Addiction Information for Church Leadership

by the Addiction Ministry Network
of the Presbytery of Redstone
Presbyterian Church, (U.S.A.)

This introductory guide serves to inspire further exploration into addiction, recovery, and the impact on family, friends, and communities. The guide addresses the basic foundations of addiction; importance of relational and spiritual recovery; and the vital role the church and its leadership play in addressing recovery, hope, support, and discipleship.

For further information or assistance, contact the Addiction Ministry Network by sending email to redstonetogether@gmail.com

PREFACE

I have been involved in addiction treatment and prevention since 1979 as a counselor, supervisor, executive director, and pastor. Through the years I have engaged in hundreds of conversations with people inside and outside the church about addiction and recovery. I have endeavored to discern ways to engage church leadership in addressing addiction and the people and families impacted.

I provided pulpit supply in hundreds of Presbyterian Church (U.S.A.) congregations over the past 40 years and served as solo pastor for 20 of those years. I would mention during worship my experience in addiction treatment which led to numerous conversations with recovering people and family members impacted by someone deep within their addiction. One of the chief overriding themes of these conversations is the fact that these people were keeping this information a secret from the rest of the congregation for a variety of reasons. They simply did not know how the congregation would respond to this knowledge. They were afraid of a negative response rather than a loving, supportive, and caring approach.

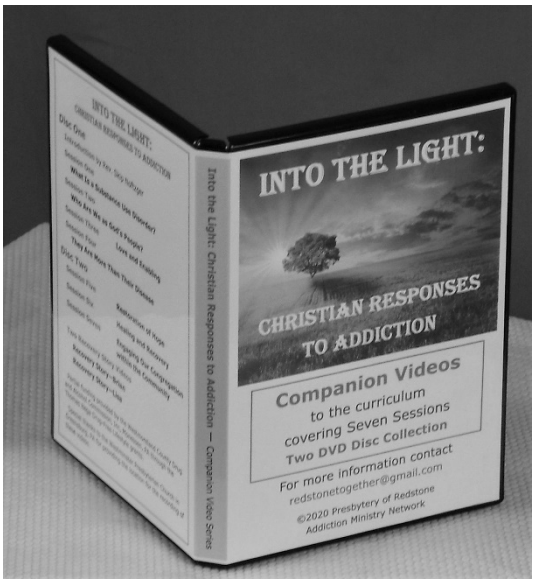
Fortunately, I have met pastors, church leaders, men and women in recovery, medical professionals, educators, etc. who had an interest in finding ways to persuade congregations to face the challenges of addiction. They were determined to discover ways their communities and the church could faithfully respond. Since 2016, I had the privilege to work with a group in Redstone Presbytery called the Addiction Ministry Network. The group is comprised of diverse people from different denominations, professional experience, backgrounds, and people in recovery. We have discussions among ourselves and with others in the community who provide addiction treatment and other support services. We work to develop strategies to address addiction in our region. Our work has led to worship services of remembrance, Lenten devotional, addiction curriculum with companion videos, Narcan® training and distribution, etc. Each group member has discovered their own unique calling to address addiction in their communities. My calling has been to educate and encourage empathy, therefore the idea for this introduction into addiction and recovery was born.

The content offers a basic introduction into addiction and recovery for church leaders who have little or no experience with addiction. Some may wonder why specific populations are not addressed, the simple answer is that this was not our objective. Our country and churches represent a diverse spectrum of ethnic groups, races, religions, sexual orientation, criminal justice issues, and drugs of choice, etc. and covering the specifics would be a massive undertaking and beyond

the scope of our current objective. Each region has unique issues and challenges related to addiction in their communities. Our objective in this document is only to serve as a beginning to embolden further discovery by encouraging you to seek connections to local professionals who can help you understand the unique situation in your region of the country.

Each Sunday people active in addiction and those in recovery and their families sit in our pews struggling with some aspect of addiction and/or recovery. These people are unsure where to turn. They would like to share their struggles, pain, and loss with their community of faith, like other members have done related to other illnesses, grief, and loss. We hope this guide will serve to lead you to a hopeful and faithful approach to reaching out to people within our communities who have too long been suffering in silence.

Rev. F. Lee McDermott
Addiction Ministry Network, Redstone Presbytery



The Addiction Ministry Network also produced a curriculum with companion videos called **Into the Light: Christian Responses to Addiction.** The curriculum contains nine sessions. This document can serve as a resource to prepare individuals who will be leading groups using the curriculum.

Curriculum & videos are available in a variety of formats:

Curriculum is available in either a three-ring notebook, a flash drive containing PDF files, or files may be e-mailed upon request.

Companion Videos cover the first seven sessions in the curriculum which are available on DVD, on a flash drive, or as a download on the Synod of the Trinity's YouTube channel.

Questions and Discussion Questions for Video Segments

As you view the videos, notice that each speaker segment begins with a question and is followed by discussion questions. The curriculum appendix contains a list of speakers and discussion questions for each session. These can be used as you develop your own plans to deliver each session. For further questions or feedback contact: **redstonetogether@gmail.com**

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Introduction

Alcohol and other drug (AOD)[1] usage is seldom spoken about within the walls of most churches and when it is, it is often expressed with negative overtones toward the people suffering. When the topic comes up, you might hear comments, like, "They made their choice to use, now they can live with the consequences," or "Their sinful behavior is unacceptable and they are getting what they deserve," or "We don't have to concern ourselves with this problem. We don't have anyone in our church who has that problem."

Myths and misconceptions about substance use disorders (SUD)[2] abound within the church and the surrounding community. Most church members know someone with a substance use disorder, and many know someone who has lost or nearly lost a family member because of substance abuse and/or misuse. Sadly, few other medical conditions are surrounded by as much shame, stigma and misunderstanding as substance use disorders. Many congregations have at least one family who is secretly struggling to understand someone in their immediate or extended family with a substance use disorder (SUD).

These families are living silently experiencing feelings of distress and hopelessness. SUD is a secret that people are too afraid to share. The family is unsure whether their church family is a safe place to share their stories. They dread the consequences, if they speak about their struggles, hurt and pain. They are unaware if anyone would be willing to understand and not judge them. When the church is in denial and/or silent about people with a substance use disorder (SUD) in their communities, these families are cut off from those whom they need the most.

My great-aunt Louise was born in 1900.[3] She worked as a registered nurse all her life. When I was a child, we would frequently visit Aunt Louise. One day I remember, Aunt Louise was chatting with my parents at the kitchen table. She was telling my parents about a local family she knew. At one point, she told my mother about a person in the family who had the "Big C." I was puzzled. What was she

[1] The acronym **AOD** means "alcohol and other drugs" and will be used throughout this document.

[2] The acronym **SUD** means "Substance Use Disorder" and designates the condition suffered by individuals with problems related to AOD usage.

[3] First person accounts are shared by Rev. F. Lee McDermott based on his experiences from 40+ years as an addiction's counselor and pastor, unless otherwise noted.

talking about "the Big C?" Later at home, I asked my mother what Aunt Louise meant by "the Big C." My mother said she was talking about someone with cancer.

During the years Aunt Louise was a nurse, cancer was essentially considered a death sentence. Cancer created considerable fear within the lives and minds of people in Aunt Louise's generation. As a nurse, she witnessed many people suffer painful cancer related deaths. Aunt Louise was so disturbed by these experiences that she found it difficult, if not impossible, to verbally say the word cancer. For Aunt Louise and many others of her generation, cancer equaled no hope because of the fear cancer instilled in people's souls.

As medical treatment options increased and survival rates for cancer improved, hope for recovery and the possibility for life after cancer improved. As more effective treatments began to develop and fear began to subside, hope of recovery grew. As hope increased, more and more people were willing to get screened for cancer and take advantage of available treatments. People began to speak openly about the reality of cancer and their hope for a cancer-free future.

Today, cancer still brings some degree of fear to people's lives and families, but cancer is not deemed by the public as an automatic death sentence. People have come to believe that survival from cancer is possible through effective treatment approaches and long-term management of cancer. When people survive treatment and live years after the initial cancer diagnosis, hope becomes real and tangible. Paradoxically, as more people believe in the potential for hope in recovery, then more people are detected with cancer earlier and more enter treatment, surviving and succeeding.

As medical science has progressed in finding effective treatments for a variety of diseases, the same has occurred in the treatment of substance use disorders (SUD). For those in addiction recovery, hope has once again established a foothold in their lives. As the apostle Paul declares, *"And now faith, hope, and love abide,"* (1 Cor. 13:13) Extending hope to others around us is an essential calling of disciples of Jesus Christ, which leads us to love. As we face an epidemic of addiction in our communities and among our neighbors, we need to learn how to provide faith, hope and love for treatment and recovery.

The Addiction Ministry Network of the Presbytery of Redstone was created to provide pastors and church leadership a place to have a conversation about the impact of AOD use, abuse, and dependency. The network serves as a place to discern how the Holy Spirit might help us to bring hope and new life to these dealing with a SUD and their families. We need to engage in a conversation about addiction, though to enter any productive discussions we need to know some basics. This

guide into addiction is one approach the Addiction Ministry Network is using to present some of the basic facts and information about addiction and the people suffering from a substance use disorder. We invite you to join us and begin a conversation within your own congregations.

The problems and challenges AOD abuse and SUD bring to the forefront of congregational life are not something that only exists at an external level. AOD issues are not someone else's problem to solve. We can't simply state that if only the government, the police, or social services did this or that specific thing, the problem will go away in a few months. We, as a society, as a church, have an AOD problem. The AOD problem is ours by omission. Our neglect creates a missed opportunities to live out the full expression of the Good News and to proclaim that the Kingdom of God has come near us. Substance Use Disorders are as much a spiritual and relational problem as they are a physical, mental, or economic problem.

Our communities have found themselves in the grips of a serious alcohol and other drug problem and are struggling to find answers. Heroin, alcohol, cocaine, prescription pain killers and a host of other drugs are destroying families, homes, children, parents, grandparents, neighborhoods, communities, and individuals. Communities are faced daily with death, destruction, violence, hopelessness, disability, criminal behavior, and imprisonment. The people impacted are individuals both far and near to us, our sons and daughters, our neighbors, and friends.

As disciples of Jesus Christ, we can't allow our neighborhoods to decline around us and watch passively as our sons and daughters perish. Our calling is to *"boast in our hope of sharing the glory of God."* (Rom. 5:2) Alcohol and other drugs (AOD)[1] have created a serious health and mental illness crisis, emotional pain, despair, and unspeakable sinful behavior. God does not wish us to be silent. Our calling is not to speak harshly, but lovingly of the hope and grace that comes by facing our brokenness and proclaiming the Good News found in Jesus Christ.

The Current Epidemic

The U.S. has found itself in the middle of an epidemic of opioid addiction and overdoses. Opioid overdose continues to be a major public health problem in the United States. Opioids include illegal drugs such as heroin, as well as prescription medications used to treat pain such as morphine, codeine, methadone, oxycodone (OxyContin®, Percodan®, Percocet®), hydrocodone (Vicodin®, Lortab®, Norco®), fentanyl (Duragesic®, Fentora®), hydromorphone (Dilaudid®, Exalgo®), and buprenorphine (Subutex®, Suboxone®).

Over-prescription of powerful opioid pain relievers beginning in the 1990s led to a rapid escalation of use and misuse of these substances by a broad demographic of men and women across the country. This led to a resurgence of heroin use, as some users transitioned to using the cheaper street cousin of expensive prescription opioids. As a result, the number of people dying from opioid overdoses soared—increasing nearly four-fold between 1999 and 2014.[4]

The pandemic did not slow down overdose deaths, but created an increase in one age group, those 65+. This was chiefly due to people accidentally taking too many opioid-based prescription pain killers and the isolation created by the pandemic. Pennsylvania and West Virginia have a higher overdose rate than most states. According to Centers for Disease Control and Prevention (CDC) data, health care providers wrote 259 million prescriptions for painkillers in 2012, enough for every American adult to have a bottle of pills. Also at risk are people who misuse opioids and combine them with sedative hypnotic agents, such as alcohol, diazepam (Valium®), clonazepam (Klonopin®), and alprazolam (Xanax®), resulting in sedation and respiratory depression.

Currently, many communities are focusing on an epidemic regarding opioid related substances. We need to remember, if we somehow miraculously solved this specific problem with opioids in the next year, serious AOD problems in our communities would still exist. Removing one specific substance from the community landscape will not solve the problem. Many, many more drugs, particularly alcohol will continue to hold our neighbors in bondage to addiction.

Would solving the heroin/opioid problem help? Of course, it would help, but addictive behaviors would remain with us in many other forms. Alcohol and a host of other drugs will still fuel the behaviors and actions of a society addicted to substances among other addictive behaviors, such as, food, gambling, sex, etc. Alcohol alone outpaces all other drugs combined, which creates its own serious abuse and dependency problems, i.e., DUI, domestic abuse, violence, and workplace accidents to name a few.

Alcoholism is an extremely serious problem in our world today. In 2019, 25.8 percent of people ages 18 and older (29.7 percent of men and 22.2 percent of women in this age group) reported that they engaged in binge drinking in the past

[4] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016.

month, and 6.3 percent (8.3 percent of men and 4.5 percent of women in this age group) reported that they engaged in heavy alcohol use in the past month.[5]

According to the 2019 National Survey on Drug Use and Health (NSDUH), 14.5 million people aged 12 and older (5.3 percent of this age group) had an Alcohol Use Disorder (AUD). This number includes 9.0 million men (6.8 percent of men in this age group) and 5.5 million women (3.9 percent of women in this age group). According to the 2019 NSDUH, an estimated 414,000 adolescents ages 12 to 17 (1.7 percent of this age group) had an Alcohol Use Disorder (AUD). This number includes 163,000 males (1.3 percent of males in this age group) and 251,000 females (2.1 percent of females in this age group).[6]

Over the past 40 years, communities have experienced many different cycles of specific drugs impacting their neighborhoods, from cocaine, prescription sedatives, crack cocaine, crystal methamphetamine (meth), etc. All these drugs still pose a serious problem for many but have faded from our memories due to current media attention on opioids. In a few years, the attention could and probably will shift to some other new or old drug. Recently, the rise of fentanyl (another opioid based drug) which is often added to or substituted in the distribution of other drugs has created a major upswing in overdose deaths.

The church's primary role should be in addressing the community challenges from the relational and spiritual perspective so we can make our communities whole. Our focus should not simply rely upon a short-term goal of ending the current opioid crisis but should also focus on long-term objectives of addressing the reduction of addictive behavior in our communities. In the process, we can learn new approaches for living a life of discipleship which upholds healthy individuals, emotional stability, productive relationships, service, etc.

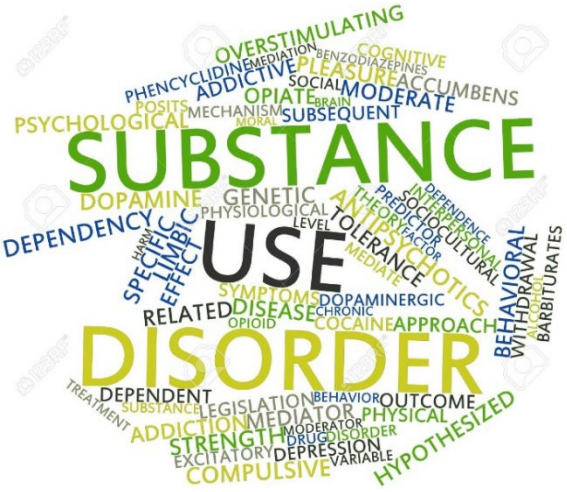
How do we respond to the crisis of AOD abuse and SUD within our communities and the church? Pastors, ruling elders, deacons, and other church leaders must be open to learning about the disease. Whether we desire it or not we will be faced with confronting the problem, sooner or later. We must learn and listen to individuals and their families who are suffering and in pain. We need to know where to turn for resources, ideas, and how to create a safe place where they can speak

[5] SAMHSA, Center for Behavioral Health Statistics and Quality. 2019 National Survey on Drug Use and Health. Table 5.4B – Alcohol Use Disorder in Past Year among Persons Aged 12 or Older, by Age Group and Demographic Characteristics: Percentages, 2018 and 2019.

[6] SAMHSA, Center for Behavioral Health Statistics and Quality. 2019 National Survey on Drug Use and Health. Table 5.4B – Alcohol Use Disorder in Past Year among Persons Aged 12 or Older, by Age Group and Demographic Characteristics: Percentages, 2018 and 2019.

honestly and openly about their struggles. This must be a place where they will experience the compassion, love, and hope in Christ. We need to engage in a serious conversation about substance use disorders (SUD).

Substance Use Disorder (SUD)



In 2013, the American Psychiatric Association (APA) updated the DSM-5, replacing the categories of substance abuse and substance dependence with a single category: **"Substance Use Disorder."**[7]

Substance Use Disorder (SUD) symptoms fall into four major groupings:

1. Impaired control
2. Social impairment
3. Risky use
4. Pharmacological criteria (i.e., tolerance and withdrawal).

Substance Use Disorder (SUD) in the DSM-5 describes a problematic pattern of use of an intoxicating substance leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

- The substance is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful effort to cut down or control use of the substance.
- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- Craving, or a strong desire or urge to use the substance.
- Recurrent use of the substance resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.

