FAITH-BASED ORGANIZATIONS AND CHEMICAL DEPENDENCY RECOVERY SUPPORT SERVICES LEGISLATIVE REPORT

Engrossed Second Substitute Senate Bill 6239

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FAITH-BASED ORGANIZATION LEGISLATIVE REPORT

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Executive Summary

This report is in fulfillment of Section 111 of Engrossed Second Substitute Senate Bill 6239, Chapter 339, Laws of 2006, 59th Legislature, and 2006 Regular Session. It addresses issues and concerns of recovery communities throughout the State of Washington, and specifically the perspective of faith-based organizations (FBOs).

DSHS has an established history of working with the faith-based community in the provision of social services to needy individuals. This has included services for individuals with alcohol and other drug concerns (recovering individuals). Currently, Division of Alcohol and Substance Abuse (DASA) certifies and funds 27 faith-based agencies providing addiction treatment services.

FBOs contribute greatly in the provision of alcohol and other drug support services. Especially important are agencies providing help without fiscal support from federal, state, or local taxes. Within FBOs, recovering individuals can embrace an opportunity and behavioral framework to repent their past choices and find real acceptance in a community. Currently a number of faith-based programs offer a continuum of supportive services that often include housing, childcare, counseling, meals, employment training or support, and linkage to health care services.

Using methods listed below, DASA gathered information from over 100 FBOs ranging from individual ministries to statewide organizations. Methods used included:

- Regional meetings
- Survey
- Telephone interviews
- Site visits

Findings include the following:

- FBOs rely on the DASA certified treatment providers in their provision of support to persons struggling with addiction. In many communities and tribes, there is a strong collaborative relationship and mutual respect for the important role each plays. In other communities that relationship could be improved.
- FBOs also report wariness in dealing directly with government because of fear that their religious practices could be questioned by federal and state agencies, especially if they accept government funding.
- FBOs acknowledge the need for credentialing persons and organizations working with recovering individuals. However, they **know** that their faith-based intervention has much to offer and suggest that they be acknowledged as providing a “certified” alternative intervention.
- FBOs, like many non-profit efforts, are interested in increased availability of funding.

Recommendations include consideration of the following actions:

- Facilitate better collaboration between DSHS and FBO's in the provision of a recovery community for recovering individuals.
- Support a planning process at the local level to include all contributors to the "recovery community", especially small FBO organizations.
- Review funding priorities and funding mechanisms to allow FBOs and other community organizations a better opportunity to access state funding.

FAITH-BASED ORGANIZATIONS AND CHEMICAL DEPENDENCY RECOVERY SUPPORT SERVICES LEGISLATIVE REPORT

PURPOSE

This report is in fulfillment of Section 111 of Engrossed Second Substitute Senate Bill 6239, Chapter 339, Laws of 2006, 59th Legislature, and 2006 Regular Session. It addresses issues and concerns of recovery communities throughout the State of Washington, and specifically the perspectives of faith-based organizations (FBOs). It is provided in response to legislation directing the Department of Social and Health Services (DSHS) to consult with FBOs to discuss the appropriate role such organizations may have in filling support service delivery needs for persons with chemical dependency disorders. The report is written for the legislature but includes background information for other readers including members of FBOs.

Persons with chemical dependency disorders are referred to by several terms, ranging from alcoholic to drug offender. Some of those terms reinforce the negative impact that alcohol and drug addiction stigmas have on the individuals we are trying to help. For this report, DASA will use "***recovering individual***" to refer to a person in the process of recovery from an alcohol or other drug disorder.

BACKGROUND

In meeting the recovery needs of persons with chemical dependency disorders, a community looks to a range of providers. Evidence-based treatment must be provided in the context of community. For persons in the recovery process, there is a need for the real support of a recovery network. A community-based, recovery network includes individuals and organizations that fall into three categories:

- Voluntary activities and services that support an individual's ongoing recovery (Individual jail ministries, Alcoholics Anonymous, Celebrate Recovery, and many others) and support the individual's family (Alanon, Naranon, and others).
- Clinically-focused addiction treatment programs that rely on the medical model for intervention in the physiology and psychology of addictive disorders (State-certified chemical dependency programs and services).
- Specialized recovery systems providing structured programs to help persons make life-style changes while dealing with the underlying stressors that might otherwise contribute to ongoing addictive behaviors. (Tribal support systems, Asian Counseling, Teen Challenge, Union Gospel Missions, New Life Ministries, and many others).

The range of these services in any geographic locale provides the framework for a recovery community. Such a framework is important in that persons struggling with

addiction require community support for up to five years before they can be considered relatively stable and the risk of relapse is less than 15%. (White, 2006)

History of Legislation

Attorney General Rob McKenna convened a task force in 2005 to assess the extent of the methamphetamine problem in Washington State. The task force included legislators, law enforcement officers, prosecutors, chemical dependency treatment providers, and other stakeholders.

The task force's Subcommittee on Demand Reduction addressed the housing and support services needs of drug-law offenders and found:

- Drug-law offenders released into community supervision have difficulty finding "clean and sober", affordable housing.
- Without such housing and the opportunity to access on-site counseling services, even those drug-law offenders who have successfully completed chemical dependency treatment are more likely to suffer a relapse.
- Without a temporary or permanent address, it is difficult for recovering individuals to seek counseling, job training and employment, and to rebuild their lives.
- In addition to the treatment and health care services already being provided by the public sector to eligible recovering addicts, many faith-based organizations are providing emergency shelter and support services to recovering individuals outside the public delivery system.

