, a 9 oz. wine cooler, a 5 oz. glass of wine or 1.5 oz. of distilled spirits contain approximately the same amount of alcohol. A person can become just as intoxicated drinking beer, wine, wine coolers or distilled spirits.
   - Time between drinks.
   - Eating while drinking slows down the absorption of alcohol into the blood stream.
   - A people age, their metabolism changes reducing the amount of alcohol a person can safely consume.
   - Fatigue and emotions such as frustration, anger and loneliness can increase the effects of alcohol on a person's behavior.
   - Due to the differences in body composition and chemistry, females may be affected more than males of equal weight, after drinking the same amount of alcohol.

   a. *How do these factors influence personal limits?*

   b. *What are the gender and age differences that can affect personal limits of moderation?*

   c. *How can you help someone establish personal limits of moderation?*

6. **There are ways to minimize health and safety risks when serving alcohol.**
   Examples include:
   - Do not serve alcohol to underage youth.
   - Emphasize friendship, conversation and other activities rather than drinking alcohol.
   - Offer a variety of attractive non-alcoholic drinks that are easily available.
   - Provide a variety of foods.
   - Serve all drinks to guests rather than having an open bar.
   - Inform guests whether or not beverages such as punch contain alcohol.
   - Stay alert and assume responsibility to help a guest who may have had too much to drink.
   - Create an environment that allows guests to feel comfortable making a personal choice about alcohol use of non-use.

a. *How can non-alcoholic drinks be made to appear attractive?*

b. *What kinds of activities can reduce the emphasis on alcohol use?*

c. *What steps can be taken to help guests feel comfortable?*

d. *Should the person(s) holding social events be responsible for seeing that alcohol, if used, is used legally, moderately, and safely?*

7. **Illegal use of drugs has specific health, legal, and ethical risks and should be avoided and discouraged.**
Reasons why:
    - Dosage is unpredictable
    - Purity is unpredictable
    - Can result in a criminal record

a. *What drugs are illegal?*

b. *What are their risks?*

c. *How does illegal drug use affect behavior? Judgment? Safety?*

d. *Is it ever appropriate to use an illegal drug?*

8. **Tobacco use has significant risks and should be avoided and discouraged** *(with the exception of ceremonial use of tobacco by American Indians).*
The relationship between tobacco use and increased risk of heart disease, a variety of cancers and lung diseases has been clearly demonstrated. Current research efforts are further identifying the risks of second hand smoke for non-smokers. Tobacco is also considered a gateway drug for young people.

a. *Does your workplace have a smoke free policy?*

b. *Are you comfortable asking someone to refrain from smoking in your presence?*

c. *Do you think people believe that smokeless tobacco is low-risk behavior?*

9. **Medications should only be used as prescribed or according to directions and never mixed with alcohol.**
Drugs, both prescription and over-the-counter, should be used only when needed and never shared and all labels and instructions should be read and followed carefully.

a. *Do you think people share prescription medications? Why?*

b. *What are some of the dangers of using someone else's medication?*

10. **Avoid situations where someone else's alcohol, tobacco or other drug use may put you at risk.**
Examples include:
    - Not riding with an impaired or intoxicated driver.
    - Using seat belts at all times to protect both drinkers and nondrinkers against being injured or killed in an alcohol-related crash.
    - Exercising caution in unfamiliar environments.
    - Recognizing and avoiding high-risk sexual situations.
    - Recognizing safety risks by a co-worker's impairment.

a. *What are the risks associated with each of these situations?*

b. *Are there other examples of high-risk situations?*

Personal Guidelines for Use and Non-use

What are your personal guidelines for choices about alcohol, tobacco and other drug use and non-use? Use the space below to describe your personal guidelines.

We have found it to be helpful to make a personal commitment to follow one's personal guidelines and discuss them with a close friend, spouse or family member.

Who will you talk to about your guidelines?____________________

When will you talk with this person? ____________________

Family Guidelines for Use and Non-use

What guidelines about alcohol, tobacco and other drug use do you want to establish with your family? Use the space below to describe your family guidelines.

We have found it to be helpful to make a commitment to discuss family guidelines with other family members.

Who will you include in your guidelines discussion? ______________________

When will you have the discussion? ______________________

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