[7] Information in this section comes from the American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5)* (5th ed.). Arlington, VA: American Psychiatric Publishing.

- Important social, occupational, or recreational activities are given up or reduced because of use of the substance.
- Recurrent use of the substance in situations in which it is physically hazardous.
- Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Tolerance, as defined by either of the following:

- A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
- A markedly diminished effect with continued use of the same amount of the substance.

Withdrawal, as manifested by either of the following:

- The characteristic withdrawal syndrome for that substance (as specified in the DSM- 5 for each substance).
- The substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

Signs of a Substance Use Disorder (SUD)

People with a SUD might act differently, compared to how they typically behaved prior to their use. They might:

- spend a lot of time alone
- lose interest in their favorite things
- get messy—for instance, not bathe, change clothes, or brush their teeth
- be really tired and sad
- be very energetic, talk fast, or say things that don't make sense
- be nervous or cranky (in a bad mood)
- quickly change between feeling bad and feeling good
- sleep at strange hours
- miss important appointments
- have problems at work
- eat a lot more or a lot less than usual

People with a SUD usually can't stop taking AOD on their own. They want and need more. They might try to stop taking their drug of choice and then suffer serious physical and mental distress. Then they take the drug again to stop feeling sick. They keep using the drug even though it's causing terrible family, health, or legal problems. They need help to stop using AOD.

The Misunderstood Disorder

Many people don't understand why or how other people develop a SUD. They may mistakenly believe that those who use AOD lack moral principles or willpower. They mistakenly believe people could stop their AOD use simply by choosing to do so. SUD is a complex brain disease and quitting usually takes more than good intentions or a strong will.

AOD changes the brain in ways that make quitting difficult and complicated, even among those who have a strong desire to stop. Research over the past 45+ years has helped us to better understand the nature of a SUD and how AOD affects the brain. New and effective treatment methods have been developed to help people recover from a SUD and lead productive lives and experience restoration, healing, and wholeness.

Frequently, church people are confused by the fact that SUD is called a disease. They may ask, "Isn't this simply a way to excuse AOD dependent people from their sinful behaviors?" Nothing could be further from the truth. People seeking treatment services, attending 12 Step and/or other mutual help groups, such as Alcoholics Anonymous (A.A.) are expected to accept responsibility for their actions and, when possible, to make amends to the people they have harmed. Taking personal responsibility for their behavior is an essential component of their recovery and as one can imagine an enormously difficult part.

People with a SUD typically begin recovery because of the pain and suffering created by the disease. By the time an AOD dependent person arrives at a 12-step group and/or at a treatment center, they are in pain and struggling to understand if recovery is even possible. The most successful treatment comes to those who begin to recognize they are suffering from a **treatable** disease. A Substance Use Disorder (SUD) behaves very similarly to other chronic diseases, such as, diabetes, heart disease and cancer.

Treatment for SUD does work. Those with a SUD and their families who make the decision to get help have every reason to hope. Getting help means that a person with a SUD must admit their own powerlessness over their drugs of choice, acknowledging that they have lost control over their own lives and their lives have become unmanageable.

I was once asked to address a Sunday evening church meeting about the problems of AOD among families. A church member had heard me speak at another community meeting and invited me to attend the church's regular Sunday evening service. As I discovered upon my arrival, the pastor of the church was not happy about my invitation to speak.

When I arrived, I was told I had only 20 minutes to speak (speakers were typically given 40 minutes) and so I focused my remarks on the impact people with a SUD have on their families. Following my remarks, the pastor gave the audience a response to my presentation. In his comments he attempted to reassure me and the congregation present that my presentation about SUD in families did not apply to them. He confidently stated his congregation had never experienced any problems related to AOD or among their family members. In his opinion, he seemed confident they were all saints. At the conclusion of the night's activities everyone was invited for refreshments. I went to join them, since I have never been known to pass up a few good homemade cookies.

During this fellowship time, I had several members approach me cautiously and tell me about some relative or friend they had with an AOD related problem. A few asked for my business card and most of the literature I brought with me was gone. In the following weeks, at least, four individuals in attendance called me or one of my staff members seeking advice and guidance in dealing with some family member.

Experiences like these have been the norm over the years as I gave presentations about AOD issues in the community, particularly in churches. Many times, pastors would express total denial of the presence of any AOD problems in their congregations. Still, I repeatedly encountered member after member who needed to talk about their pain in dealing with a friend and/or family member with a SUD. About a year later, I met the man who had invited me to the above meeting. He told me, the pastor had never again asked him to arrange for the evening speaker!

Family members need to begin their recovery as well, by first recognizing that they are powerless over controlling the actions of other people, particularly those in the grip of a SUD. Often families have tried possibly for years to "fix" the family member impacted by a SUD, thinking that they are responsible in some way for that person's usage. Families get so hooked on trying to help that they end up enabling the AOD person’s continued use.

Enabling behavior is any action that covers up or removes the negative consequences of the AOD dependent person's use. Treatment for family members and friends means getting help for their own "addiction" - an addiction to the AOD dependent person. This is often referred to as codependency. Several mutual help 12 Step groups exist to assist families with their recovery. Al-Anon is for family members and friends. Ala-teen is recommended for children who live in a home

with a person with SUD. Families Anonymous is for parents and siblings of young people who have a SUD.

If not treated appropriately, a substance use disorder (SUD) will end in three undesirable ways*, incarceration (prison), permanent physical and/or mental disability or death.* Untreated SUD does not end well, nor does it improve on its own. Though physical death is the most common ending for SUD, death in other manifestations can come through many other serious life altering problems which take over a person's life, the death of a marriage, the death of relationships, death of hope, the death of faith in God, the death of a career or education, death of reputation, etc.

The apostle Paul tells us to *"present yourselves to God as those who have been brought from death to life"* (Rom. 6:13) If a SUD has created the death of many things within a person's life, can they live again? God says YES! *"This brother of yours was dead and has come to life; he was lost and has been found"* (Lk. 15:32). A life can be restored, brought from death to life by resurrection. Jesus Christ entrusted to the church a message about life, hope, resurrection, and restoration. We are called to bring hope and resurrection to new life to those impacted by a SUD and their families.

A SUD is a Brain Disease

Addiction (or SUD) is defined by the National Institute on Drug Abuse (NIDA) as a **chronic, relapsing brain disease** that is characterized by compulsive drug seeking and use, despite harmful consequences to the addicted individual and to those around him or her. **Addiction is considered a brain disease because drugs change the brain — they change its structure and how it works.** These brain changes can be long lasting and can lead to harmful behaviors seen in people who abuse AOD. Although the initial decision to take AOD is voluntary for most people, the changes occurring within a person's brain over time challenges a person's self-control and ability to resist intense impulses urging them to continue to take drugs. (adapted from the NIDA official definition on addiction)

What Happens to the Brain?

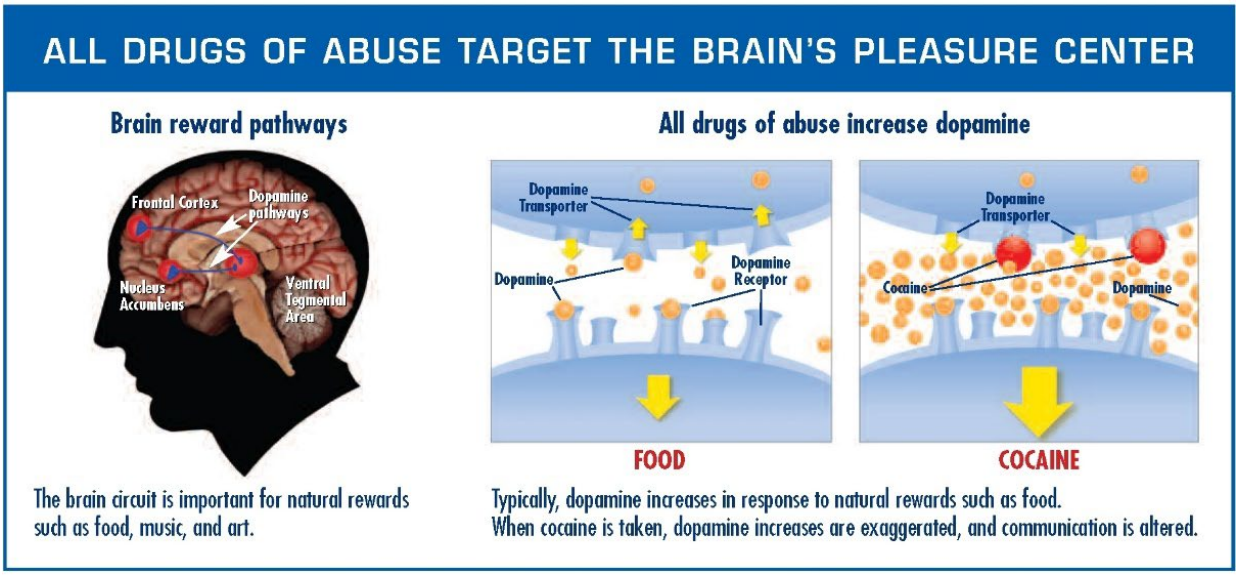
Substance use disorders result from changes in the brain that can occur with repeated use of alcohol and/or other drugs. The most severe expression of the disorder, addiction, is associated with changes in the function of brain circuits involved in pleasure (the reward system), learning, stress, decision making, and self-control.

The brain's *"reward circuit"* is flooded with the chemical messenger dopamine. This reward system controls the body's ability to feel pleasure and motivates a person to repeat behaviors needed to thrive, such as eating and spending time with loved ones. This overstimulation of the reward circuit causes the intensely pleasurable "high" that can lead people to take a drug again and again.

Every substance has slightly different effects on the brain, but all addictive drugs, including alcohol, opioids, and cocaine, produce a pleasurable surge of the neurotransmitter *dopamine* in a region of the brain called the *basal ganglia.* Neurotransmitters are chemicals that transmit messages between nerve cells. This area is responsible for controlling reward and our ability to learn based on rewards.

As substance use increases, these circuits adapt. They scale back their sensitivity to dopamine, leading to a reduction in a substance's ability to produce euphoria or the "high" that comes from using it. This is known as *tolerance*, and it reflects the way that the brain maintains balance and adjusts to a "new normal" – the frequent presence of the substance. However, as a result, users often increase the amount of the substance they take so that they can reach the level of high they were accustomed to achieving.

These same circuits control our ability to take pleasure from ordinary rewards like food, sex, and social interaction. When they are disrupted by substance use, the rest of life can feel less and less enjoyable to the user when they are not using the substance.[8]



[8] Paragraph based on information from the: U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health, References

According to the report, *"Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health"* repeated use of a substance "trains" the brain to associate the rewarding high with other cues in the person's life. These cues can include such things as friends they drink or do drugs with, places where they use substances, and paraphernalia[9] that accompany substance-taking. As these cues become increasingly associated with the substance, the person may find it more and more difficult not to think about using, because so many things in life are reminders of the substance.

Changes to two other brain areas, the *extended amygdala* and the *prefrontal cortex*, help explain why stopping use can be so difficult for someone with a severe substance use disorder. The *extended amygdala* controls our responses to stress. If dopamine bursts in the reward circuitry in the *basal ganglia* are like a carrot that lures the brain toward rewards, bursts of stress neurotransmitters in the *extended amygdala* are like a painful stick that pushes the brain to escape unpleasant situations. Together, they control the spontaneous drives to seek pleasure and avoid pain and compel a person to action.

In substance use disorders, however, the balance between these drives shifts over time. Increasingly, people feel emotional or physical distress whenever they are not taking the substance. This distress, known as *withdrawal*, can become hard to bear, motivating users to escape it at all costs. As a substance use disorder deepens in intensity, substance use is the only thing that produces relief from the bad feelings associated with withdrawal.

Like a vicious cycle, relief is purchased at the cost of a deepening disorder and increased distress when not using. The person no longer takes the substance to "get high" but instead to avoid feeling low. Other priorities, including job, family, and hobbies that once produced pleasure have trouble competing with this cycle.

Healthy adults are usually able to control their impulses, when necessary, because these impulses are balanced by the judgment and decision-making circuits of the *prefrontal cortex*. Unfortunately, these prefrontal circuits are also disrupted in substance use disorders. The result is a reduced ability to control the powerful impulses toward alcohol and/or other drug use despite awareness that stopping is in the person's best long-term interest.

[9] Paraphernalia in the context of addiction refers to any equipment, product, or material of any kind that is modified for making, using, or concealing a controlled substance. Examples of drug paraphernalia are rolling paper (a specialty paper used for making a marijuana cigarette); needles and/or small spoons; straws or paper tubes, pipe, small mirrors, and razorblades or cards; aerosol cans, tubes of glue, balloons, nozzles, or rags, etc.

This explains why substance use disorders are said to involve compromised self-control. It is not a complete loss of autonomy, as addicted individuals are still accountable for their actions, but they are much less able to override the powerful drive to seek relief from withdrawal provided by alcohol or drugs. At every turn, people with addictions who try to quit find their resolve challenged. Even if they can resist drug or alcohol use for a while, at some point the constant craving triggered by the many cues in their life may erode their resolve, resulting in a return to substance use, or *relapse*.[10]

Why Do People Take Alcohol and other Drugs (AOD)?

In general, people begin taking drugs for a variety of reasons:

* **To feel good.** Most AOD produces intense feelings of pleasure. This initial sensation of euphoria is followed by other effects, which differ with the type of drug used. For example, with stimulants such as cocaine, the "high" is followed by feelings of power, self-confidence, and increased energy. In contrast, the euphoria caused by opiates, such as heroin, is followed by feelings of relaxation and satisfaction.

* **To feel better**. Some people who suffer from social anxiety, stress-related disorders, and depression begin using AOD attempting to lessen feelings of distress. Stress can play a major role in beginning drug use, continuing drug abuse, or relapse in patients recovering from addiction. Initially, many people take powerful medications to relieve pain, due to injuries or surgery. Most people can stop using these medications without any problems once their pain subsides. Other individuals' brains respond differently to these medications which sets the stage for the beginning of a cycle of addiction. Consequently, the person continues to seek pain medication to relieve their pain, whether real or imagined.

* **To do better.** The increasing pressure that some individuals feel to chemically enhance or improve their athletic or cognitive performance can similarly play a role in initial experimentation and continued drug abuse.

* **Curiosity and "because others are doing it."** In this respect adolescents are particularly vulnerable because of the strong influence of peer pressure; they are more likely, for example, to engage in "thrilling" and "daring" behaviors.

[10] Above four paragraphs from the: U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health, References

* **Belief in their exemption from the norms.** They know about addiction and what it does, and they may even know someone or several others who suffer from SUD, but they personally believe they are too smart, too clever, too successful to allow that to happen to them. Drugs are no respecter of persons regardless of our status in life.

Is Continued AOD Use a Voluntary Behavior?

Throughout much of the last century, scientists studying AOD labored in the shadows of powerful myths and misconceptions about the nature of addiction. When serious scientific research began in the 1930s, people addicted to AOD were thought to be morally flawed and lacking in willpower. Those views shaped society's responses to AOD abuse and dependency, treating it as a moral failing rather than a health problem. Thereby society's response was punitive rather than taking preventative and therapeutic actions.

Today, thanks to science, our views, and our responses to AOD abuse and dependency have changed dramatically. Groundbreaking discoveries about the brain have revolutionized our understanding of AOD use and SUD, enabling us to respond more effectively to the problem.

The initial decision to take AOD is mostly voluntary, which is why prevention efforts are important. However, when AOD abuse and SUD takes over, a person's ability to exert self-control can become seriously impaired. Brain imaging studies from drug-addicted people show physical changes in areas of the brain that are critical to judgment, decision-making, learning, memory, and behavior control.

As a result of scientific research, we know that SUD is a disease that affects both brain and behavior. Researchers have identified many biological and environmental factors. Researchers also began searching for the genetic variations that contribute to the development and progression of the disease. Scientists used this knowledge to develop effective prevention and treatment approaches that reduce the toll AOD abuse takes on individuals, families, and communities.

Despite advances in prevention and treatment, many people today do not understand why people become addicted to AOD or how AOD changes the brain to foster compulsive usage. Societal attitudes continue to persist in believing myths and misconceptions, which bring harm to our communities, rather than offering hope.

Why Does SUD Impact Some and Not Others?

No one single factor can predict if a person will develop a SUD. A combination of factors influences increased risk for SUD. The more risk factors a person has, the greater the chance that taking AOD can lead to abuse and dependency and eventually SUD. For example:

Biology. The genes that people are born with account for about half of a person's risk for addiction. Gender, ethnicity, and the presence of other mental disorders may also influence risk for AOD use and dependency.

Environment. A person's environment includes many different influences, from family and friends to economic status and general quality of life. Factors such as peer pressure, physical and sexual abuse, early exposure to drugs, stress, and parental guidance can greatly affect a person's likelihood of AOD use and SUD.

Development. Genetic and environmental factors interact with critical developmental stages in a person's life to affect AOD risk. Although taking AOD at any age can lead to a SUD, the earlier that drug use begins, the more likely it will progress to addiction. This is particularly problematic for teens, because areas in their brains that control decision-making, judgment, and self-control are still developing. Teens may be especially prone to risky behaviors, including trying AOD.