The subcommittee recommended DSHS' Division of Alcohol and Substance Abuse (DASA) meet with faith-based organizations (FBOs) to discuss the following:

- The appropriate role for FBOs in filling support service delivery gaps to recovering individuals.
- The needs of specific populations currently outside the state treatment and health care and chemical dependency treatment delivery systems.
- Guidelines to expedite DASA certification for FBOs where appropriate.

The 2006 Legislature responded to the specific recommendations of the Subcommittee by directing DSHS to consult with FBOs on the issues identified. Section 111 of Engrossed Second Substitute Senate Bill 6239, Chapter 339, Laws of 2006, 59th Legislature, 2006 Regular Session, requires DSHS/DASA to:

- Consult with faith-based organizations to discuss the appropriate role that such organizations may have in filling support service delivery needs for persons with chemical dependency disorders.
- Report its findings and recommendations to the legislature by November 1, 2006.

DSHS/DASA Described

The State of Washington takes pride in the leadership it assumes in providing publicly-funded treatment of chemical dependency to low-income persons in our state. DSHS/DASA helps to provide chemical dependency treatment and rehabilitation services as well as primary prevention services. Treatment services are available to any Washington resident who falls below 200% of the Federal Poverty Level, is eligible for the state-funded Alcohol and Drug Addiction Treatment and Support Act (ADATSA), or is eligible for Medicaid.

DASA's total annual budget is approximately $155 million. More than 98 percent of DASA funding is contracted through county governments, Tribes, service providers, and other entities to provide a statewide network of prevention, public education, intervention treatment, and support services to help people avoid and recover from chemical dependency. DASA has no field operations nor does it own any institutions. DASA staff does strategic planning and policy implementation, as well as providing basic services such as certification of chemical dependency treatment agencies, contract processing, contract monitoring, bill paying, information systems, grants management, research, and other special projects.

The treatment system serves recovering individuals who are financially eligible for publicly-funded services. These are adults and adolescents clinically assessed at Level 1 or higher on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria-2R (PPC-2R). Funding requirements give priority for treatment and intervention services to pregnant and postpartum women and families with children, families receiving Temporary Assistance for Needy Families (TANF), Child Protective Services (CPS) referrals, youth, injection drug users, and people with HIV/AIDS.

DASA currently certifies 560 agencies to provide some aspect of chemical dependency treatment, with 85 certified to provide residential treatment. Of those, DASA contracts with 328 agencies to provide publicly-funded services.

Outpatient treatment is contracted directly with the counties that, in turn, contract with the provider networks in their communities. Services include, but are not limited to: assessment, detoxification, outpatient treatment, and opiate substitution. In addition to previously noted priority groups, special efforts are made to provide services to ethnic minorities, criminal justice system referrals, and persons with co-occurring mental health and chemical dependency disorders. Counties may also contract with Tribes to provide treatment and prevention services.

Residential services are contracted directly by DASA and include specialized programs for youth and pregnant women as well as intensive inpatient treatment, long-term residential, recovery house, extended recovery house, and involuntary treatment. DASA currently contracts with 41 residential service providers, providing various levels of care, serving youth and adults.

Specialized contracted support services for eligible individuals include child care, translation services (including deaf/hard of hearing), transportation assistance, integrated crisis response/secure detox services, case management, youth outreach, cooperative housing (Oxford House), and other transitional housing support.

Prevention services are contracted directly with counties and Tribes to provide services at the community level. DASA's goal is to delay onset of alcohol and tobacco use and prevent the misuse of alcohol, tobacco and other drugs. The framework of reducing risk factors and increasing protective factors is an essential part of prevention services.

This system is operated primarily within schools. Primary prevention services include: school-based K-12 substance misuse curricula; programs with institutions of higher learning; education and support programs for children of recovering individuals; peer support programs; school staff education, intervention team programs; student assistance programs; cross-age teaching models; community-based parent training; early childhood prevention models; and mentoring.

FBOs and Chemical Dependency Services

DSHS has an established history of working with the faith-based community in the provision of social services to needy individuals. This has included services for recovering individuals. Currently, DASA certifies and funds 27 faith-based agencies providing addiction treatment services. (See Appendix A)

DASA began implementing the provisions of federal law for faith-based programs in 2002. DASA understood that the Charitable Choice regulations required States receiving Substance Abuse Prevention and Treatment (SAPT) Block Grant (as authorized by 42 Code of Federal Regulations (CFR) part 54 and discretionary funding under 42 CFR Part 54a) to implement regulations and reporting requirements as part of the SAPT Block Grant report.

During 2002 and 2003, the Certification Section developed rules for the Washington Administrative Code (WAC) 388-805 that support faith-based programs. DASA certified faith-based programs meet the requirements of WAC 388-805. Requirements developed that were specific to faith-based programs include:

- WAC 388-805-005: What definitions are important throughout this chapter? "Faith-based organization" means an agency or organization such as a church, religiously affiliated entity, or religious organization.

- WAC 388-805-015: How do I apply for certification as a chemical dependency service provider? (3) In addition to the requirements in this section, a faith-based organization may implement the requirements of the federal Public Health Act, Sections 581-584 and Section 1955 of 24 U.S.C. 290 and 42 U.S.C. 300x-65.

- WAC 388-805-305: What are patients' rights requirements in certified agencies?

(2) A faith-based service provider must ensure the right of patients to receive treatment without religious coercion by ensuring that:
(a) Patients must not be discriminated against when seeking services.
(b) Patients must have the right to decide whether or not to take part in inherently religious activities.
(c) Patients have the right to receive a referral to another service provider if they object to a religious provider.

In October 2004, the DASA Certification Section developed some initiatives to support monitoring faith-based programs to include:

- The Certification Section staff members will survey all certified agencies to identify which are faith-based, and how to identify them in its Directory of Certified Providers.

- The Certification Section will work with DASA Information Services to include faith-based organizations as a data element in the Certification Information System.

- The Certification Section Staff members will ensure contracted and non-contracted faith-based organizations have policies and procedures in place to comply with faith-based requirements that are in WAC 388-805.

ATR Project

In the fall of 2004, the Substance Abuse and Mental Health Service Administration (SAMHSA - see Appendix B for background) awarded DASA a federal "Access To Recovery" (ATR) grant. ATR is a three-year grant to pilot services that specifically support recovery for persons struggling with drugs or alcohol misuse. (This grant is considered to be part of President Bush's Faith-Based Initiative – See Appendix C for more information.) With the ATR grant, and DASA's emphasis on developing recovery services, new opportunities were created to link with existing faith-based systems already serving persons misusing or abusing alcohol or other drugs became apparent. This model was developed from multiple community meetings held throughout the state in the spring of 2004. During those meetings, DASA received input and noted the needs of faith-based providers.

After being awarded the ATR grant, community leaders were included in planning with continued emphasis on faith-based involvement. With an existing treatment program that valued faith-based participation, preplanning conversations before applying for the grant, and open dialogues in the implementation stage, faith-based providers were easily included in Washington State's ATR program. As of August 1, 2006, DASA and ATR had over 65 faith-based organizations enrolled as providers of recovery services. (See Appendix D for a list of FBO providers in the ATR program.)

FBOs Described

FBOs contribute greatly in the provision of alcohol and other drug support services. Especially important are agencies providing help without fiscal support from federal, state, or local taxes. Within FBOs, individuals can embrace an opportunity and behavioral framework to repent their past choices and find real acceptance in a community. Currently a number of faith-based programs offer a continuum of supportive services that often include housing, childcare, counseling, meals, employment training or support, and linkage to health care services. A few examples are:

- Union Gospel Missions – Spokane, Seattle, Aberdeen, Bellingham, Olympia, Everett, Pasco, Tacoma, Walla Walla, Wenatchee, and Yakima. The Association of Gospel Rescue Missions was founded in 1913. If annual cash contributions were combined, the 300 Association member RESCUE missions would be among the ten largest nonprofit organizations in the United States. RESCUE missions provide emergency food and shelter, youth and family services, rehabilitation programs for the addicted, education and job training programs and assistance to the elderly poor and at-risk youth. http://www.iugm.org/
- Haven Ministries – Yakima. Haven Ministries exists to offer long-term residential recovery for women with chemical dependency. Set in a safe, nurturing environment, the programs are solidly Bible-based while incorporating sound scientific and medical research. The goals of Haven House are to lead women out of the bondage of addictions into a new life: one of physical, emotional, and spiritual wholeness; and thereby help break the generational cycles of addiction and abuse. http://www.havenministries-yakima.org/
- Port Angeles Association of Religious Community (PAARC) – Port Angeles. This is an interfaith group that serves educational and ministry needs of the Port Angeles community including recovery services.
- Teen Challenge – Spokane, Ballard, Renton, Graham. Since its beginning, Teen Challenge centers have founded their programs on the teachings of Jesus Christ. These Biblical truths have physically, mentally, emotionally and spiritually unchained the lives of thousands of addicts. Instead of 'dope' pushers, Teen Challenge ministries are serving as 'hope' pushers. As their personal testimony, Teen Challenge students often claim the scripture, "I have plans to give you a hope and a future". (Jeremiah 29:11, NIV) http://www.teenchallengeusa.com/
- The Matt Talbot Center – Seattle. Established in 1985, the Matt Talbot Center (MTC) is a recovery program and treatment center for the addicted, the homeless and mentally ill. Located in Seattle's Belltown neighborhood, the Matt Talbot Center offers hope, services and support to individuals ready to commit to their recovery with an intensive clinical outpatient treatment program offered in a Christian context. Supervised by a Certified Chemical Dependency Counselor (CDCIII), this recovery and relapse prevention program addresses the physiology, psychology, and sociology of addiction. The program's primary goals are to restore participants to healthy lives, and to encourage them to take responsibility for their actions and family obligations. MTC treats "members" holistically, recognizing that each of them has individual needs for physical, mental and spiritual healing. http://www.matttalbotcenter.org/