The younger a person starts AOD use the more profound are the impacts on the brain. "Until the age of 25, the human brain is still developing and thus vulnerable to neurotoxins like alcohol and other substances, and to activities like violence, driving under the influence, and others."[11] Substance misuse can permanently change brain areas, resulting in lower intelligence (IQ), reduced motivation, increased impulsivity, and reduced attention span.[12]

Not everyone who uses AOD becomes addicted. Each person's body and brain respond differently. While under the influence of AOD, people respond differently to their surroundings, relationships, and stressful situations making a person more or less likely to use AOD abusively.

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[11] Arain, M., Haque, M., Johal, L., Mathur, P., Nel, W., Rais, A., . . . Sharma, S. (2013). Maturation of the adolescent brain. Neuropsychiatric Disease & Treatment, 9, 449–461. doi: 10.2147/NDT.S39776

[12] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2019). Results from the 2018 National Survey on Drug Use and Health: Detailed tables.

Casey, B. J., Getz, S., & Galvan, A. (2008). The adolescent brain. Developmental Review, 28(1), 62–77.

Armstrong, K. H., Dedrick, R. F., & Greenbaum, P. E. (2003). Factors associated with community adjustment of young adults with serious emotional disturbance: A longitudinal analysis. Journal of Emotional and Behavioral Disorders, 11(2), 66–76. doi: 10.1177/106342660301100201

Opioid Overdoses and Naloxone (NARCAN®)

Opioid overdose incidents and deaths, either from prescription pain relievers, heroin, or fentanyl are a serious threat to public health in the United States. Overdose deaths have risen dramatically, and most were preventable. Rates of opioid overdose deaths are particularly high among people with an opioid use disorder who have recently stopped their use due to an episode of detoxification or incarceration. During this period of abstinence their tolerance for the drug is reduced, making them more vulnerable to an overdose. Those who mix opioids with alcohol, benzodiazepines, or other drugs also have a high risk of overdose.[13]

An analysis of opioid-related overdose deaths found that synthetic opioids, such as illicit fentanyl, have surpassed prescription opioids as the most common drug involved in overdose deaths in the U.S. A research letter published in the *Journal of the American Medical Association (JAMA)* concluded that nearly half of opioid-related deaths in 2016 involved fentanyl. Although some users seek out fentanyl, it is often ingested unintentionally. It is commonly used to adulterate heroin as well as counterfeit prescription pain pills and sedatives that are purchased on the street.

Opioid-related overdoses do not occur immediately after a person has taken the drug. The effects of the opioid develop gradually as the drug depresses a person's breathing and heart rate. This eventually leads to coma and death if the overdose is not treated. This gradual progress means that there is typically a 1- to 3-hour window of opportunity after a user has taken the drug in which bystanders can take action to prevent the user's death.[14]

Naloxone (commonly know it by its brand name NARCAN®) is an opioid antagonist medication approved by the FDA to reverse opioid overdose in injectable and nasal spray forms. It works by displacing opioids from receptors in the brain, thereby blocking their effects on breathing and heart rate. Until 2015, only injectable forms of naloxone were approved by the FDA. However, in November 2015, the FDA approved a user-friendly intranasal formulation of naloxone that matches the injectable version in terms of how much of the medication gets into the body and how rapidly.

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[13] Hawk, K. F., Vaca, F. E., & D'Onofrio, G. (2015). Reducing fatal opioid overdose: Prevention, treatment, and harm reduction strategies. *The Yale Journal of Biology and Medicine, 88*(3), 235-245.

[14] Hawk, K. F., Vaca, F. E., & D'Onofrio, G. (2015). Reducing fatal opioid overdose: Prevention, treatment and harm reduction strategies. *The Yale Journal of Biology and Medicine, 88*(3), 235-245.

The rising number of deaths from opioid overdose has led to increasing public health efforts to make naloxone available to at-risk people and their families, as well as to emergency medical technicians, police officers, and other first responders, or through community-based opioid overdose prevention programs. Although regulations vary by state, some states have passed laws expanding access to naloxone without a patient-specific prescription in some localities. Naloxone is readily available throughout Pennsylvania in pharmacies and local treatment and prevention services in many counties. Beginning in September 2023 an over-the-counter version of naloxone will be available in most pharmacies in the U.S.

Interventions that distribute take-home doses of naloxone along with education and training for those actively using opioids and their peers and family members, have the potential to help decrease overdose related deaths.[15] Some schools across the country are stocking naloxone for use by trained nurses and churches can get training and obtain naloxone for use in church first aid kits.

Current evidence from nonrandomized studies also suggests that family, friends, and other community members who are properly trained can and will administer naloxone appropriately during an overdose incident.[16] And, despite concern that access to naloxone might increase the prevalence or frequency of opioid use, research demonstrates that neither of these problems has occurred.[17]

The Addiction Ministry Network in Redstone Presbytery has network members trained to instruct pastors, church leaders and members on the use of naloxone within their congregations. The network can provide information related to how to obtain free kits containing naloxone.

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[15] European Monitoring Centre for Drugs and Drug Addiction. (2015). *Preventing fatal overdoses: A systematic review of the effectiveness of take-home naloxone*. Luxembourg: EMCDDA Papers, Publications Office of the European Union.
Walley, A. Y., Xuan, Z., Hackman, H. H., Quinn, E., Doe-Simkins, M., Sorensen-Alawad, A., . . . Ozonoff, A. (2013). Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: Interrupted time series analysis. *BMJ, 346*(f174).

[16] National Institute on Drug Abuse. (2012). *Principles of drug addiction treatment: A research-based guide*. (NIH Publication No. 12–4180). Rockville, MD: National Institutes of Health, U.S. Department of Health and Human Services.

[17] Kim, D., Irwin, K. S., & Khoshnood, K. (2009). Expanded access to naloxone: Options for critical response to the epidemic of opioid overdose mortality. *The American Journal of Public Health, 99*(3), 402-407.

Why Is It So Hard to Quit AOD?

Healing, restoration, and recovery from a substance use disorder (SUD) takes time. Bringing a person to the point where they will commit themselves to the hard work of recovery and stop using AOD is a big step. A willingness to surrender to the disease is not easy. As some people in Alcoholics Anonymous have said about their early recovery, *"I got sick and tired, of being sick and tired."* Being addicted makes a person afraid of what will happen if they don't keep taking their drug of choice and fearful of what their life will look like if they do stop. People often won't try quitting until their backs are against the wall and they see no other path open to them.

A story shared with me by one of my colleagues concerned a man he had worked with for alcoholism after a DUI conviction. Like many clients, this man simply was unwilling to see the damage his alcohol use had left behind and the consequences he would experience in the future from his driving under the influence of alcohol. One day, he came into the office looking very depressed and despondent. He said he was ready to stop using alcohol. When he was asked why he had so suddenly arrived at this conclusion, he told a story about what happened the day before.

Despite his court ordered conditions which stated he was not to use alcohol or drive, he did both. He described that he was intoxicated and got into his car, and he backed out of his driveway and ran over his dog and killed him. He stated that while he held his dog's lifeless body in his arms, he realized that his careless disregard for his alcohol use and behavior had caused the death of the only creature on this earth who loved him. Everyone else he knew in life; he had driven away. This dog loved him unconditionally and was always there for him and now he had just killed his best and only friend. For this man, at this moment, he had hit bottom. The consequences and the pain had become too great.

When a person stops using their drug of choice, it upsets their entire body and brain. They will feel very sick for a while and have a very strong compulsion to take the drug. With some drugs, like alcohol, stopping without medical supervision can be deadly to some. People in withdrawal may experience episodes of physical distress and pain, anxiety, fear, confusion, and lack of understanding of their current emotional state. It becomes extremely difficult to refuse or resist using their drug of choice. They know that if they return to using their drug of choice their symptoms and pain will diminish.

What people with a SUD need to believe is that they don't have to do it alone. Support groups, doctors, trained professionals, treatment programs, and sometimes medications can help. Meeting and trusting people who understand

what they are going through is vital in taking the early steps to recovery. They need others who can give them encouragement, tell them what to expect and how to deal with the difficulties and cheer them on. For example, in many Pennsylvania counties they have teams of Recovery Specialists trained to respond to people seeking help. These Recovery Specialists are themselves in recovery and can share and relate well to those people who have not started their recovery journeys.

Even after stopping AOD use, a person with a SUD still has many challenges and obstacles to recovery and they will need to learn how to overcome these obstacles and thrive:

- They will have to re-learn how to live their lives without using AOD. Many people who initially stop using are convinced they are the only people on the planet who are no longer using AOD, since they believed everyone used before.
- They will need to learn how to deal with the negative consequences that their AOD use caused among their family members, their job, their friends, their neighbors, and their futures. Confronting and admitting to these consequences is not easy. The consequences created by their SUD can be grim and quite disturbing. Family, friends and others impacted by their SUD will find it difficult to forgive them. For some they will find forgiveness and for others forgiveness will never come and that can be quite distressing to overcome and accept.
- They will need to learn how to shape new relationships and stay away from destructive relationships related to continued AOD usage and places where they used.
- They may also need to seek more specialized treatment for problems that contributed to or resulted from their AOD use, such as depression, anxiety, or other mental health problems.
- They will need to learn what makes them want to take drugs again, what are the unique triggers in their life which would lead them back down the wrong road and learn how to stay focused on a new journey leading to recovery.

A trigger is anything that makes a person feel the urge to return to AOD use. Triggers can be a place, person, thing, smell, sound, feeling, or memory that reminds the person of their unique experience of using AOD and getting high. A trigger can be something stressful that they may want to escape. A trigger can even be something that makes them happy. People recovering from a SUD need to identify their unique triggers and learn to stay away from them. They need to

learn how to deal with the triggers when they are encountered, just like people with breathing problems need to avoid smoke and dust. Even under the best of circumstances, triggers cannot be avoided completely, so a plan to effectively respond to the trigger needs developed.

Scorn, Shame and Stigma

> "I am the scorn of all my adversaries, a horror to my neighbors, an object of dread to my acquaintances; those who see me in the street flee from me. I have passed out of mind like one who is dead; I have become like a broken vessel. For I hear the whispering of many — terror all around! — as they scheme together against me, as they plot to take my life. But I trust in you, O LORD; I say, "You are my God." (Ps. 31:11-14)

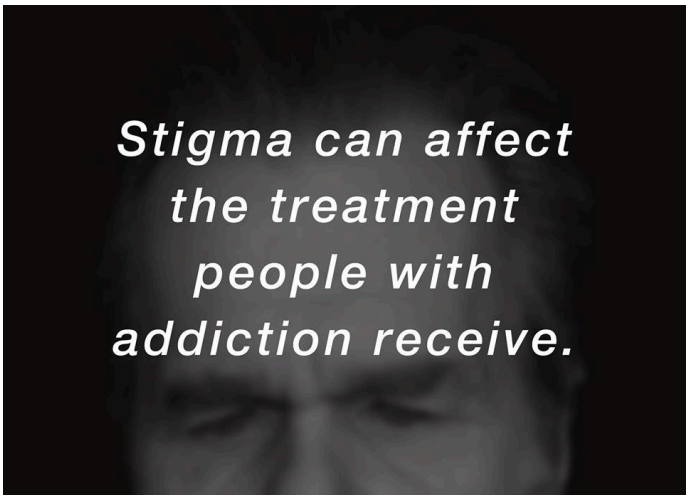
A person in the depths of their SUD does at some point begin to comprehend the gravity of their situation. Many come to believe they have simply gone too far for anyone to help them including God. Unlike the psalmist, they would find it difficult to affirm *"I trust in you, O Lord; I say, "You are my God."* (v. 14)

The Psalmist expresses a sentiment experienced by those currently in their AOD induced dependency. Amid all their problems and the consequences people with a SUD have suffered, they find themselves living uncomfortably, often for years, understanding that they are scorned by their communities and a horror to their neighbors. They understand why people flee from them and why their acquaintances, family, and friends find them a subject of dread. They interpret this scorn, shame, and stigma as evidence that all hope for their future is lost, never again to become a reality.

Substance Use Disorder (SUD) is deadly. The percentage of those who recover is low and the end for many is dismal. As disheartening as the statistics are regarding addiction, this does not need to be the norm. **Treatment does work, recovery is possible.** In 2017, approximately 1 in 13 people needed substance use treatment. However, only 12.2% of those people received the substance use treatment they needed.[18] Getting people to accept treatment and begin the process of recovery will always be difficult. The challenge becomes even more difficult, if people with a SUD believe they have traveled too far for mercy, hope, or grace to apply to them. Beginning recovery from a SUD is littered with

[18] Substance Abuse and Mental Health Services Administration. (2018). *Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health* (HHS Publication No. SMA 18-5068, SDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

obstacles, but scorn, dread and whispering by others takes a toll on entering treatment for many people.



If our continuing and persistent reaction is only to flee from them and treat them with scorn and dread, we are only intensifying the hopelessness to the stranger rather than offering hospitality and grace.

Our reactions, whether deliberate or passive, reduce the chances for recovery to begin for our neighbors, friends, and family. However, stigma often factors into the reasons why people who need help do not seek treatment. In 2020, about 12% of people who felt they needed substance use treatment but did not receive it in the past year saying they did not seek treatment because they feared attracting negative attitudes from their communities.[19]

The word "stigma" resonates with most recovery leaders as the number-one obstacle to their ministries. For many churchgoers, a fear of stigma prevents their own participation in recovery groups. Fear of embarrassment or shame prevents them from seeking help, even when it's available through the sponsorship of their own church. Many churches conduct ministries related to recovery ministry, such as prison inmates, SUD, the mentally ill, sex addicts, and emotionally or physically abused people, and still these ministries and the people they serve face stigma in many forms.

Stigma shows up in stares and disparaging comments from churchgoers. Parking-lot signs that declare "this is a nonsmoking campus." Church leaders who relegate recovery meetings to the back room of their facilities, create harm to people who would rather suffer in silence than face the embarrassment of being seen at a recovery meeting. Facing these real-life situations, some leaders have taken daring steps to break down stigma in their churches.

Shame often finds futile ground for growth because many people don't feel safe sharing their struggles, pain, or their simple questions with others, even in the

[19] Substance Abuse and Mental Health Services Administration. (2021). Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

church. One of the wonderful things I liked about the church where I grew up was their willingness to listen to the crazy and often stupid questions of a maturing adolescent. I frequently took my questions to the pastor or a church elder and they would patiently listen and help me think through the questions and help point me in the direction to find my answer. Sometimes the answers were simple, sometimes they were difficult and not easily answered, but they always listened and showed they cared about all my questions.

Community or church disapproval prevents many from seeking treatment because maintaining anonymity while in treatment can be difficult. They don't want to expose themselves to the additional stigma and shame from the critical judgment in their local community. The stigma associated with seeking treatment may forestall their decision to enter treatment until the problem results in an acute crisis where treatment can no longer be avoided.

Back in the 1980's, I had a middle-aged gentleman from a nearby small town come seeking treatment for an alcohol problem. Initially, he was very paranoid about treatment. He asked many questions about confidentiality and who would know he was seeking treatment. I was able to convince him that our services could protect his confidentiality. He did quite well in treatment and took all aspects of treatment recommendations seriously.

He had grown up in the town where he lived and was a successful professional in the community. He was quite embarrassed that he had allowed his use of alcohol to get out of control. At the same time, he mistakenly believed that he had carefully managed to hide his alcohol consumption.

After about nine months in outpatient treatment, I was preparing to discharge him from treatment. One day he came into my office quite outraged with me. He was convinced I had violated his confidentiality and I had told people in his hometown that he was in treatment. I spent several minutes trying to reassure him I had not violated his confidentiality and offered to let him speak to my supervisor if he preferred. Finally, after a few minutes his anger subsided, and I got him to explain why he believed I had violated his confidentiality.

A few days before, he was walking down the main street of his hometown. He stopped to talk with a man he had known for years. They had not spoken for several months and were exchanging casual conversations about family and friends. Then the man expressed his happiness over seeing that my client had stopped drinking and complemented him on how good he now looked. He also related how he had heard others express the same favorable opinion about his abstinence, about how much more productive he appeared, and how impressed they were with his

progress. The client then looked at me and said, "so how did he know I stopped drinking, unless you told him I was in treatment."

Now I knew the answer and why he was upset. Our day's session concentrated on this experience and his mistaken assumptions about this event. First, he lived in a small town where everyone notices just about everything and everyone, whether good or bad. Second, he mistakenly assumed he had successfully covered up his alcohol use problems. The fact is everyone in town already knew he had a problem before he did. Third, after several months of recovery he now looked better, looked healthier, was more productive, was easier to socialize with and everyone in town took notice of the positive change and they liked it. Fourth, and related to his basic assumption, when the town folks saw a positive change, they arrived at a logical conclusion. He must have gone for help. They did not know this for sure, but they were just making a reasonable guess based on their personal observations.

No one had to tell them he was getting help. It was readily apparent by the change in his behavior, and no one had violated his confidentiality. Strangely, as frequently happens, his own successful recovery broke his confidentiality. He now knew the secret was out. In fact, the secret never had been a secret. He reconciled himself to the fact it was better they knew he was in recovery.