- Celebrate Recovery- Spokane. The purposes of Mt. Spokane Church Celebrate Recovery ministry is to fellowship and celebrate God's healing power in our lives through the "8 Recovery Principles" that are based on "The Beatitudes" from Jesus' Sermon on the Mt. This experience allows us to "be changed." By working and applying these Biblical principles, we begin to grow spiritually. We become free from our addictive, compulsive and dysfunctional behaviors. This freedom creates peace, serenity, joy and most importantly, a stronger personal relationship with God and others. As we progress through the program we discover our personal, loving and forgiving Higher Power - Jesus Christ, the one and only true Higher Power. http://www.cbcmin.com/celebrate.shtml
- Mountain Ministries Ranch – Kelso. A Christian drug and alcohol rehabilitation support center. It is a one-year residential program located in Rose Valley. It is designed to give people the opportunity to: Rely on the Lord, learn basic life skills, acquire job training, Build relationships, receive biblical counseling, receive drug education, attend support groups, and attend Bible study groups. Mountain Ministries Ranch follows strict guidelines and applies Christian principles that teach people to live responsible lives.
- Open House Ministries – Vancouver. A drug and alcohol support program for the whole family. It is a special treatment model for families suffering from addiction, which addresses the issues of both the AOD individual and those who struggle in their wake, while keeping the entire family intact. All of their programs include a spiritual dimension, with linkage to the local church community. www.sheltered.org
- House of Boaz – Tacoma The Houses of Naomi, Ruth and Boaz are residential programs offering males and females' clean and sober housing. Residents residing in the houses attend church services regularly, participate in community activities which promote the teachings of Christ, and engage in daily bible studies. The overall goal is to provide spiritual counseling and wellness while pursuing a drug-free lifestyle.
- God Heals - Tacoma God Heals is a multi-denominational certified outpatient substance abuse program that combines traditional chemical dependency treatment methods with prayer, Christian support, and biblically based teaching with life applications. Groups are opened and closed with a short prayer and staff are committed to treating others in accordance with the teachings of Christ. The belief is that God is the "higher power" and that many Biblical principles help in the recovery process. There is an ongoing group exclusively dedicated to spiritual issues, and information presented will stem from various Christian backgrounds.

Faith-based organizations are also involved in the provision of DASA's substance misuse prevention services. Community prevention coalitions regularly involve faith-based community leaders of diverse religious denominations in the design and implementation of prevention services. There are 28 federally-funded Drug-Free Communities Coalitions in Washington State that involve faith-based organizations in their coalitions. In many communities, faith-based organizations contract directly with counties and Tribes to provide specific services such as after school programs, mentoring, and tutoring services. In all communities, faith-based organizations are encouraged to apply for funding to provide prevention services.

CONSULTATION

Consultation Process

Using methods listed below, DASA gathered information from over 100 FBOs ranging from individual ministries to statewide organizations.

- Regional meetings - Meetings in all six DSHS service regions took place. Meetings were in the evening and early morning to accommodate the schedules of persons who might be interested in discussing their perspective on FBOs and services to support persons dealing with chemical dependency. (See Appendix E for the meeting schedule.)

- Survey - Based on the language in the legislation, DASA composed a survey asking for the opinions of respondents. The survey was mailed in July and August 2006 with a modest response rate. (See Appendix F – Survey and Appendix G – Survey results.)

- Telephone interviews - From existing contacts and from interest generated by the survey, several telephone interviews were completed.

- Site visits - DASA staff visited with many FBOs on site to discuss the issues focused on in this report.

FINDINGS

FBOs offer an impressive range of important and effective recovery support to recovering individuals. These services range from providing a safe place for support groups to meet to providing DASA-certified chemical dependency treatment. Other services include alternative addiction intervention, spiritual counseling, food, shelter, child care, clothing, and help with bills. FBOs are, in fact, groups of community members actively helping those in need.

FBOs rely on the DASA-certified treatment providers in their provision of support to persons struggling with addiction. In many communities, there is a strong collaborative relationship and mutual respect for the important role each plays. In other communities that relationship could be improved. Many FBOs would like to see the treatment network strengthened, especially in having resources more readily available and without perceived barriers. Some of those perceived barriers include:

- Different eligibility rules for different people (priority populations – pregnant women, injection drug users).
- Extended waiting lists or lengthy protocols resulting in AOD individuals' delayed entry into treatment.
- Limited resources for detoxification services.

FBOs also report wariness in dealing directly with government because of fear that their religious practices could be questioned by federal and state agencies, especially if they accept government funding. This distrust stems from existing myths and misunderstanding about existing policies to protect the religious freedoms of all persons. (The myths are described more fully in Appendix H)

FBOs acknowledge the need for credentialing persons and organizations working with recovering individuals. However, they **know** that their faith-based intervention has much to offer and suggest that they be acknowledged as providing a "certified" intervention. FBOs are interested in models from other states (Florida and Missouri – see Appendix I). In those states, FBOs receive certification for their alternative approach or are minimally given credentials for completing training on the medical model of chemical dependency intervention. With such recognition, FBOs would gain acceptance and build trust within the treatment community, and faith-based intervention could become another accepted choice offered to persons needing treatment.

FBOs, like many non-profit efforts, are interested in increased availability of funding.

- FBOs view funding in ways that set them apart from publicly-funded systems. FBOs are in the business of compassionate caring and they see funding as compassionate giving. Public funding comes with expectations of accountability and of service outcomes. While no one objects to those expectations, they shift an organization's focus away from the spiritual basis of their interest in serving those in need.