During our final session, he had time to reflect on this experience. He acknowledged the fact he had only been deceiving himself into thinking he was maintaining this big secret. He also confessed that many of the people who were now expressing their delight at his sobriety were the same people who had attempted to confront him about his usage. He had only chosen to suppress his memory of the truth everyone else already knew. He recognized the only person being deceived was him.

He stated that he was relieved to know the community knew the reality of his situation and he could now freely discuss it. Fortunately, for this man, he had a positive experience with the knowledge of his alcoholism becoming public. Many others are not so fortunate. There are many other stories from individuals who experienced continued stigmatization and shame even in recovery within their communities.

AOD abuse and dependency is no respecter of people, social status, economics, or profession. Stigma can prove a powerful roadblock for many people regardless of social status or geography. The stigma and resulting consequences can be particularly difficult for professional individuals, including pastors, and those in the medical, judicial, and education systems.

A SUD exacts a huge economic, physical, and emotional toll on the lives of many people. The effects extend well beyond the toll on the individual who is misusing alcohol and/or other drugs. Many families live in fear and confusion, not knowing where to turn for help. Often, when they do reach out for help, they first turn to their communities of faith. Regrettably, those seeking help often face a wall of silence or worse, scorn and dread.

Faith communities provide a unique opportunity to help families and people affected by alcohol or other drugs and to support continuing recovery. However, many pastors and church leaders lack the knowledge and skills to provide support for those affected by alcohol and drugs.

In a research survey conducted in November 2001 by The National Center on Addiction and Substance Abuse at Columbia University, (CASA) their studies on the role of clergy in dealing with alcoholism and addiction in their congregations estimate that:

- 94.4% of pastors surveyed consider alcohol and other drug abuse and addiction important issues in their congregations, yet only 12.5% received any coursework on this issue during their studies in seminary (CASA, So Help Me God! 2001)

- Referrals from pastors have represented only 4% of the total referrals to Al-Anon and Alateen in recent years (Al-Anon studies, 1988 – 2003); yet these mutual support programs have a 70-year history of helping affected family members recover and are available free of charge in almost every community.

> "The pastor has a significant role . . . Greater familiarity with the problem is necessary. This can be achieved by enhancing the curricula of seminaries on this subject and by post-graduate seminars." - Rabbi Abraham J. Twerski, MD, Founder and Medical Director Emeritus, Gateway Rehabilitation Center, Aliquippa, PA

The Church's Calling – Relational and Spiritual

Over the years I have been asked to describe the impact of addiction on people with a SUD. This led to my describing the impact of this disease as it related to five facets of a person's life. Physical, Mental, Economic, Relational, and Spiritual facets are simply one of many ways to describe the impact of addiction.

Physical facet

The physical facet deals with a person's body and brain, how they function, and how SUD impacts the health and physical condition of the person. We covered the impact on the brain earlier in the section on "What Happens to the Brain".

The physical impact of AOD use/abuse and a SUD can be far reaching. The physical facet deals with genetic predisposition, physical reactions to alcohol and other drug use, and short- and long-term health consequences to the brain, liver, heart, kidneys, and other organs. Other health issues can include nutritional deficiency and the physical consequences from injuries and accidents that can produce long term disability issues.

SUD creates a wide range of health-related disorders, i.e., overdoses, diabetes, hypertension, heart disease, sleep apnea, cardiovascular diseases, respiratory diseases, cancers, liver and kidney damage, prenatal defects, and potentially many others. Injectable substances can increase the risk of infections such as the human immunodeficiency virus (HIV) and hepatitis C (a serious liver disease). Some of these effects occur when drugs are used at high doses or after prolonged use, however, some may occur after just one use.

In early recovery people are concerned with their general health, which has most likely been neglected, sometimes for many years. Dental problems are also common. For those who have been living in the cramped and crowded conditions of shelters, jails, or prisons, multiple-drug-resistant tuberculosis and other infectious diseases can be a major problem, not just for the people directly affected but also for the communities to which they return.

A person will often appear older than their stated age and even after recovery it may take years for the damage to the body to moderate. For many complicated health issues linger for the rest of their lives. For some, as they progress in their recovery their health does improve, and they once again appear their stated age.

The physical facet impacts a person's emotional state and how this manifests itself in outward expressions. When a person suffers illness, withdrawal, tolerance, or even good health these conditions can often dictate how a person expresses

feelings, senses their surroundings, and acts. Their physical state determines the intensity of how they feel and how they respond to urges, impulses, thoughts, drives and instincts.

In the pre-treatment and recovery treatment planning phases, these problems are best left to the health care system, addiction professionals, and treatment centers to determine the proper treatment. Even during these times, the church can have a positive and uplifting impact.

- Learn how to make referrals to the health care system and treatment centers.
- Provide pastoral care through support, prayer, and encouragement.
- Send cards and notes of encouragement expressing that others are praying for them.
- Address the problems of overdose by learning how to use and make Naloxone (NARCAN®) available.

Mental facet

Our minds are always working to figure out how to "achieve" specific tasks. Our mental facet is concerned with functioning, arranging, and executing ideas, objectives, and strategies. Our minds are always planning, organizing, and executing, whether we are starting a non-profit, figuring out a sermon, organizing a worship service, or deciding what we will watch on TV. When we are unimpaired by any addiction, this process serves us well.

The impact SUD has on the brain and body has consequences for a person's emotional and psychological health. A person beginning their recovery will have difficulty dealing with the increase of emotional distress in their lives. These emotional disruptions can include depression, anxiety, stress, increased suicidal ideation, etc. Simple actions which we perform daily without any conscious thought, like, planning, organizing, and taking appropriate actions are difficult, if not extremely challenging to a person with SUD particularly in the early days of recovery.

These initial disruptions are due to the detoxification process and may last several months depending upon which drug and/or drugs were used, and the frequency and length of use. With some, these emotional disruptions existed in their lives prior to the beginning of their substance usage and the drug usage intensifies their emotional distress.

Many people with a substance use disorder also have a mental disorder, and some have multiple substance use disorders. For example, according to the 2015 *National Survey on Drug Use and Health* (NSDUH), of the 20.8 million people aged 12 or older who had a substance use disorder during the past year, about 2.7 million (13 percent) had both an alcohol use and an illicit drug use disorder, and 41.2 percent also had a mental illness. It is estimated that 30-60 percent of patients seeking treatment for alcohol use disorder meet criteria for post-traumatic stress disorder (PTSD)[20] and approximately one third of people who have experienced PTSD have also experienced alcohol dependence at some point in their lives.[21]

The reasons why substance use disorders and mental disorders often occur together are not clear and establishing the relationships between these conditions is difficult. Still, three possible explanations deserve attention.

One reason for the overlap may be that having a mental disorder increases vulnerability to substance use disorders because certain substances may, at least temporarily, be able to reduce mental disorder symptoms and thus are particularly negatively reinforcing in these people. This is often referred to as "self-medicating".

Second, substance use disorders may increase vulnerability for mental disorders, meaning that the use of certain substances might trigger a mental disorder that otherwise would have not occurred. For example, research suggests that alcohol use increases risk for PTSD by altering the brain's ability to recover from traumatic experiences. Similarly, the use of marijuana, particularly marijuana with a high THC content, might contribute to schizophrenia in those who have specific genetic vulnerabilities.

Third, it is also possible that both SUD and mental disorders are caused by shared, overlapping factors, such as particular genes, neurobiological deficits, and exposure to traumatic or stressful life experiences. As these possibilities are not mutually exclusive, the relationship between substance use disorders and mental disorders may result from a combination of these processes.[22] Studies of people with schizophrenia, some of whom have co-occurring substance use disorders,

[20] Post-traumatic stress disorder (PTSD)

[21] Above paragraph from the: U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health, References

[22] Above paragraph from the: U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health, References

have found that recovery is often characterized by increased hope and optimism, and greater life satisfaction.[23]

Primary treatment of people with mental health issues is best left to mental health professionals, though pastors and church leaders can provide support, prayer, and stability for these people in their recovery. Learning how to best accomplish these goals is something pastors should seek from mental health professionals.

Economic Facet

The economic facet addresses the financial and monetary stability of those impacted by addiction and the direct and indirect costs to society. In 2016, the yearly economic impact of alcohol misuse and alcohol use disorders is estimated at $249 billion ($2.05 per drink) and the impact of illicit drug use and drug use disorders is estimated at $193 billion. These figures include both direct and indirect costs related to crime, health, and lost productivity.[24]

Although the United States spends roughly $35 billion across public and private payors to treat substance use disorders, the social and economic costs associated with these disorders are many times higher. The moral obligation to address substance misuse and substance use disorders effectively for all Americans also aligns with a strong economic imperative.[25]

A person dealing with a SUD suffers many economic losses, which translates into difficult financial challenges in their recovery. These challenges can include lack of health insurance, loss of income, loss of employment, inability to secure employment due to criminal records, lack of job skills, a poor reputation in their chosen profession, loss of stable housing, debt, poor credit rating, food insecurity, etc. Pastors and church leaders can help connect recovering people to programs the church or neighboring churches might offer them and make referrals to local social services which address these types of services.

The physical, mental, and economic facets are largely outside the scope of the church's reach. The church can achieve some limited positive effects with a person

[23] From the: U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health, References

[24] National Drug Intelligence Center. (2011). *National drug threat assessment*. Washington, DC: U.S. Department of Justice.

[25] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health, References

in recovery in these three facets, but these facets should point out to the church our need to work collaboratively with other organizations to have a significant impact. We need to refer, support, and permit the health care system, treatment centers, social services, etc. to improve their ability to respond appropriately to these facets in the lives of family members and people impacted by a SUD.

The relational and spiritual facets are the two areas in which the church should excel, and they are our God directed calling. If we wish to enhance our abilities to welcome and encourage others to join our fellowship, learning how to reach out to the recovering person and their families will greatly enhance our ability to reach out to many other people in our communities. These facets are not the exclusive domain of the church but are shared with other groups, which together play a role in the continuum of care in recovery. The church can have a huge impact in providing the potential for long-term recovery for many, if we are willing to learn the steps to enhance our outreach.

Relational Facet

Our lives are comprised of an interconnected web of relationships from the moment we are born. These relationships begin with our parents, siblings, and extended family. As we grow our lives become interdependent upon a host of other relationships, including neighbors, childhood friends, teachers, coaches, pastors, colleagues, church members, and others.

Human beings were created for relationships. Evidence for our need for relationships is all around us, and it shows in the ways we form into family groups, establish friendships and colleagues, establish schools, churches, political organizations, clubs, companies, etc. These individuals and groups are reflections of our need for relationships. We all seek a place where we belong within the whole of humanity. The relational facet is concerned with maintaining, facilitating, and deepening our relationships. How well we cope with problems, learn, and grow largely depends upon how functional these relationships are in our lives.

The relationships those with a SUD have among family and friends are loosely based on the factors necessary for them to get out of the relationship what they need to continue their usage. They progressively destroy these relationships through an escalating series of lying, stealing, and sometimes violence and/or anti-social behavior. Individuals who suffer from social awkwardness, poor interpersonal skills, and isolation are more easily influenced by negative peer pressure and these deficits are more likely to impact their choices.

Any contact with others, which they might call a relationship, is typically based on meeting their short-term needs and any other needs they can get from it. Their relationships are maintained based on a fragile balance of lies, deception, guilt, and shame. They avoid anyone who appears healthy and knowledgeable who might have the capability to intervene in addressing their many problems.

Often, any human contact they have may chiefly be based on meeting sexual needs and desires, the need for shelter and safety, and even any minimal ability to protect them from the consequences of their usage. Their only genuine relationship is with whatever drug they are presently using to meet their needs.

As important as our current relationships are to our physical and mental health: the relationships we share with people who come before us and come after us contribute to our wellbeing. One of the foundations of Christianity is that we are not only the present-day body of Christ, but we are also part of the past and future body of Christ. So as disciples and the church we build our faith and love on the teachings of those who came before us, and for the benefit of those who will live tomorrow. We are to learn from the traditions of our faith to care for everyone in the present and future. Ultimately, this relational facet connects us to an ever-deepening relationship with God, who is love. We are to live in relationship with God, with others, and with the world.

When we teach others to be disciples of Jesus Christ, we do not only build up the church in making new disciples, but we in turn impact our own lives in our own spiritual formation. In the years that I worked as an addictions counselor I helped to guide others to the realization of their own recovery in the transformation of their lives. And even though this was my chief objective. I discovered that my own discipleship and relationship with God deepened and became more comprehensible, more recognizable, and took on a new dimension that I did not previously experience or appreciate.

While working as an addiction counselor our treatment center recommended to all our clients that they needed to attend 12 step groups. Frequently, a client might state they did not want to attend because they did not relate well in groups or with others. We responded by telling them this was exactly why they needed to attend these groups. Their SUD had created a wedge between them and the possibility of healthy relationships. They had only been maintaining unhealthy, dysfunctional relationships which supported their continued usage. Their recovery would largely depend on their ability to establish, sustain, and nurture future healthy relationships. Recovery is not a lone activity and without others the chances for long-term recovery are diminished.

For some clients, their unwillingness to attend 12 step groups was simply an excuse to avoid recovery. For others, they did have a genuine fear of being in groups or the inability to form healthy relationships. In these cases, we would frequently arrange for one of our A.A./N.A. contacts to take the client to their first meeting and introduce them to others where they might be able to establish a mutually beneficial friendship.

Research studying 12-step mutual aid groups, specifically those focused on alcohol, has shown that participation in the groups promotes a person's recovery through the following ways: by strengthening their recovery-supportive social networks; increasing members' ability to cope with risky social contexts and negative emotions; augmenting motivation to recover; reducing depression, craving, and impulsivity; and enhancing psychological and spiritual well-being.[26]

In the Criteria for Diagnosing Substance Use Disorders one of the indications for this disorder is continuing to use the drug, even when it causes problems in relationships. Deteriorating relationships with friends, family, spouses, children, and employers impacts a person in several ways and they often deal with it through isolation from others. During their usage, interpersonal relationships produce stress and anxiety. People and their families impacted by SUD need someone they can trust to tell their stories, their struggles and fears. Thus, a pastoral presence is vital for these families and for the church.

The relational facet is one area where 12 step groups shine during early and long-term recovery of an individual. These groups encourage people early in their recovery to hear the stories of others who are working on a program of recovery and build relationships with them to provide ideas and inspiration for their own recovery. Every new member of a 12-step group is encouraged to find a sponsor, someone who has a long, stable recovery who would help them learn about the program and fellowship of the group and whom they could call when faced with the urge to use.

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[26] Kelly, J. F., Hoeppner, B., Stout, R. L., & Pagano, M. (2012). Determining the relative importance of the mechanisms of behavior change within Alcoholics Anonymous: A multiple mediator analysis. Addiction, 107(2), 289-299.

Morgenstern, J., Labouvie, E., McCrady, B. S., Kahler, C. W., & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. Journal of Consulting and Clinical Psychology, 65(5), 768-777.

Kelly, J. F., & Yeterian, J. D. (2013). Mutual-help groups for alcohol and other substance use disorders. In B. S. McCrady & E. E. Epstein (Eds.), Addictions: A comprehensive guidebook. (2nd ed.). New York, NY: Oxford University Press.

Christo, G., & Franey, C. (1995). Drug users' spiritual beliefs, locus of control and the disease concept in relation to Narcotics Anonymous attendance and six-month outcomes. Drug and Alcohol Dependence, 38(1), 51-56.

In the meetings of A.A. I attended; I had the privilege of being asked to attend what in A.A. they called *"the meeting after the meeting."* These were small groups of people generally invited by someone's sponsor to go out for coffee or dessert after the regular meeting. The conversations and discussion were in a more relaxed setting where stories about sobriety and recovery were shared. You would hear many of the unwritten stories not found in any A.A. literature.

Many of these early recovery stories were told by older members who became sober in the early days of A.A.. Since we were located close to Akron, Ohio where A.A. began, some of the members knew the co-founders of A.A., Bill W. and Dr. Bob. Many of these people desperate for sobriety travelled regularly to meetings in Akron and eventually started their own local meetings. Many A.A. sponsors thought it was important to pass on these stories from an older generation to a new generation of members. These gatherings resulted in producing and strengthening a person's sense of belonging and building lasting relationships.

Early in my counseling career, I met David, who became a friend and a colleague. David was a recovering alcoholic. I had the chance to hear David tell his story of alcoholism and recovery at a couple of A.A. meetings. David experienced many struggles during his first year of recovery. During his first year, David frequently shared with his sponsor his personal doubts about ever achieving long-term recovery. As David was approaching his first anniversary of sobriety, his A.A. sponsor invited him to attend an annual A.A. gathering in Chautauqua, New York.

As David described it, he found himself standing among a few thousand recovering alcoholics, each one struggling with the same problems and fears of recovery he faced daily. He said he now got it. He understood how all these recovering alcoholics were succeeding by helping each other. And he came to understand he was not alone. For the first time, David recognized the reality of hope and with the help of thousands who went before him, he could also make the A.A. program work. All those recovering alcoholics served as a living example of hope for David and the hope of forming new healthy relationships. At this stage in David's recovery, he needed help replacing his fear with hope and trusting in what hope could do. Then he could proceed forward.