- There exists a gap in understanding the funding mechanisms and accountability requirements that come with accessing government funding. Also, there is a real issue of resource utilization in the pursuit of government or other funding. FBOs, especially small FBOs, rely on volunteer efforts and do not have the depth of knowledge and staff to generate the necessary grant applications and related information for accessing available funding. FBOs have a limited capacity to devote to the administration and infrastructure requirements of a funding agency beyond their own internal administration and infrastructure needs. Examples include differing accounting and data collection systems, and the technical expertise to navigate such systems.

- A related challenge is the pursuing of funds from various systems (county, state, city, United Way, and others). This quickly can overtax a volunteer organization especially when each of those systems has different protocols for accessing funding. Also, the varying budget cycles create difficulties for fiscal planning. It was noted that funding priority of grantors routinely change while the grantee's efforts to help the needy are relatively constant. These annual or biennial changes again require attention for which an FBO organization is not staffed or equipped.

FBOs have been particularly frustrated by the difficulty of accessing the federal Food Stamp Program for the homeless or recovering individuals they serve. (The Food Stamp

Program is administered in Washington State by DSHS.) Existing federal regulations place barriers to FBOs utilizing the food stamp programs support like other nonprofit organizations helping those in need. Efforts by the Bush Administration are just now changing this situation at the time this report was written. (See Appendix J) This soon to be resolved disconnection between FBOs and the Food Stamp Program is an example of the invisible wall between government and FBOs. This wall is (or was) based on the belief by some that government funds should not be utilized by organizations openly linked to religion.

RECOMMENDATIONS

After review of the findings of DSHS' consultation with FBOs, DSHS/DASA staff recommends consideration of the following actions:

1. Facilitate better collaboration between DSHS and FBOs in the provision of a recovery community for recovering individuals. Mechanisms for improved collaboration include:

    - Making chemical dependency program and recovery information more easily available to FBO, community, and tribal staff.
    - Facilitating Web access to information on recovery community resources.
    - Using DSHS resources to better highlight community and tribal resources like FBOs.
    - Including representatives of smaller FBO organizations on DSHS advisory committees.
    - Making DSHS alcohol and drug treatment and recovery system training available to FBO representatives.
    - Training DSHS staff on effective partnering with FBOs.

2. Support a planning process at the local level to include all contributors to the "recovery community", especially small FBO organizations. Such an effort would be consistent with the new federal focus on community for the recovering individual: "A life in the community for everyone".

3. Review funding priorities and funding mechanisms to allow FBOs and other community organizations a better opportunity to access state funding. Within state government, there are various mechanisms to implement this recommendation. They include:

    - Set-asides of expenditures (a portion of agency's operating budget must go for a specified target); examples include Art set asides, prioritizing funding to businesses owned by women.
    - Delegate funding decisions to local communities and Tribes, as with the state's Regional Support Networks.
    - Provide for small, short-term grants with limited expectations, as with DASA-funded Prevention grants.

4. Implement the FBO-Food Stamp Work plan (Appendix K) to help explain new changes in the Federal Food Stamp program that impact FBOs, with the goal of facilitating fair access to this resource.

Department of Social and Health Services
Division of Alcohol and Substance Abuse

DASA Certified Faith-Based Programs
July 2006

DASA Certified Agency	Agency Number	Type of Service
Addictions Recovery Center – Longview 1322 Commerce Avenue Longview, WA 98632 (360) 414-8771	08 098300	ADATSA Assessment, ADIS, IOP & OP
PeaceHealth St. John Medical Center – Recovery NW 600 Broadway Street Longview, WA 98632 (360) 414-2026	08 056000	Acute Detox, ADATSA Assessment, & IP
Lourdes Counseling Center – Pasco 520 North 4th Street Pasco, WA 99301 (509) 546-2377	11 025202	ADIS, DUI, IOP & OP
St. Peter CD Center – Aberdeen 415 W. Wishkah Street Aberdeen, WA 98520 (800) 332-0465	14 104800	ADATSA Assessment
St. Peter CD Center – Hoquiam 508 ½ 8th Street, Suite 300 Hoquiam, WA 98550 (360) 533-8813	14 108500	ADATSA Assessment, DUI, IOP, & OP
Catholic Community Services – Seattle 100 23rd Avenue South Seattle, WA 98144 (206) 328-5774	17 034300	DUI & OP
Catholic Community Services – South 1229 West Smith Street Kent, WA 98032 (253) 854-0077	17 112500	DUI, IOP, & OP
New Life Family Counseling Christian Counseling Center 33320 Pacific Hwy South, Suite 107 Federal Way, WA 98003 (253) 223-3149	17 108800	DUI, IOP, & OP

Swedish Medical Center 5300 Tallman Avenue NW Seattle, WA 98107 (206) 781-6209	17 044901	Detox, IP, IOP, & OP
Addictions Recovery Center – Chehalis 500 S.E. Washington Street Chehalis, WA 98532 (360) 748-4357	21 035400	ADATSA Assessment, IOP & OP
Addictions Recovery Center – Morton 218 A Main Street Morton, WA 98356 (360) 496-6216	21 088100	DUI, IOP, & OP
St. Peter CD Center – Belfair 24070 Hwy #3, Suite A Belfair, WA 98528 (360) 277-0523	23 092000	ADATSA Assessment, IOP & OP
St. Peter CD Center – Shelton 2521 Olympic Hwy North Shelton, WA 98584 (360) 432-8692	23 091900	ADATSA Assessment, IOP & OP
Addictions Recovery Center – Long Beach 103 E. 6th Long Beach, WA 98631 (360) 642-5059	25 085900	ADATSA Assessment, IOP & OP
Addictions Recovery Center – South Bend 914-B W. Robert Bush Drive South Bend, WA 98586 (360) 875-4172	25 085800	ADATSA Assessment, IOP & OP
God Heals, LLC 9401 A Street Tacoma, WA 98444 (253) 538-8500	27 1285 00	DUI, IOP, & OP
Catholic Community Services – Everett 1918 Everett Avenue Everett, WA 98201 (425) 257-2111	31 034400	ADATSA Assessment, IOP & OP
Catholic Community Services – Tree 10110 19th Avenue SE, Suite R-100 Everett, WA 98208 (425) 337-7817	31 073200	ADATSA Assessment, IOP, OP & OP Childcare

Northwest Alternatives-Lynnwood Catholic Community Services 4230 198th Street SW #100 Lynnwood, WA 98036 (425) 774-4333	31 047600	ADATSA Assessment, ADIS, DUI, IOP, & OP
Northwest Alternatives-Marysville Catholic Community Services 1227 2nd Street Marysville, WA 98270 (360) 651-2366	31 085700	ADATSA Assessment, ADIS, IOP, & OP
Providence Recovery Program Providence Medical Center 916 Pacific Avenue Everett, WA 98206 (425) 258-7390	31 035700	IP & IOP
St. Peter CD Center 4800 College Street Lacey, WA 98503 (360) 459-8811	34 015300	Detox, ADATSA Assessment, IP, IOP & OP
St. Peter CD Center – Tenino 224 W. Sussex Avenue Tenino, WA 98589 (360) 407-0360	34 091500	ADATSA Assessment, IOP & OP
St. Peter CD Center – Olympia Thurston Co. Corrections Olympia, WA 98502 (360) 459-8811	34 015300	IOP & OP
St. Joseph Hospital – Bellingham 809 E. Chestnut Street Bellingham, WA 98225 (360) 715-6400	37 034500	Detox, ADATSA Assessment, IP, IOP, & OP
St. Joseph Hospital – Bellingham 1209 Girard Street Bellingham, WA 98225 (360) 715-6595	37 034501	Recovery House
St. Joseph Hospital – Ferndale 2376 Main Street, Suite 1 Ferndale, WA 98248 (360) 384-2427	37 090000	ADIS, DUI, IOP, & OP

SAMHSA

The Substance Abuse and Mental Health Services Administration (SAMHSA), is a federal public health agency within the Department of Health and Human Services. The agency is responsible for improving the accountability, capacity and effectiveness of the nation's substance abuse prevention, addictions, treatment, and mental health services delivery system.

It was established by an act of Congress in 1992 under Public Law 102-321. With the stroke of a pen, an agency, separate and distinct from the National Institutes of Health or any other agency within the HHS, was created to focus attention, programs, and funding on improving the lives of people with or at risk for mental and substance abuse disorders.

Much has changed since then in the mental health and substance abuse fields, and so, too, has SAMHSA. To that end, SAMHSA's mission and vision have been more sharply focused and aligned with HHS goals and President Bush's administration priorities. It is a vision consistent with the President's New Freedom Initiative that promotes a life in the community for everyone. Moreover, SAMHSA is achieving that vision through a mission that is both action-oriented and measurable: to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness. In collaboration with the States, national and local community-based and faith-based organizations, and public and private sector providers, SAMHSA is working to ensure that people with or at risk for a mental or addictive disorder have the opportunity for a fulfilling life that includes a job, a home, and meaningful relationships with family and friends.

FBO Initiative

President George Bush has made it a priority of his administration to bridge the gap between FBOs and government funding of community services. This effort has included changes at DASA and the availability of discretionary funding such as the Access to Recovery program. (See Appendix D for a full description of the FBO Initiative and links for further information.)

Faith Based Providers

Abundant Life	Tacoma
Abundant Life Outreach Ministry for Families	Tacoma
Alberta House	Spokane
Alex Parthenay	Prairie
Ani Sahoni Consulting Services	Yakima
Another Chance for Women and Children	Tacoma
B.J.'s	Spokane
Bakers Auto Repair	Yakima
BBL Housing	Yakima
Bernard Oxford House	Spokane
Betty and Harold Harmon	Brush Prairie
BIC Automotive	Yakima
Bob's Automotive Inc Ridgefield	Ridgefield
Bread of Life Mission	Seattle
Breaking Free Ministries	Vancouver
Bridge Ministries	Kirkland
Camas Hotel Inc	Camas
CAMAS Outpatient Treatment	Airway Heights
Catholic Community Services	Kent
Catholic Community Services	Everett
Catholic Community Services	Gig Harbor
Catholic Community Services	Puyallup
Catholic Community Services	Yakima
Catholic Family & Child Services	Yakima
Center Street Commercial LLC	Tacoma
Choice Counseling	Yakima
Christian Supply Store	Veradale
Christmas House	Spokane
City Team Ministries	Seattle
Coalition for Community Development & Renewal	Seattle
Columbia Pastoral Counseling	Vancouver
Community Resource Group	Yakima
Community-Minded Enterprises	Spokane
Compass Center	Seattle
Conquest Center	Tukwila
Dales Big and Tall Shop	Spokane
Dave White	Vancouver
Deaconess Medical Center	Spokane
Dightman's Bible Book Center	Tacoma
Downtown YMCA	Seattle
Dr. Kent Vye DO	Yakima
Emmanuel Counseling & Educational Services	Seattle
Eutychus Ministries Inc	Vancouver
Everett Gospel Mission	Everett
Faith Homes	Tacoma