Making new friends can be exciting or intimidating, depending on your personality and your circumstances, but ultimately it is rewarding. To meet new people who might become your friends, you must go to places where others are gathered. The hardest thing about going out and doing anything in the community is doing it for the first time. It's hard for everyone. A person new to recovery needs our help to reach out and develop new, healthy relationships.

Spiritual Facet

In the early literature of A.A. one of the co-founders, Bill Wilson tells the story where his recovery began as an encounter with God in his hospital room or as he called it, he underwent a *"spiritual awakening."* Bill had many prior episodes in alcohol detox, but all his previous attempts to stay sober proved futile until one day when he was detoxing in what would be his last detox experience. He prayed a desperate plea to God for help. He states that God did in fact respond to his plea and he had a very vivid encounter with God that day.

As a result, his journey of sobriety was only beginning. He was led to the decision that he needed to share his story with other alcoholics in detox as a means for maintaining his sobriety. His journey led him to a hospital bed in Akron, Ohio where he met a doctor who was detoxing, Dr. Bob Smith, who became the other co-founder of A.A. These two men together set out to share their stories of struggle with alcohol and what they were doing to maintain their sobriety and inviting others to join them.

What these early experiences of Bill Wilson and Dr. Bob Smith reveal is that for these two men and many others who would eventually join them was that the spiritual and relational facets played a major role in their recovery.

Our yearning for God is the most significant facet of our humanity, even for those in the middle of their addiction and/or in early recovery. A person with SUD will often offer up desperate prayers for God's help, like, Bill Wilson. The how and why God might respond to their spiritual pleas is most likely not well expressed nor understood, but the desire remains. They may simply hope that their spiritual life will give their existence meaning and direction.

Sadly, too often during these times their SUD clouds their comprehension of the divine. They may have simply viewed God as having given up on them or their guilt is so great that the only way, they can deal with God is to deny God's existence. They may also rationalize a variety of other distorted views attempting to make sense of their life of addiction in God's presence.

God creates each of us uniquely, creates us good, and for freedom. As the psalmist proclaims, *"for I am fearfully and wonderfully made."* (Psalms 139:14) God creates us for love and freedom. God calls us to love God, one another, and ourselves. *"You shall have no other gods before me."* (Deuteronomy 5:7) And as Jesus later clarifies, *"You shall love the Lord your God with all your heart, and with all your soul, and with all your strength, and with all your mind; and your neighbor as yourself."* (Luke 10:27)

We are also created for freedom, even the freedom to choose poorly. Addiction clouds this choice in all its expressions by unhealthy and destructive behavior. For many with SUD, their understanding and expression of love is selfishly focused on physical and emotional gratification rather than any attention on the wellbeing of others. As Paul states in his declaration about love, *"Love is patient; love is kind; love is not envious or boastful or arrogant or rude. It does not insist on its own way; it is not irritable or resentful;"* (1 Cor. 13:4-5) A SUD distorts the person's expression of love, and their idea of love is only directed to their selfish interests.

Addiction holds them hostage to their own impulses and slaves to their own selfish obsessions. This denies them the ability to see the world as God would want them to view it. This is in general a human condition and not exclusive to SUD. As Paul reminds us, *"For there is no distinction, since all have sinned and fall short of the glory of God;"* (Romans 3:22-23)

God promises a response: *"When you search for me, you will find me; if you seek me with all your heart,"* (Jeremiah 29:13) But since we often fall short, we frequently seek the least threatening ways of trying to satisfy our longing for God, ways that guard our sense of personal power and requires the least sacrifice. Even when we know that our hunger is for God alone, we are still looking for loopholes. In A.A. when speaking about those people who have a difficult time making the 12-step program work for them, they are described as seeking "an easier, softer way" which simply does not exist. Sadly, for many people with a SUD their limited spiritual understanding of their lives at this point only binds them to a false narrative, which is used to maintain their addiction.

Their souls have become scarred by the chains of addiction which bound them, but in their own minds, they are at least familiar chains. They have grown accustomed to the chains. As the chains begin to loosen, in the early or pre-recovery stages, they are likely to feel a vague sense of loss. The things to which they were addicted remain, but hopefully do not have ultimate importance as they once had, if they can journey into a life which is less fearful, and more grace filled.

They are like caged animals beginning to experience freedom, and still there is something quite familiar which they miss about the cage. Like the Israelites during the exodus, they know they do not want to go back to slavery in Egypt, while sensing they are moving on to a better existence. They still grieved the loss of the life which they had grown accustomed.

In twelve step groups they speak of a *"spiritual awakening"* occurring in the life of the recovering person. This awakening and growth spiritually involve far more relinquishment or surrender to old ways of doing and thinking rather than the

attainment of new information or understandings. Although the introduction of some new facts, instruction, traditions, and beliefs may help along the way, the essential process is one of transformation, not education. If anything, it is an unlearning process in which old approaches to life are cleansed, liberated, and redeemed.

The bottom line is that spiritual growth in this facet is focused on God's work. It is primarily about God's work of grace. Through the spiritual facet they aspire to live the lives God seeks for them. This facet is where they receive guiding and sustaining inspirations from God's spirit. This guiding inspiration is one of the factors that led Bill Wilson to share his story with other alcoholics who still suffered as a means for him to stay sober.

Within some communities, recovery is seen as being aligned with a particular religion, yet in other communities such as 12 Step fellowships, recovery is explicitly not religious but is instead considered spiritual. In studies on spirituality in 12 step groups, almost all study participants viewed their recovery as a process of growth and development, and about two-thirds saw it as having a spiritual dimension.[27]

We must recognize that everyone enters their spiritual lives at different points. The recovering person needs in their early recovery the ability to speak in more general terms about God, by speaking of a higher power, a God of their understanding or a generic spirituality. Discipleship training is a process and we cannot force it and expect them to start with the same passion we have. In 12 step groups they speak more generally in terms of a "spiritual awakening". This is not an attempt to diminish the importance of discipleship, but to acknowledge that spiritual growth is a process and generally begins with a simple understanding.

Our job is to reveal to them in the course of time the living presence of God revealed in Jesus Christ. What is most important for them in early recovery is that they have a trusting and open relationship with someone willing to listen to their wild spiritual ideas and guide them to scripture, prayer, and study to move them ever forward to meeting Jesus Christ face-to-face for themselves. Some people get stuck in their spiritual growth in later recovery because they have never had the opportunity to have a positive relationship with someone willing to guide them through these questions in their lives.

The spiritual facet should not be treated as a stand-alone area of life; it is closely linked to the relational facet because our spiritual lives do revolve around others

[27] Laudet, A. B. (2011). The case for considering quality of life in addiction research and clinical practice. *Addiction Science & Clinical Practice, 6*(1), 44-55.

whom we are called to love. The spiritual facet can also help us in our understanding and life practices related to all the facets, our mental and physical well-being, our economic stability, and then again helps them reflect upon their spiritual development. A weakness in one of the facets can create an imbalance in the others and make life more difficult.

Discipleship and Recovery

Discipleship and recovery share a great deal in common, each requiring a lifetime of devotion, reflection, and perseverance in maintaining the faith until the end of life. Discipleship and recovery require attention to detail, following a mentor, building healthy, nurturing relationships, striving for something outside and beyond yourself, and many other parallels. In my experience, many people in the first few months of their recovery are very skeptical of anything that is spiritual or Christian. They may have had some very bad experiences with pastors or church leaders.

These encounters may simply reflect their distorted interpretation of the situation. The pastor or church leader may have responded appropriately and was unwilling to enable their continued behavior while they were in the depths of their addiction. Of course, they may have met pastors or church leaders who in fact had very little respect for them because of their addiction. They may have encountered Christians who believed and shared with them that they were going to hell, regardless of whether they recovered from their addiction or not.

Despite these negative encounters, this does not mean they are not open to a discussion about all things spiritual. Generally, in the first few months of their recovery their brains are still recovering from the physical effects of their drug of choice. Their minds remain clouded and confused. Their attempts at clear thinking about things such as spiritual matters are difficult to comprehend.

If I concentrated my early efforts on building a good, trusting, and respectful relationship, they would in about four to six months, sometimes longer, begin to ask me questions related to spiritual recovery. I did not have to start the discussion they would be eager to begin one with me. Often, they began by asking simple questions for which simple answers needed to be given.

What you need to be careful about is to not jump right in and share with them your view of the gospel or what you think they need to do to accept Jesus Christ into their life. What you first need to do is listen. Listen to their viewpoint about the Christian faith, listen to their struggles and bad experiences with the Christian faith, listen to their difficult encounters with other pastors or church leaders, and the difficulty that this creates for them in trying to believe.

Bringing them to discipleship will take time. Don't rush the process. You can and should ask them some basic questions about their religious background related to worship, Sunday school, VBS, early childhood and adult experiences in church, if any. This can help provide a context for asking questions later about how they feel about God and spiritual matters.

You need to stay mindful of the fact that how we view God, see our journey as disciples, and our relationship with God, even if we can articulate all of this with great mastery, that our understanding will not be interpreted the same by a person in the depth of their addiction and/or early recovery.

Over the years, I have encountered many people who were told by sincere fellow Christians that if they gave their lives to Christ, they could overcome their addiction. These people recognized this decision was only the first step of many they would need to take through their recovery and discipleship. While others interpreted it as God was now going to do all the heavy lifting and they did not need to exert any energy into their own recovery. God was going to do it all for them. Their failure was not difficult to predict. As a result, these people sadly developed a very sour view of the Christian faith and would declare it does not work.

First it is important to create a relationship where they trust your opinion and your viewpoint. They need to come to a point where they can trust that you will respect where they are at this moment in their spiritual journey. Their description of where they are spiritually may be very generic. They will use language and stories which most likely will not match up with what you know and have believed about the Christian faith. It's important that you do not come across as being someone who insists they must believe how you believe. They need the ability to disagree, ask questions and challenge your opinion and viewpoints.

In the early stages of their spiritual journey, you need to keep a couple of factors in mind. They need to accept that their everyday problems are not separate from their ordinary daily lives. They need to accept and understand that everyone has trials and struggles in their everyday lives and that the world and God are not out to get only them and make their lives miserable. God is not setting out to get even with them because of their addiction.

As James states, *"My brothers and sisters, whenever you face trials of any kind, consider it nothing but joy,"* (James 1:2) Now a person in recovery will initially have a difficult time seeing anything they are currently encountering in life as joy. At this stage, they need someone they can trust to tell them that joy and satisfaction

in life will come in time. We need to give them confidence they are indeed travelling along a healthy and productive path.

Second is they need to understand that wherever they go and whatever they encounter in their ordinary lives they are interacting with God's spirit in and around them. As the apostle Paul points out, living in the spirit allows us to *"walk in"* the spirit. I have heard people speak in A.A. meetings how they had come to believe that God had been responsible for getting them into A.A. and/or treatment. This recognition for many only came to them months or years later. They began to understand that God had never given up on them and how grateful they were to have listened to God's spirit speaking to them in that still small voice. They recognized that God had indeed responded and helped them get to the right place at the right time. Often, they need the help from others to recognize this encounter with God.

The third factor you need to remember in these early stages is to keep things simple. You want to engage them in simple things through which they can explore their own spiritual journeys. These include discussions and activities which allow them to expand their thoughts and understanding leading to further explorations with people they trust. Thereby, teaching them simple things like spiritual disciplines, prayer practices, regular scripture reading, memorizing some select scripture passages, attending worship, etc. are important elements now. They need to understand that what they do now is as important as what God can do in them.

A pastoral role is important at this stage in helping them ground their newly discovered trust in God. Sharing, studying, and discussing some carefully selected scripture passages can help.

The Twenty-Third Psalm

The Ten Commandments

The Lord's Prayer

The Sermon on the Mount

Romans 8

Colossians 3

Philippians 2-4

These scriptures and others like them form the basis for productive and fruitful engagement in discipleship.

One characteristic a recovering person in early recovery may lack is the necessary patience to let their spiritual formation mature based upon God's timing. They want to rush their recovery, rush relationships, make swift recovery of their

health and emotional well-being, expect urgency in advancing employment and economic improvements in their lives. At this point, they are behaving as if there were some perfect endings to any of these aspects of life. They sometimes develop a desire to make up for lost time as quickly as possible.

For example, if a normal activity would take an average, ordinary person six years to accomplish under the best of circumstances, they believe they should be able to do it in two. They will want to rush everything, and they will have a difficult time understanding that the spiritual facet of their life as well as the relational facet will take a lifetime. You will need to help them recognize the progress and maturity they have achieved and that there is no end point, only a lifetime of learning, reflecting, transformation, and reevaluation of their direction. Like many people they will want immediate results.

As a person progresses in their recovery and discipleship, you will see clear signs of their spiritual journey going in the right direction when you see as Paul states the fruit of the Spirit, *"By contrast, the fruit of the Spirit is love, joy, peace, patience, kindness, generosity, faithfulness, gentleness, and self-control. There is no law against such things."* (Galatians 5:22-23)

Remember what Jesus said, *"I am among you as one who serves"* (Luke 22:27). Jesus also said, *"whoever wishes to become great among you must be your servant"* (Mark 10:44). Jesus is not giving us a formula for spiritual enlightenment, but he is telling us who is the greatest person among us. He or she is the one who is a servant of all. In A.A. meetings you can clearly see the people who have really taken to the program and understand their recovery as service to others. The A.A. step twelve reads, *"Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs."* The steps were written in the past tense and so a sign of spiritual awakening was service to others, *"carry this message to alcoholics."*

In the early stages of recovery, it's important to consider ways in which we can engage people in simple acts of service. They need not be complicated but simple ways of serving others in the church and/or community. For example, being a part of a cleanup crew, helping in the food pantry, serving as usher and greeter for worship, setting up or cleaning up for a church supper, etc.

These simple acts help prepare the person for what will come eventually in the 12 step groups when they get to step 12, which involves giving back what they have received. Giving back God's grace, which we have received freely and abundantly, is important in our discipleship. Simple acts of service aid the recovering person to develop relationships with others they met along the way.

This transformation of the spirit takes on a deeper character when we recognize our need to be a servant of Christ and others.

When I was pastor of a church in southern WV, the church had a food pantry and with an aging congregation the physical labor to prepare the monthly food boxes became more difficult. An addiction treatment center for men opened down the street from the church and they were looking for volunteer opportunities for the twelve men in the program. They accepted our invitation to help with the monthly food pantry and it was a blessing to the church and to these men. Our church members who volunteered were welcoming, accepting, and showed their gratitude to these men for their assistance.

At this stage in these men's lives they needed to hear and experience positive feedback and at the end of each food pantry they left with smiles on their faces. This experience was also valuable to the church members present. As one gentleman volunteer told me, "any of these men could be my son, grandson, or nephew." These church members without any direction from me began to invite these men to church dinners, picnics, worship, etc. because they had built a relationship with them, and they were overjoyed to have them present.

Most importantly discipleship instruction involves listening to the feedback of each person. This may have been the very first time in their lives they have read any scripture passages, attended worship, met church members who showed them respect and understanding. We need to patiently help them process their experiences and how this applies to their recovery and the life God is preparing to offer them. Recovering people are frequently far more intelligent than we often give them credit for. It is important for us to listen. We should not make assumptions but help them process what their opinions, thoughts, and experiences mean in their own spiritual recovery.

Recovery

Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. Even people with severe and chronic substance use disorders can, with help, overcome their illness and regain health and social function.

The brain can take a long time to return to health following a long period of heavy substance use, and the risk of relapse is high at first. It can take a year of abstinence before a person can be said to be in remission;[28] for people recovering from an alcohol use disorder it can take 4 to 5 years of abstinence for the risk of relapse to drop below 15 percent.[29]

Successful recovery often involves making significant lifestyle changes to create a healthy and supportive environment that helps to identify and avoid substance use or misuse cues or triggers. These changes may include switching jobs, finding more stable housing, learning to find new healthy, supportive relationships, and learning to engage in activities that do not involve substance use. Pastors and church leadership can play an important role within the scope of a comprehensive treatment plan for each person in helping them resist relapse and rebuild lives that may have been devastated by years of substance abuse.

A survey of more than 3,000 people in recovery indicated that fulfilling important roles and being civically engaged, such as paying taxes, holding a job, and being a responsible parent and neighbor, became much more common after their substance use ended.[30] While many people in recovery believe that abstinence from all substance use is a cardinal feature of a recovery lifestyle, others report that handling negative feelings without using substances and living a contributive life are more important parts of their recovery.

Some types of recovery programs include:

- **Recovery-oriented systems of care:** These programs embrace a chronic care management model for severe substance use disorders, which includes longer-term, outpatient care; recovery housing; and recovery coaching and management checkups.
- **Recovery support services:** These services refer to the collection of community services that can provide emotional and practical support for continued remission. Components include mutual aid groups, recovery coaching, recovery housing, recovery management

[28] American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (DSM-5) (5th ed.). Arlington, VA: American Psychiatric Publishing.

[29] White, W. L. (2012). Recovery/remission from substance use disorders: An analysis of reported outcomes in 415 scientific reports, 1868-2011. Philadelphia, PA: Philadelphia Department of Behavioral Health and Intellectual Disability Services.

[30] Laudet, A. (2013). Life in recovery: Report on the survey findings. Washington, DC: Faces and Voices of Recovery.

(checkups and telephone case monitoring), recovery community centers, and recovery-based education (high schools and colleges).

- **Social and recreational recovery infrastructures and social media:** These programs make it easier for people in recovery to enjoy activities and social interaction that do not involve alcohol or drugs (e.g., recovery-specific cafes and clubhouses, sports leagues, and creative arts programs).

Recovery: The Many Paths to Wellness

Recovery from Substance Use Disorder (SUD) is a process of change through which people achieve abstinence and improved health, wellness, and quality of life. In 2005, at the National Summit of Recovery Conference, they issued a report through the Center for Substance Abuse Treatment (CSAT) regarding some of the guiding principles of recovery. The National Institute on Drug Abuse's (NIDA) principles focus on the process of delivering effective treatment. The National Summit on Recovery's 12 principles of recovery provides guidelines on the process associated with recovery.

Guiding Principles of Recovery:[31]

There are many pathways to recovery. Individuals are unique with specific needs, strengths, goals, health attitudes, behaviors, and expectations for recovery. Pathways to recovery are highly personal, and generally involve a redefinition of identity in the face of crisis or a process of progressive change. Furthermore, pathways are often social, grounded in cultural beliefs or traditions and involve informal community resources, which provide support for sobriety. The pathway to recovery may include one or more episodes of psychosocial and/or pharmacological treatment. For some, recovery involves neither treatment nor involvement with mutual aid groups. Recovery is a process of change that permits an individual to make healthy choices and improve the quality of his or her life.

Recovery is self-directed and empowering. While the pathway to recovery may involve one or more periods of time when activities are directed or guided to

[31] This section on recovery from the Center for Substance Abuse Treatment, National Summit on Recovery Conference Report, 2005. A more comprehensive explanation of treatment and recovery principles can be found in Section Six of the White Paper called: *"Guiding Principles and Elements of Recovery-Oriented Systems of Care: What do we know from the research?"* Published August 2009, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. This publication may be downloaded at www.samhsa.gov/shin or pfr.samhsa.gov/rosc.html.

a substantial degree by others, recovery is fundamentally a self-directed process. The person in recovery is the "agent of recovery" and has the authority to exercise choices and make decisions based on his or her recovery goals that have an impact on the process. The process of recovery leads individuals toward the highest level of autonomy of which they are capable. Through self-empowerment, individuals become optimistic about life goals.

Recovery involves a personal recognition of the need for change and transformation. Individuals must accept that a problem exists and be willing to take steps to address it; these steps usually involve seeking help for a substance use disorder. The process of change can involve physical, emotional, intellectual, and spiritual aspects of the person's life.

Recovery is holistic. Recovery is a process through which one gradually achieves greater balance of mind, body, and spirit in relation to other aspects of one's life, including family, work, and community.

Recovery has cultural dimensions. Each person's recovery process is unique and impacted by cultural beliefs and traditions. A person's cultural experience often shapes the recovery path that is right for him or her.

Recovery exists on a continuum of improved health and wellness. Recovery is not a linear process. Recovery is based on continual growth and improved functioning. Recovery may involve relapse and other setbacks, which are a natural part of the continuum, but not inevitable outcomes. Wellness is the result of improved care and balance of mind, body, and spirit. Improved health and wellness are a product of the recovery process.

Recovery emerges from hope and gratitude. Individuals in or seeking recovery often gain hope from those who share their search for or experience of recovery. They see that people can and do overcome the obstacles that confront them, and they cultivate gratitude for the opportunities that each day of recovery offers.

Recovery involves a process of healing and self-redefinition. Recovery is a holistic healing process in which one develops a positive and meaningful sense of identity.

Recovery involves addressing discrimination and transcending shame and stigma. Recovery is a process by which people confront and strive to overcome stigma.

Recovery is supported by peers and allies. A common denominator in the recovery process is the presence and involvement of people who contribute hope

and support and suggest strategies and resources for change. Peers, as well as family members and other allies, form vital support networks for people in recovery. Providing service to others and experiencing mutual healing helps create a community of support among those in recovery.

Recovery involves (re)joining and (re)building a life in the community. Recovery involves the process of building or rebuilding what a person has lost or never had due to his or her condition and its consequences. Recovery involves creating a life within the limitation imposed by that condition. Recovery is building or rebuilding healthy family, social and personal relationships. Those in recovery often achieve improvements in the quality of their life, such as obtaining education, employment, and housing. They also increasingly become involved in constructive roles in the community through helping others, productive acts and other contributions.

Recovery is a reality. Recovery can, will, and does happen.

Twelve Step Groups and other Mutual Help Groups

Members of 12-step mutual aid groups tend to have a history of chronic and severe substance use disorders and participate in 12-step groups to support their long-term recovery. About 50 percent of adults who begin participation in a 12-step program after participating in a treatment program are still attending 3 years later.[32] Rates of continued attendance for individuals who seek A.A. directly without first going to treatment are also high, with 41.6 percent of those who start going to meetings are still attending 9 to 16 years later.[33]

A.A. is often referred to by some as a self-help group. If A.A. was a self-help group, it probably wouldn't work. Those who approach A.A. as a self-help group behave as if success all depends upon them. Practicing the A.A. program in this fashion likely would not work. A.A. is what is called a "mutual-help group" based on community life formed in relationships.

Twelve step groups don't see themselves as the final word on spirituality or even on recovery from a SUD. Bill Wilson, one of the co-founders of A.A. spoke of A.A. as a *"spiritual kindergarten."* A.A. urges people to make peace with faith

[32] Kelly, J. F., Stout, R., Zywiak, W., & Schneider, R. (2006). A 3-year study of addiction mutual-help group participation following intensive outpatient treatment. *Alcoholism: Clinical and Experimental Research, 30*(8), 1381-1392.

[33] Moos, R. H., & Moos, B. S. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical and Experimental Research, 29*(10), 1858-1868.

communities in which they were raised if there was one. It is said within A.A. meetings *"God brings you to A.A., and A.A. brings you back to God."*

Bill Wilson said over and over that A.A. did not have the only answer to everything in the world. He had seen a psychiatrist for years and said that psychiatric treatment helped him tremendously. He warned people about the dangers of arrogance and shortsightedness in thinking that the alcoholics in A.A. were the be-all and end-all of life.

Early A.A. members considered it important for the recovering person to seek medical attention from medical professionals, psychological help from psychologists and psychiatrists and spiritual help from pastors and congregations. A.A. never intended to establish itself nor planned to set itself up as a one-stop shop for the recovering alcoholic. A.A. recognized early in their formation that their chief and sole purpose needed to focus on keeping the alcoholic sober. Without sobriety the recovering alcoholic could not grow in other areas and achieve their full potential.

The A.A. Preamble, read at the opening of every meeting, simply states, **"The only requirement for membership is a desire to stop drinking"** (Alcoholics Anonymous World Services, Inc., 1986). Narcotics Anonymous (NA), an alternative Twelve-step organization for people addicted to drugs other than alcohol, is also a program of complete abstinence, including abstinence from alcohol.

When I first began working in the AOD treatment field, I was told to attend as many A.A. meetings as I could and to read their literature. As the faith community we need to learn from Twelve step groups, such as, A.A. and N.A. and other mutual aid groups who have learned repeatedly over the years how to reach out to those affected by addiction in our communities who are "still suffering" from the dangers of addiction.

Twelve Step groups can help refresh the church's memories regarding the nature of hospitality, acceptance, surrender, outreach, creating a community, transformation, and spiritual development when ministering to a difficult segment of the population. The ironic thing about what Twelve step groups achieve daily are skills initially learned from churches and pastors.

If you read the history of A.A. and its founders, you will discover that most A.A. practices were approaches borrowed from what churches were good at doing, but have slowly over time forgotten how to implement some of the basics. In a way, things have come full circle. Pastors and congregations could potentially learn a great deal about how to effectively communicate the gospel by learning from the practices, attitudes, and principles of A.A.

During the time I attended A.A. meetings, what I did not expect was the exceptional gift God was preparing to give me. I was introduced to some truly astonishing, gracious, and thankful people. I encountered people whom I found compelling, refreshing and completely alien to my limited perception of the world. I was intrigued with these recovering alcoholics. I found myself drawn to how they formed relationships with one another, welcomed one another, showed hospitality to newcomers, and with courage and strength told their personal stories.

They spoke about conflict, struggle, pain, and recovery. I was astonished with the numerous ways they expressed their gratitude to God and to others. I found it interesting how the A.A. fellowship offered them hope and how the program rescued and saved their lives. God had allowed me the privilege of witnessing some of God's best work.

My experiences in attending A.A. made me recognize the existence of a major disconnect between Twelve Step programs, pastors, church leaders and congregations. A disconnect which the early founders of A.A. did not want nor desired. They wanted the church, pastors and others involved in what they were hoping to achieve. What they had learned from pastors and churches aided them as they developed the core principles of A.A. and became a major turning point in the recovery for alcoholics around the world. These initial lessons helped them to shape the direction of their traditions and practices. A.A. had learned valuable lessons from the church and in turn, A.A. opened a door of unlimited mission possibilities for the church, opening opportunities where they could reach out to the recovering community. Unfortunately, this was an opportunity missed by many churches and church leaders.

Many meetings of A.A. occur within the walls of churches and what always surprised me was how little interaction there was between church leadership and A.A. members. Whenever a person walks into our church buildings, we should take the time to figure out how to show them hospitality, care about their presence and offer our assistance and guidance in doing what they do best.

I have heard countless excuses, rationalizations, and criticism of Twelve step groups. Frequently there is an unwillingness to become partners with others outside the church, particularly recovering people. With many 12 step meetings within church facilities, God is indeed at work within the walls of the church and as I believe, hoping we take notice. God is and always has been at work outside the church. Our task is in discovering where God is already at work within our communities. God is calling us into the world, to become God's partner where God is already preparing the harvest.

During presentations I have made to congregations and their leadership, I often hear the refrain that Twelve step groups were too secular. In some locations throughout the U.S. this viewpoint is a reasonable observation. Interestingly, there are many "secular" mutual help groups in existence in the U.S. and the reason for their development is that they believed that 12 step groups were too spiritual.

The perception that 12 step groups were too secular chiefly came from pastors and church leaders, who were upset that 12 step groups did not specifically proclaim Jesus Christ as the only way. This viewpoint comes basically from people who don't understand the reason for the 12 step groups view of spiritual recovery. As a result, this perception too frequently caused the church to miss an opportunity to respond to the needs of the recovering community.

The co-founders and early members of A.A. made a conscious decision to speak of *"spiritual awakenings"* in more generic terms, because they did not wish to engage in any theological or doctrinal debates. To engage in any specific theological positions would only distract them from what they discovered needed to be their primary role. As the program and practices developed, A.A. came to recognize their success depended on a singular purpose, keeping each other sober. Early A.A. meetings were distinctively Christian in structure and character. Early meetings included scripture readings, prayer, and testimonies, in which elements of these still exist in the form of what A.A. calls a "lead meeting" where someone shares their personal recovery story.

A.A. recognized and still does recognize that spiritual concerns and one's relationship with God were important to a person's ultimate recovery. A.A. envisioned their primary role in spiritual matters was to assist each person to come to their "awakening" moment, helping the person to recognize their need for God to further their recovery and growth. A.A. helps the newcomer to come to their "awakening" moment through their ability to bring the person through the steps of surrender, acknowledgment of their inability to control their usage, and willingness to seek help outside of self.

A.A. determined it was best to leave the specifics of this "awakening" to God's presence to remaining within the context of a person's own choice of a faith tradition. Important to this approach was the development of respectful and trusting relationships with other recovering people whom they could seek counsel and guidance and whose help they found supportive and uplifting in recovery.

When A.A. was founded, earlier members had a faith tradition to which they or their families related. Today many people have no such faith tradition, so many growing up now have no religious background to rely upon. The challenge for the

church today is how will we respond to the growing number of people who have grown up with no religious frame of reference, no experience of worship, no experience of hearing or reading scripture or no thoughts or concern about God or whether it is even important. I feel that learning how to work with recovering people and their families struggling with addiction can unlock for us within the church the necessary wisdom and knowledge to meet the challenges the church will face in the years ahead.

Co-founders of A.A. valued the role of religion and "spiritual awakenings" to the ultimate recovery of alcoholics. As the program of A.A. took in a more diverse membership and they had more experiences about the recovery process of its members, they began to develop a more quantified definition of their primary purpose. If you read the Twelve Steps of A.A. you will discover that they are written from the perspective of their experience, "We made a decision," written in the past tense, these are things we did. The steps indicate from the experience of their members that these were the things we needed to do to make recovery possible.

As A.A. developed they made a conscious decision to purposefully not take a stand on any specific religion or faith. Not because they felt it unnecessary, but it distracted from their chief purpose, being sober one day at a time. This approach is not intended as a disrespectful attitude toward faith communities and the role faith plays in the lives of recovering people, but as an acknowledgment of its importance.

The Journey of Recovery Takes Faith and Trust

> *"Now the LORD said to Abram, "Go from your country and your kindred and your father's house to the land that I will show you. I will make of you a great nation, and I will bless you, and make your name great, so that you will be a blessing."* (Gen. 12:1-2)

When we ask someone to give up their drugs of choice and begin a journey of recovery, we are asking them to begin a difficult journey. Beginning the journey of recovery takes faith and trust in God. We are asking them to give up what they have known for quite some time in their life, something they have grown accustomed to, even if it is destroying their life. We are asking them to begin a journey to a new and different place. In their minds this new place is often a very frightening destination. Abram discovered himself called out to go in a different direction and found within himself the capacity to trust God, and eventually this experience transformed Abram into Abraham.

When God called Abram in Genesis 12, that call utterly turned Abram's world upside down and totally reshaped his life and his family members' lives. *"Go from your country"* (v. 1). Abram had just been uprooted from Ur; now he's to uproot again from Haran. God has something in mind about Canaan, and he wants Abram to continue the family journey to get there.

Recovery from any illness, cancer, heart disease, diabetes or addiction creates a great deal of confusion, fear, struggle, and pain. In the early stages, we may find the road set before us too treacherous and difficult to travel. We find we are too anxious to begin the journey. We may feel overwhelmed by the decisions that need to be made, in order, to travel into this unknown territory. Those who have decided to begin the journey are filled with apprehension and need the support of others to discover the courage to open themselves to the opportunities that treatment and recovery brings. A congregation would not desert a church member newly diagnosed with cancer, heart disease or diabetes, nor should we be so quick to dismiss a person with a SUD.

"Go from where you live and whom you know to a place I won't reveal yet." That's a crazy calling. God says that if Abram does that, he'll bless him. Barrenness will turn into family. Family will turn into a nation. By taking the risk and completing the journey, not only will Abram be blessed, but he will become a blessing to others. Abram's calling in Genesis 12 gives us an overview into our mission to assist others in their recovery: Trust God. Follow God. Be blessed by God. Bless others.

A difficult journey requires a lot of trust in God to take those many steps of obedience along an indeterminate journey. But the Lord said, *"Go,"* and Abraham *"went"* (vv. 1, 4a), at the age of 75 (v. 4b), leaving much of what was near and dear to him. The people starting their recoveries are called to this and the church also receives the same call. When we trust the journey set before us and follow God, we will be blessed and people who are actively working a program of recovery become a blessing to so many others.

The Harvest Is Ready

"*The fields are ripe for harvesting."* (John 4:35) Jesus reminds us that we only need to look around us to find opportunities for mission. Jesus is calling us to hear the cries of those suffering. A field of mission lies before us and is ripe for the harvesting. What churches need to discern is how to recognize when it's time for the harvest. The Samaritan woman recognized something special in the person of Jesus, *"Come and see a man who told me everything I have ever done!"* (John 4:29). The harvest is upon us, and our communities need to see something distinctive in us, so they will feel safe in speaking about their pain and suffering.

The message of the harvest is always urgent. The fate of neighborhoods, communities and families hangs in the balance. Every generation is crucial; every generation is strategic. We are not responsible for the successes or failures of a past generation, and we cannot fully determine how future generations will answer the call. However, we do have our current generation! God will hold us responsible for what we do or choose not to do now in our moment in the sun. Someday, Jesus will ask us why we did not recognize Him in our neighbor.

This relationship between God's mission and the church's work in the world is the reason Jesus reminds his disciples that sometimes the fields are ripe for harvesting - not just for sowing (John 4:35). When the fields have already been plowed, and planted by God's own Spirit, then Jesus' disciples simply need to decide to join with God's ongoing actions, for we are called to harvest a field which we have not sown.

Offering Hope

> "For surely, I know the plans I have for you, says the LORD, plans for your welfare and not for harm, to give you a future with hope. Then when you call upon me and come and pray to me, I will hear you. When you search for me, you will find me; if you seek me with all your heart," (Jeremiah 29:11-13)

There are times when life seems utterly hopeless. When it seems that even God has forgotten us. The only thing we can imagine in such times is despair. In our moments of despair, when circumstances seem to overwhelm us, hope helps us to trust that God is present, loving us and working in powerful ways. Hope is a wonderful gift. It fills us with vitality.

Without hope, life is difficult to sustain. Hope keeps us going. Hope keeps us from giving up when outward appearances might lead us to despair. Hope is the

capacity to trust that something bigger is taking shape which we are currently unable to see — a bigger picture which will give meaning to our lives whether they are big or little, glorious, or difficult.