First AME Child Center	Seattle
Freedom House	Spokane
Freya Oxford House	Spokane
Goodwill - Spokane	Spokane
Grand Oxford House	Spokane
Guadalupe House	Tacoma
Hamblen Oxford House	Spokane
Harmony Counseling	Federal Way
Haven House	Yakima
Helena Oxford House	Spokane
Hillyard Oxford House	Spokane
HOF - Portage Owner LLC	Spokane
Hope House	Spokane
House of Esther	Tacoma
House of Faith	Medical Lake
House of Naomi Ruth and Boaz	Auburn
House of Vision Number One	Tacoma
House of Vision Number Two	Tacoma
Impact House	Spokane
Inland Oxford House	Spokane
Interfaith Coalition	Yakima
Ivory Denture Care	Yakima
Jeff Yellow Owl	Vancouver
Jewish Family Services	Spokane
John P. Holgren	Utica
Joyful Noise Childcare	Tacoma
Kings Travel Inn Motel	Tacoma
Kirkland Interfaith Transitions in Housing (KITH)	Kirkland
Kwawachee Counseling Center	Tacoma
Landlord - Faith-Based - Individual Basis	Tacoma
Landlords - Faith-based	Tacoma
Latawah Oxford House	Spokane
Life Change Ministry	Everett
Lincoln Heights Oxford	Spokane
Lutheran Community Services	Spokane
Manito Oxford House	Spokane
Mental Health Counseling - Jeffrey D. Thompson	Yakima
Mercy Housing	Tacoma
Michael A Chapel	Vancouver
Michael Carpenter	Puyallup
Milestone	Yakima
Miryam's House of Transition	Spokane
New Beginnings Community	Yakima
New Hope Center	Vancouver
New Life Friends Church	Vancouver
Northwest Christian School Thrift Store	Spokane
Oakbrook Oxford House	Vancouver
Our House	Tacoma

Overlake Christian Church	Redmond
Patricia Byers	Yakima
Patricia Ferguson	Vancouver
Patrick McKinney	Spokane
Post Oxford House	Spokane
Post Treatment House	Tacoma
Pratt Oxford House	Spokane
Randy Heinemann	Spokane
Refugee Recovery House	Lakewood
REM Associations	Spokane
Robert Dillion	Vancouver
Rowan Oxford House	Spokane
Safe Harbor House	Spokane
Salvation Army	Everett
Salvation Army	Seattle
Salvation Army Transitional Housing	Spokane
Shelle Marie Beatty	Vancouver
Spavinaw Dental Clinic	Sunnyside
Spokane Falls Oxford House	Spokane
Spokane Grand Oxford	Spokane
Spokane Produce	Spokane
Spokane Valley Nazarene	Veradale
St Vincent de Paul	Spokane
St. Margaret's Shelter	Spokane
Stillaguamish Tribe of Indians	Arlington
Sue Roberts	Vancouver
Sun Ray Court	Spokane
Tabernacle Missionary Baptist Church	Seattle
Tamara Thompson - Psychiatric-Mental Health Services	Yakima
Teen Challenge International	Spokane
The Hub for Incident Prevention	Yakima
The Josephine	Seattle
Transitional Living Center	Spokane
Trinity Lutheran Childcare	Tacoma
Union Gospel Mission	Seattle
Union Gospel Mission	Yakima
Victoria SmithBattle Ground	Battleground
VOA Hope House	Spokane
Walter Sosky	Vancouver
William Booth Center	Seattle
Y.M.C.A.	Spokane
Yakama Indian Nation Comprehensive Alcoholism	Toppenish
YWCA	Seattle

Faith-Based Community Meeting Schedule

These community meetings provided an opportunity to share information and discuss issues related to faith-based organizations' interests in serving persons misusing alcohol or drugs. The information gathered at these meetings was contributed to this Faith-Based Legislative Report as required by the 2006 State Legislature.

- **Vancouver**
  August 1, 2006 6:00-8:00pm
  August 2, 2006 7:00-10:00am

  To be held at the Red Lion @ The Quay: 100 Columbia Street, Vancouver

- **Yakima**
  August 2, 2006 6:00-8:00pm
  August 3, 2006 7:00-10:00am

  To be held at the Red Lion: 607 East Yakima Avenue, Yakima

- **Everett**
  August 3, 2006 6:00-8:00pm
  August 4, 2006 7:00-10:00am

  To be held at the Best Western Alderwood: 19332 36th Avenue West, Lynnwood

- **Tacoma**
  August 15, 2006 6:00-8:00pm
  August 16, 2006 7:00-10:00am

  To be held at the La Quinta Inn: 1425 East 27th Street, Tacoma

- **Spokane**
  August 16, 2006 6:00-8:00pm
  August 17, 2006 7:00-10:00am

  To be held at the Hampton Inn Spokane: 2010 S Assembly Rd, Spokane

- **Seattle**
  August 17, 2006 6:00-8:00pm
  August 18, 2006 7:00-10:00am

  To be held at the Best Western Executel: 20717 International Blvd, SeaTac

Which direction?