Clearly, we need hope. We need it every day. We find it difficult to move forward without it. It keeps us engaged in life. It is like a candle burning steadily in a room that otherwise would only be a place of darkness.

Deep within the souls of those struggling with a SUD is the belief that they are beyond hope. They believe they are lost within the depths of despair. Recovery offers the possibility of resurrection. They need us to help them believe that recovery is possible. People within their addictions view their lives much in the same way Ezekiel describes the whole house of Israel in Chapter 37, *"Our bones are dried up, and our hope is lost."* (v. 11) Jesus' disciples need to exercise their ability to proclaim their own stories of redemption and hope, to lead others to trust in what God is doing and proclaim what God can do.

We are called to proclaim a message they have never heard and to believe in someone they have never known. This is a message consistent with the aim of Paul when he in writes in Romans 10, *"But how are they to call on one in whom they have not believed? And how are they to believe in one of whom they have never heard? And how are they to hear without someone to proclaim him? And how are they to proclaim him unless they are sent? As it is written, "How beautiful are the feet of those who bring good news!"* (Romans 10:14-15) We are the people of beautiful feet who God has called to make His grace known to those broken and in despair. We are the ones who extend Christ's invitation for them to enter the Kingdom of God and once again experience hope.

Through the ages, prophets shared the word of God with us, reminding us of who we are as God's people. This is something which has been true from the beginning of time but may have faded from our memories. We all have days and moments when we feel, *"Our bones are dried up, and our hope is lost."* (Ezek. 37:11) These moments come at times of grief, during sudden and rapid life changes, or emotional distress. As the church we are called to revive our memories regarding who we are as God's people and addressing AOD issues in our communities can help us regain our memories to what we have been called to do.

The whole church is called by God to have a prophetic voice in our communities and proclaim that together with the Holy Spirit we have a partner in our faith. Jesus Christ leads us to the harvest which will breathe new life into our communities and help those affected by AOD problems rise to their feet to new life. We are also called to teach them how to tell their stories of restoration and

redemption, how *"they lived, and stood on their feet."* (Ezek. 37:10) They have rich and meaningful stories about how God's love and grace transformed their lives and we as the church need to hear their stories and the hope it brings the whole body of Christ and the greater community.

We all have stories of faith, heartache, hope, and grief capable of breathing new life into our communities. Our voices allow these stories to live and breathe new life into our communities. We are called to tell our stories and share our hope, to encourage those with recovery stories, those with stories of grief and loss, those with stories of transformation, and those with stories of resurrection which lifted them up from the darkness. We have stories to tell which can breathe new life and raise our communities from their graves of despair. What stories is God's Spirit calling your church to tell and teach others to tell? *"Let us therefore no longer pass judgment on one another, but resolve instead never to put a stumbling block or hindrance in the way of another."* (Romans 14:13)

The Challenges Ahead

While living in southern WV, I often heard people make a comment when someone asked for directions. "How do I get to (some particular town or place)." Often a humorous reply consisted of two similar responses, either "If I was going there, I wouldn't start from here" or "You can't get there from here." Neither reply was correct, but the responses did indicate the proposed route they needed to navigate was not going to be easy. The challenge with any journey is we seldom get the option to pick our starting point. We can only begin at the point where we currently find ourselves.

People faced with beginning the journey of recovery are beginning at a point that will be challenging in numerous ways. Beginning recovery is frequently located in the middle of damaged relationships, great losses in property, ill health, people, respect, or freedom. The recovery journey is slowed by criminal records, poor education, few employment opportunities, and/or lack of necessary resources. They might not like the starting point, but what they need to recognize and what we need to appreciate is that they are indeed starting a journey.

As church leaders and pastors, we may not like the place where we are in beginning our journey to address the problems of AOD in our communities. We may find our starting point intimidating and too overwhelming, but it is where we are. The journey can only begin from where we are now, but we are not alone and God is already at work, even if, we cannot currently perceive it. Our task is to

start and find the path and begin the journey to where God will be leading us as we step forward in faith.

When the Addiction Ministry Network in Redstone Presbytery began in the Fall of 2016, we were not sure where to start. We decided to begin a journey together, to start a conversation, and to discover where the Holy Spirit might lead us as we gathered. We shared our common and uncommon stories of facing addiction in its many aspects among the people we had encountered.

We invited professionals and volunteers from different organizations who were already engaged in addressing addiction in different ministries and approaches. We extended invitations to people from different backgrounds and experiences, i.e., social services, local providers, recovering people, other denominations, etc. We wanted to learn and grow in our understanding and how we might best respond.

We wrote a Lenten devotional guide, planned worship services of remembrance, got trained to use naloxone and how to train others. We distributed NARCAN® kits at presbytery meetings. We provided recovery bibles to congregations in the presbytery, wrote grant proposals to support our work, wrote a curriculum to help others understand addiction and produced videos to complement the curriculum. We engaged presbytery congregations in collecting items for "Hope in a Bag" project, which is a local ministry to provide personal items for people entering treatment services.

One member submitted a commissioner's resolution at the 2018 General Assembly meeting regarding pastoral approaches to addiction which in part was adopted into the denomination's official policy. We engaged in many other activities, while all along learning more and discovering new trails where the spirit might be leading us.

As a pastor and as a counselor my obligation is to respect each person's starting point, regardless of the difficulty of the route which lies before them. My task is to guide them to discover the path forward and occasionally spend some time walking side by side with them. This path will hopefully lead to a life God has packed with spirit-filled moments and productive experiences where they will discover the fullness of God's grace and love by following Jesus Christ into the future. Recovery and discipleship both take time.

Even if we only have a minor understanding of AOD problems, we are aware that AOD problems are destroying the moral and spiritual character of our community. We need to recognize that the unique voice of the church is needed by our community to help focus the conversation on compassion, kindness, and hope. We need to provide our communities with vision and speak out about how addiction is

destroying our children, families, relationships; how it breeds violence, crime, poverty, despair, and hopelessness.

We need to be present to keep the conversation from becoming about punishment, revenge, and hate. A major opportunity exists before us to speak for hope, faith, and love. As spiritual leaders we need to provide a vision that our communities can be different and healthier.

- We need to change the conversation from one that condemns, to a conversation that offers hope.
- We need to change the conversation from one that punishes, to a conversation that holds people accountable with compassion and grace.
- We need to change the conversation from one that shames, to a conversation that offers forgiveness and redemption.
- We need to change the conversation from one that blames, to a conversation where we all recognize we had a role in why the world is the way it is, not to scapegoat other segments of our society.

Collaboration and Cooperation

Addressing AOD problems in our communities has no quick fix, only a lot of hard work over the next 70-90 years to significantly reduce the problems. We must engage the culture that promotes specific conditions which encourages AOD misuse and abuse. We need to develop short and long-term strategic plans and goals to change attitudes, beliefs, and habits over several generations.

Take for example, efforts on tobacco use since the 1960's. Some of you might remember the days when non-smoking areas did not exist and every meeting you attended generally included a smoke-filled room. In the 1950's and 60's taking on big tobacco companies and the public perceptions about tobacco were not easy and for many people seemed impossible. Through the hard work of a lot of dedicated and committed people willing to fight the social forces for smoking, they slowly and steadily changed the social attitudes and behaviors of millions of citizens. This change occurred gradually over 40 to 60 years. We still have a long way to go but progress is clearly being made. The hard and dedicated work of a lot of different people made the difference and we are witnessing the fruits of their efforts.

Congregations and church leadership need to learn how to cooperate with other organizations, community groups and other churches who view addiction as a primary community issue. Congregations need to join with or begin local AOD related networks, coalitions, and collaborative community projects to learn how to

work with others already engaged in the fight to reduce AOD abuse and dependency. Cooperation with other groups will help congregations partner with others to make changes in their community involving public and private policy, advocacy, education, prevention, and strategic planning.

We need to learn about local treatment and prevention programs and how to make referrals and how to work with them to assist those entering recovery. Preventing overdose, providing prevention and treatment service referrals requires collaboration with a diverse range of partners—some familiar and some new to our scope of understanding. The list below presents just a few of the different sectors in our community we can partner with in addressing the issues of AOD in our location. This list is not all inclusive nor complete but is a start in offering opportunities for meaningful engagement. These sectors include:

- Criminal Justice
- Government, local, county and state.
- Harm Reduction Programs
- Health Care Providers
- Law Enforcement
- Medical and Pharmacy Schools
- Medical Examiners and Coroners
- Mental Health Providers
- Parents
- People Who Use Drugs
- Pharmacies
- Prescribers
- Professional First Responders
- Recovery Community
- Treatment Providers
- Universities/Colleges
- Youth-serving Agencies
- Other Faith Communities

Where to Start

To be effective in ministry, we need to embark on a journey that God has already begun in our communities. Ask the Holy Spirit to reveal to you where God's kingdom is already evident within your community. We need to reflect on Jesus' action of sending out the 70, *"After this the Lord appointed seventy others and sent them on ahead of him in pairs to every town and place where he himself intended to go."* (Luke 10:1) Jesus does not send us out alone and never sends us to a place he does not already intend to go himself.

While we often gravitate toward the movers and shakers in our communities, scripture makes it plain that God chiefly chooses to work among those in the margins. Seek out the people who demonstrate God's love and who build up the community through the actions of ordinary life. These people are already doing extraordinary work consistent with God's vision of the kingdom. God can work through any person or institution to achieve God's purposes.

We need to differentiate between the person active in their SUD and the recovering person. We need to learn how we can productively help both groups and learn that each group requires us to respond differently to the benefit and health of each. We need to learn how to not enable the behavior of the person who is actively using AOD, while learning how to provide support and guidance to the person struggling with their recovery.

Getting churches ready to minister to this population requires teaching them many things and one primary lesson is that little things don't matter. Being late for worship or talking are just not that important to the possibility to do ministry. We are all sinners struggling to become saints created by God, struggling to live out our lives as full, authentic human beings. Having to pick up some cigarettes butts in the parking lot is not a reason to become alarmed, just time to buy an outdoor ashtray. I have heard it said, "before we can have butts in our pews, we need to learn to deal with butts in the parking lot." We need to stay mindful that discipleship is about working toward a God given goal. It is not about the church only accepting people who have already reached the goal, because we ourselves haven't reached it.

We need to develop an appreciation for the assets which already exist within your community. How might the church nurture a relationship with those assets and support the community development work that is already taking place? How might the church invite members of the community to share their gifts to bless one another, and to join the church in doing the work of the kingdom? Also consider the ways your church is already being used by God to bless your community.

Who in the community is crying out for God's healing, compassion, hope and love? Ask the Holy Spirit to help you see the community through God's eyes, looking past the superficial appearance of things to the heart of the matter. In more affluent communities, we may be inclined to conclude that everything is fine. Refined exteriors can mask many forms of brokenness, struggles and pain — family conflict, addictions, the scars of abuse, and spiritual emptiness. While in low-income communities, our eyes may be drawn to physical evidence of need — graffiti, crime, violence, abandoned buildings, and trash in the street. God can redirect our vision to the asset He cares about most: the people.

What could your communities look like if people embraced God's transforming redemption? What would it look like, if neighbors loved one another, if the natural environment was flourishing, and if people demonstrated compassion and hope to all its residents?

What would our community look like if social institutions treated people as responsible, valued creations made in the image of God? Implementing these visions requires caution. There's a fine line between dreaming of desired changes and imposing your will on others. Never assume that you know what is best for other people.

Your vision must take the hopes and dreams of members of the community into account. This means building relationships with people and really listening to them. Make room for possibilities that are so big that only God could bring them to a healthy and successful conclusion.

Recommendations for Moving Forward Faithfully

The following recommendations are offered as suggestions for your consideration, some will be useful to your situation and others beyond your current scope of ministry. You need to first seek and ask for the guidance of the Holy Spirit to lead you to the most effective ministry for your situation. Many of these recommendations can work regardless of the size of your congregation. If you seek the guidance of the Holy Spirit, the Spirit will lead you to people who have a passion for this ministry.

First and foremost, pastors and church leaders must be willing to state where they stand and share their opinion about the AOD epidemic facing their communities. You need to share your opinion and approaches toward those who are suffering and their families. Families and recovering people will be unwilling to approach you if they don't know where you stand. If you hold a harsh, judgmental opinion of those suffering from a SUD, be honest and let it be known, thereby those who need to find someone who will listen to their concerns can avoid you.

When speaking about your position on AOD, it is okay to state what you don't understand, or you lack necessary knowledge on how to appropriately respond. You don't have to have all the answers, only that you are willing to listen and ask the appropriate questions. We need to remain open to allowing God’s spirit to move us to the point where God is leading us to serve. As a pastor or congregation who is only beginning to explore the world of AOD issues there will be a learning curve, a time of discernment, and the development of a path forward together as a congregation where you will need to learn where God is calling you. Your congregation might already have people in recovery who are looking to find a place to share their stories and expand their ministry, but they are waiting to discover what the leadership of the church believes regarding AOD and SUD.

If you demonstrate your willingness to be open, honest about the people suffering from AOD you need to be prepared for those in your congregation who will be sharing their stories.

If you are willing to listen, let it be known.

If you are aware of local referral resources, let it be known.

If you have some type of experience with AOD, are you willing to share your personal story? For example, did you grow up in an alcoholic family, did you have to deal with family members with a problem, or did you have friends who fell into an AOD lifestyle and can describe how it affected you?

Even if your congregation is small and has limited resources, you can still make an important impact on your community. You can learn what other congregations are doing and find ways you can help them in their efforts as partners or become active participants with them. Seek opportunities to engage church members in conversations about whether they have been impacted by AOD problems in their families or community.

1. Prevention and Informational Strategies

Promoting prevention strategies is a good starting point for any congregation beginning this journey. We begin by first educating ourselves and the congregation about the impact of AOD on people both currently active in usage and those in recovery. Family members such as spouses, parents, and children, and close friends and associates are often keys to a person seeking help for an SUD and staying in recovery. The more these individuals learn about addiction and how to respond in healthy ways to the behaviors they see in their addicted loved one, the better chance of recovery for the person with the SUD and themselves. Learning communication and coping skills along with eliminating enabling actions are most important for the journey toward recovery.

Communicate clearly how church members can recognize SUD as a treatable disease through:

- Sermons
- Bible Studies
- Sunday School
- Study groups
- Pastoral care sessions

Acknowledge that the prevention of AOD problems is a major concern in determining our community's future and should be a concern within our churches.

Establish a Prevention Bulletin Board in your church building where you can provide important AOD related information:

- Local news clippings on Prevention events
- List of websites and/or phone numbers for addiction information
- Community resources
- Seek published information and pamphlets from local prevention providers.

Provide easily accessed information regarding:

- Treatment centers and facilities
- List of local A.A., N.A., Ala-Anon, Ala-Teen, and other mutual aid groups.

You want the community to know that addressing AOD issues is important to your church. If your congregation sponsors community outreach programs which brings others into your facility, i.e., food pantries, clothing drives, service clubs, etc. make sure the location is easily seen by these groups.

If you have a church newsletter:

- Set aside a section with regular short informational and educational materials on specific topics.
- Include short segments from government websites on addiction.
- Include healthy lifestyle articles which include recovery stories from other diseases in your newsletters.
- Recovery stories are a method for sharing and giving hope.

Use church social media to share information about AOD, SUD and recovery.

- Share any programs or services your church or the community will be holding on SUD or 12 step programs.
- These media posts communicate the message that your church is welcoming to those seeking help and recovery.

Provide education to church youth groups related to AOD prevention with an emphasis on its impact on the developing brain.

- Church youth are often interested in how they can help their peers who are using AOD.
- Some youth may currently be in a high-risk category for developing a future SUD.
- Educating youth establishes your congregation as a safe place for them to return.

Pre-marriage counseling sessions can provide information regarding:

- Fetal Alcohol Spectrum Disorders
- Parents as role models
- Warning signs of AOD, etc.

Again, this helps to establish the church as a safe place to discuss these issues if they arise in the future.

Actively become involved within local prevention efforts – discuss, listen, learn, and share. Most importantly, listen and be open to what you hear. People in recovery, family members, staff in local prevention and treatment programs will use language different than the language used in the church, so try to not be judgmental about what you hear simply because the language used is different. They are struggling, like most of us, in attempting to understand the challenges, hopes and fears which all of us encounter in life.

People in recovery and their families are seeking to understand God, love, belonging, hope, and joy. They don't need others telling them they got it all wrong because they are using different language, expressing different beliefs, and asking confusing questions. They need and want a relationship with someone who will be willing to listen and take a journey with them. Someone willing to help them understand the important questions in life. You first need to build a trusting, enduring relationship.

Watch for locally available workshops, conferences, or information sessions sponsored by county or state AOD organizations, churches, or coalitions. These are good opportunities to learn what others are currently doing in your community.

2. Outreach and Referral

Have the church leadership approve a statement on AOD and SUD which can be communicated to the congregation and community in different ways, i.e., worship bulletins, bulletin boards, newsletters, website, social media, etc. A statement that indicates that the church is supportive and willing to assist others about their concerns makes the church a safe place for people to share their stories and talk about their struggles.

List local and national resources on your church web site with links to where information, referrals and treatment can be accessed. Also, make available web links to organizations or coalitions which will help people get involved in prevention efforts.

Does your church have a library? Include information about local treatment and prevention resources in the library. Purchase books about addiction and recovery to include in your collection.

Be sure to include children's books in the library as well. There are many books written that help children understand how alcohol and other drugs can change the way people talk and behave when they are under their influence. Children who live with someone in active addiction often think they are the reason their addicted family member's use of alcohol or other drugs. Somehow, they feel they are to blame. Books can help dispel these misconceptions and help them begin their own healing.

Allow 12-Step programs to use the church facility for meetings. Don't just provide space but take the time to meet the leaders, hear their stories, ask how the church can assist and listen to the needs of the individual members.

If the 12-Step meeting is an open meeting, attend a few to learn more about the group.

- Build relationships first.
- Tell them about the ministries of the church available to those in recovery, i.e., assistance with rent and utilities, employment, food, counseling, children's programs, etc.
- Extend invitations to church events, such as church suppers, special events, bible studies, picnics, concerts, etc.
- After you get to know them and their unique backgrounds, then you might invite them to worship.

Ask for prayer concerns during pastoral prayers on Sunday that includes references for intercessory prayer for families and people struggling with a SUD.

If you would prefer to not to ask for public requests for prayers, create a special prayer group with select church members. The group can meet regularly to pray for people suffering from a host of diseases including SUD and/or offer daily prayer for people who need prayer for confidential problems and others lost within the community.

Develop methods and approaches unique to your church and community on how to support and encourage a recovery-friendly attitude in your congregation.

3. Community Engagement

If your town or county has a local Community Anti-Drug Coalition have the church leadership designate one or two church leaders to become active members of this coalition and make regular reports to the church leadership regarding actions of the coalition.

Plan a community wide worship service of remembrance for family members who are grieving the loss someone in their immediate or extended family.

Plan and organize special event opportunities for parents to increase their awareness and understanding of underage drinking and other AOD related issues. Make use of local community resources and potential speakers they can offer you to help. Parents are frequently interested in learning how to prevent AOD use among their children.

Develop strategies for the community, church members, and the general faith community so that they can turn to your church for support and assistance if they have concerns about their own or someone else's SUD or general usage. Make sure that you have educated yourself on referral sources for a wide range of issues and methods while developing these strategies.

Encourage participation in a church and community wide "Prevention Sabbath," through local church organizations, such as a ministerial association. This could be done during Recovery Month which occurs each year in September to focus on alcohol and drug prevention and recovery messages.

4. Recovery Support

Once or twice a year pastors should focus their sermons on the issues of AOD and recovery. These can provide guidance on healthy, positive responses that the church and church members can use to show compassion and concern.

Preach sermons on brokenness and healing by Christ to those impacted by AOD problems. Tell recovery related stories within sermons.

Have someone in long-term recovery and/or a recovering family member speak to the congregation about their personal experience, i.e., during worship, special worship services, church supper, Adult Sunday School, Bible study, or other study groups, etc. Local treatment centers or county AOD administrative offices can help recommend appropriate people.

Take time to learn about local treatment and prevention efforts. Meet the people in your community who are working in the prevention and treatment fields. Invite

staff or community members from other social services directly or indirectly related to SUD treatment or AOD prevention to give presentations during worship, church supper programs, bible studies, committee meetings or special community workshops.

Possible Topics:

- Helping parents speak to their children about AOD use.
- How the church can enhance local protective factors for community children.
- The impact of AOD on families and strategies to help families.
- Description of local treatment programs and how to make referrals.
- Description of local prevention programs and how the church can become involved and enhance local prevention efforts.
- How to deal with those asking for financial assistance who have AOD problems.

Have discussions with local SUD treatment and prevention providers and ask:

- Where have they assessed gaps in recovery and prevention services
- Can the church help fill these voids

Provide transportation to counseling sessions, appointments, and 12 step group meetings.

Help with job assistance, education and training needed to enhance employment opportunities.

Assist children in recovering families with their education, through tutoring, school supplies, encouragement, and support. Assist with celebrating birthdays, holidays, like Thanksgiving and Christmas.

Let them know that they matter to others in the community, and they belong.

Consider your ability to help in budgeting, utilities, furnishings, auto repairs, etc.

An important and vital objective is to build lasting relationships with affected families for their long-term health and safety and for the benefit of the congregation in their being faithful to the gospel.

Conclusion

The Addiction Ministry Network of the Presbytery of Redstone wrote this guide as a point of beginning for pastors and church leaders. We don't offer this as an exhaustive description of substance use disorders or the impact of alcohol and other drugs. We hope that it is a beginning to persuade you that this subject is a vital issue in our communities and our communities need us. Most importantly, we can never forget that the faces of substance use disorders are real people. They are a beloved family member, a friend, a colleague, and a neighbor. Despite the significant work that remains ahead of us, there are reasons to be hopeful.

I find hope in the people I have met in recovery who are now helping others with substance use disorders find their way. I draw strength from the communities I have visited that are coming together to work on prevention initiatives and to connect more people to treatment. I am inspired by the countless family members who have lost loved ones to addiction and who have transformed their pain into a passion for helping others. These people and communities are rays of hope and provide light in a world that seems dark. It is now our collective duty to bring such light to all corners of our communities.

We must recognize that we all have a role to play, a role which calls us to reach out to parents, families, educators, health care professionals, public policy makers, researchers, and all community members.

How we respond to this crisis is a moral test for the church. Are we willing to take on an epidemic that is causing great human suffering and economic loss? Are we able to live up to that most fundamental obligation we have as human beings: to love and care for one another?

Let us end with Jesus' instruction to us,

> *"Teacher, which commandment in the law is the greatest?" He said to him, "'You shall love the Lord your God with all your heart, and with all your soul, and with all your mind.' This is the greatest and first commandment. And a second is like it: 'You shall love your neighbor as yourself.' On these two commandments hang all the law and the prophets."* (Matt. 22:36-40)

Glossary and Acronyms

12 Step Groups typically are groups like A.A. and/or N.A. which use the 12 steps to guide the practice of members recovery.

A.A. Alcoholics Anonymous – in some communities A.A. meetings are called "Friends of Bill W."

Addiction, Alcoholic, Addict, Chemical Dependency, Substance Abuse: Many terms over the years have been used to define those with a substance use disorder. The word "Addiction" is still used extensively, but the treatment and prevention fields are attempting to get others to use the term, "substance use disorders" (SUD). This term carries less stigma and shame for those suffering from this brain disease.

AOD or ATOD these abbreviations are related, **AOD** "Alcohol and other Drugs" and **ATOD** "Alcohol, Tobacco, and other Drugs."

Al-Anon 12 step group for family and friends

Ala-Teen 12 step group for Teens

APA American Psychiatric Association

AUD Alcohol Use Disorder

CASA National Center on Addiction and Substance Abuse at Columbia University

CDC Centers for Disease Control and Prevention

Chronic Diseases are disorders that cannot be cured with existing medical technologies and whose symptoms and damage to the individual are progressive unless treated. Chronic disorders vary in their onset from sudden to gradual and are highly variable in their course (pattern and severity) and outcome. The prolonged course of these disorders places a sustained strain on the resources of the person and their family and friends. Chronic addictive disorders call for a process of sustained recovery management.

CSAT Center for Substance Abuse Treatment

Detoxification is a process of allowing the body to rid itself of AOD while managing the symptoms of withdrawal; often the first step in an AOD treatment program.

DSM-5 The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), is the 2013 updated version, the taxonomic and diagnostic tool published by the American Psychiatric Association (APA). In 2022, a revised version (DSM-5-TR) was published. In the United States, the DSM serves as the principal authority for psychiatric diagnoses.

DUI – Driving Under the Influence The classification of a criminal offense where a person is operating a motor vehicle under the influence of a substance which impairs their ability to operate a vehicle. Most common is alcohol, but other drugs can impair a person's ability to operate a vehicle, i.e., prescription medication, marijuana, cocaine, and other illicit drugs.

Enabling is a term used in treatment and prevention, in which the act of "enabling" means any actions intended to help a person with a SUD which inadvertently results in harm to the enabled and the enabler. These actions protect the person not yet in recovery from the consequences of their addictive behaviors, rather than being helpful, and increase the probability they continue in their AOD usage.

Hitting Bottom is a term used in treatment to indicate an experience by an person with a SUD of complete anguish and despair. Studies have long affirmed the role of this "hitting bottom" experience: heightened AOD-related consequences and threat of greater consequences and/or a dramatic breakthrough in self-perception in the initiation of recovery.

Intervention is a process of precipitating a change-eliciting crisis in the life of a person experiencing a substance use disorder by conveying the consequences of his or her behavior on family, friends and co-workers.

JAMA Journal of the American Medical Association

Mutual Help Groups typically refer to groups which tend to be more secular in their approach to recovery and generally do not use the 12 steps.

N.A. Narcotics Anonymous

Naloxone is an opioid antagonist medication approved by the FDA to reverse an opioid overdose. Naloxone (also known by brand names Narcan® and Evzio®) is the medication historically used in hospitals and ambulances to reverse opioid overdose and keep people alive. Naloxone is only effective for opioid overdoses. It cannot reverse an overdose from alcohol, cocaine, or other drugs if opioids are not present. But since most overdose deaths involve opioids, it is an important rescue medication. Naloxone is very safe. Giving naloxone to someone who has not taken opioids will not harm them, so it is routinely used whenever overdose is suspected.

NIDA - National Institute on Drug Abuse

NSDUH National Survey on Drug Use and Health

Paraphernalia in the context of addiction refers to any equipment, product, or material of any kind that is modified for making, using, or concealing a controlled substance. Examples of drug paraphernalia are rolling paper (a specialty paper used for making a marijuana cigarette); needles and/or small spoons; straws or paper tubes, pipe, small mirrors, and razorblades or cards; aerosol cans, tubes of glue, balloons, nozzles, or rags, etc.

Powerlessness is the acknowledgement of one's inability to control the frequency and quantity of AOD intake and its consequences through an act of personal will. It is most embodied in Step One of the A.A. program: "We admitted we were powerless over alcohol—that our lives had become unmanageable."

Program has come to have many meanings within American communities of recovery. Using the term "program" has come to be synonymous with Twelve Step recovery, as "How long have you been in the Program?" and with the Twelve Steps, as in "I've been in the A.A. Fellowship for quite a while, but I've only been working the Program (the Steps) this past year." The term reflects the combination of activities that make up Twelve Step recovery: meetings, reading, fellowship, prayer and meditation, service work, and other activities reflected in the Twelve Steps.

PTSD Post Traumatic Stress Disorder

Relapse is a common occurrence in many chronic health disorders, including SUD, that requires frequent behavioral and/or pharmacologic adjustments to be treated effectively. In a SUD, relapse is not uncommon, symptoms may appear a week or two prior to a return to AOD use after an attempt to stop. Research has taught us that stress cues linked to AOD use (such as people, places, things, and moods), and contact with AOD are the most common triggers for relapse. Lapses back to AOD use indicate that treatment needs to be reinstated or adjusted, or that alternate treatment is needed. Treatment providers have been developing therapies to interfere with these triggers to help patients stay in recovery.

SAMHSA Substance Abuse and Mental Health Services Administration

Spiritual Awakening - the term comes from the A.A. Step Twelve begins, "Having had a spiritual awakening as the result of these Steps. . ." and in the book Twelve Steps and Twelve Traditions (page 106), Bill W. describes what happens: "Maybe there are as many definitions of spiritual awakening as there

are people who have had them. But certainly, each genuine one has something in common with all the others. . .. When a man or woman has a spiritual awakening, the most important meaning of it is that he has now become able to do, feel, and believe that which he could not do before on his unaided strength and resources alone. He has been granted a gift which amounts to a new state of consciousness and being. He has been set on a path which tells him he is really going somewhere, that life is not a dead end, not something to be endured or mastered. In a very real sense he has been transformed, because he has laid hold of a source of strength which, in one way or another, he had hitherto denied himself."

SUD - "Substance Use Disorder" a medical illness caused by disordered use of a substance or substances. According to the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), SUDs are characterized by clinically significant impairments in health, social function, and impaired control over substance use and are diagnosed through assessing cognitive, behavioral, and psychological symptoms. A SUD can range from mild to severe.

Surrender... according to Dr. Harry Tiebout's (1949) classic paper on the subject, is the collapse of "the unconscious forces of defiance and grandiosity" and "accepting without reservation or conflict the reality of his condition and his need for help." Tiebout noted that such a collapse could mark the beginning of a process of continuing change or could be an transient experience followed by a rigid, primitive hold on sobriety or a return to drinking and the resurgence of defiance and grandiosity. He noted that true surrender was followed not just by sobriety but "internal peace and quiet." While experiences of acceptance, powerlessness and surrender mark the very core of the change process in Twelve Step recovery, recovery programs for historically disempowered groups often emphasize self-assertion rather than surrender.

THC delta-9-tetrahydrocannabinol. THC is the primary psychoactive constituent in marijuana

Withdrawal symptoms that can occur after long-term use of a drug is reduced or stopped; these symptoms occur if tolerance to a substance has occurred and vary according to substance. Withdrawal symptoms can include negative emotions such as stress, anxiety, or depression, as well as physical effects such as nausea, vomiting, muscle aches, and cramping, among others. Withdrawal symptoms often lead a person to use the substance again.

More In-depth Information and Resources

National 211 Toll-free Help Number

211 is the most comprehensive source of information about local resources and services in the country. It's powered by people: thousands of caring, local experts are available to help, 24/7. Calls to 211 are confidential and can be anonymous.

The 211 network in the United States responds to more than 20 million requests for help every year. Most calls, web chats, and text messages are from people looking for help meeting basic needs like housing, food, transportation, and health care. 211 can be accessed by phone or computer, at **211.org**. A toll-free call to 211 connects you to a community resource specialist in your area who can put you in touch with local organizations that provide critical services. You'll find information about:

- supplemental food and nutrition programs
- shelter and housing options and utilities assistance
- pandemic information
- emergency information and disaster relief
- employment and education opportunities
- services for veterans
- health care, vaccination, and health epidemic information
- addiction prevention and rehabilitation programs
- reentry help for ex-offenders
- support groups for people with mental illnesses or special needs
- a safe, confidential path out of physical and/or emotional domestic abuse

NIDA NATIONAL INSTITUTE ON DRUG ABUSE
The Science of Drug Abuse & Addiction

National Institute on Drug Abuse - NIDA

nida.nih.gov

SAMHSA
Substance Abuse and Mental Health Services Administration

Substance Abuse and Mental Health Services Administration - SAMHSA

www.samhsa.gov

Specific SAMHSA **Faith-based resources**

www.samhsa.gov/faith-based-initiatives

National Institute on Alcohol Abuse and Alcoholism - NIAAA

www.niaaa.nih.gov

PAStop.org - The Commonwealth Prevention Alliance Campaign to stop Opiate Misuse pastop.org

PAStart.org - **-** The Commonwealth Prevention Alliance Campaign on Family Prevention pastart.org

Faces and Voices of Recovery facesandvoicesofrecovery.org

National Recovery Month Resources www.samhsa.gov/recovery-month

Recommended Reading

Arterburn, Stephen and David Stoop. *Understanding and Loving a Person with Alcohol or Drug Addicton: Biblical and Practical Wisdom to Build Empathy, Preserve Boundaries, and Show Compassion*. Colorado Springs: David C. Cook, 2018. book.

Benz, Jonathan with Kristina Robb-Dover. *The Recovery-Minded Church: Loving and Ministering to People with Addiction*. Downer's Grove: IVP Books, 2016. book.

May, M.D., Gerald G., *Addiction and Grace: Love and Spirituality in the Healing of Addictions*, HarperCollins Publishers, New York, NY, 1988

Rohr, Richard. *Breathing Under Water: Spirituality and the Twelve Steps*. Cincinnati: Franciscan Media, 2011. book.

Rohr, Richard. *Breathing Under Water: Spirituality and the Twelve Steps - Companion Journal*. Cincinnati: Franciscan Media, 2015. book.

The Life Recovery Bible: New Living Translation. Tyndale House Publishers, Inc., 2017. book.

Williams, Don. *Jesus and Addiction: A Prescription to Transform the Dysfunctional Church and Recover Authentic Christianity*. San Diego: Recovery Publications, Inc., 1993. book.

Alcoholics Anonymous. Alcoholics Anonymous World Services; 4th edition (October 1, 2001) Alcoholics Anonymous (also known as the *Big Book* in recovery circles) sets forth cornerstone concepts of recovery from alcoholism and tells the stories of men and women who have overcome the disease.

Twelve Steps and Twelve Traditions. 1st Edition AA World Services; 1st edition (February 10, 2002) Originally published in 1952, it lays out the principles by which A.A. members recover and by which the fellowship functions.

The Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol, that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

The Twelve Traditions of Alcoholics Anonymous

The 12 Traditions are associated with the 12 Steps, and they were first officially published in 1946 in AA's journal, the AA Grapevine. They were officially endorsed as positive cultural attitudes and principles that could bring about change within AA groups by the International Convention of AA, which met in Cleveland, Ohio, in 1950.

The following are the traditions that serve as a guideline or manual that defines the internal operations of the 12-step programs. A.A. has what they call the long version of the 12 traditions which explains each tradition in more depth and can be found on the A.A. website.

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose, there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous, except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose: to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.
9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles above personalities.