DSHS Research and Data Analysis Division

Survey | Faith Based Organizations' role in helping recovering alcoholics and drug addicts

Tell your legislature about Faith Based Organizations' (FBOs) Role in helping recovering alcoholics and drug addicts.

About the survey

Why should I take this survey?
The Washington State Legislature wants to understand the appropriate role for FBOs in filling the support service needs for individuals and families struggling with the problems of alcohol and drug misuse. Your views on this subject can make a difference in public policy and programs.

What does the survey ask?
- What do recovering alcoholics and drug addicts need (we list some common needs and ask you to list more)
- What should be the role of FBOs and government in meeting these needs
- What are the barriers to meeting these needs

Can other interested people take the survey?
Yes, please feel free to copy the survey and share with others.

How do I mail it?
Use the enclosed pre-paid, addressed envelope, if possible. Mail to:
Survey Section, DSHS Research and Data Analysis
PO Box 45204
Olympia, Washington 98504

What will be done with survey results?
The survey responses will be compiled and shared with the Washington State Legislature. Division of Alcohol and Substance Abuse (DASA) will post a copy of the report on their web site. The web site address is: http://www1.dshs.wa.gov/dasa/default.shtml.

If I have questions?
Please call Vince Collins at 360-725-3713 or collivl@dshs.wa.gov with any questions or additional comments.

Washington State Department of Social & Health Services

Tell us who you are so we can ask follow-up questions and track how different types of agencies respond:

Name:	**Telephone/Email**
First:	
Last:	Telephone:
Address:	E-mail :
Street:	
City:	
WA zip code:	

Questions

1. **Write in the field below each question, what your thoughts on the role of government and the role of Faith Based Organizations' in your area?**

Column 1	Column 2	Column 3
Identified need of person or family struggling with alcohol or drug misuse.	**Government Your thoughts: What should be the role for State and Local Government in this area?**	**FBO Your thoughts: What should be the role for FBOs in this area?**
a. Medical Intervention - Detoxification, Inpatient and Outpatient Chemical Dependency Treatment	*For example: fund needed services, certify agencies serving clients etc:* write here:	write here:
b. Transitional Housing		
c. Crisis Counseling - Spiritual Support		
d. Emergency Support (Clothing, Car Repair, Utilities, And Others)		
e. Alcohol and Drug-Free Social Activities		
f. Family and Marriage Counseling		

g. Peer Support or Mentoring		
h. Child Care		
i. Other – (please describe)		
j. Other – (please describe)		
k. Other – (please describe)		

….here is one more question

2. Now we want to see what roles you listed above are most important. Look over all your answers and

a. **Circle the <u>three</u> most important roles for government that you listed in Column 2**
b. **Circle the <u>three</u> most important roles for FBOs that you listed in Column 3**

Don't forget there are a few more questions on the next page

3. What gets in the way of FBO's supporting recovery clients? (What are the barriers you must overcome – social, bureaucracy, attitudes, stigmas, etc?)

a. From the State? (Example – requiring data collection and reporting)

b. From the Local (City, County) Government? (Example – zoning, licenses, etc)

c. From the Community in General?
(Example - "Not in my back yard" thinking, fear, stigma)

d. Others?

4. Other Comments or Feedback?

Thanks for responding to this Survey.

Mail the survey to: Survey Section, DSHS Research and Data Analysis,
PO Box 45204, Olympia, Washington 98504

Which direction?

Survey | **Faith Based Organizations' role in helping recovering alcoholics and drug addicts**

Part 1 – What should be the roles for government and Faith-Based Organizations? Answers are highlighted if respondent thinks they are one of the three most important roles.

Need: Medical intervention, detoxification, inpatient and outpatient chemical dependency treatment		
#	State & local government role	FBO role
1	Fund services through a voucher system; **establish a reasonable certification process for FBO treatment programs.**	**Provide "niche" services that are partially funded through charitable donations and partially through vouchers. Example of niche (unmet need) is 1-2 yr programs (residential). Clients should be able to choose F.B. treatment if they want it.**
2	**Allow use of vouchers at FBO's. More options for detox services.**	Offer FBO for all modalities of treatment.
3	Fund needed services especially **preventive types.**	Support groups
4	**Certify medical standards and quality of facilities providing medical services.**	**Provide instruction and support in overcoming chemical dependency.**
5	**Remove barriers to clients with drug/alcohol and mental health issues from receiving service.**	**Program operation; long term supportive housing; accountability, support network.**
6	**We should be able to offer Detoxification and Treatment of no cost to low income clients.**	**Outreach and treatment.**
7	**Fund needed services, certify agencies serving clients.**	Provide services to address these issues - funded by state and federal grants.
8	**To regulate and fund treatment. No medical detoxing funding available.**	**To serve clients regardless of funding.**
9	**Also ensure quality training for CDP's.**	None.
10	Definitely fund needed services; it is less expensive in the long run than jail. Train and certify individuals to work with this group.	Provide space for AA and NA meetings. Attend meetings so someone can act as guide for people who need to get into these programs. It is hard to enter a group for the first time.
11	**Fund and certify.**	No role.
12	**Mostly private, under-compensated (govt funded). No med managed (level IV) facilities.**	FBO hospitals should pick up the gap with increased government funding.
13	**All medical needs served with sufficient funds.**	Spiritual counseling and emotional needs met.
15	**Fund needed services, certify agencies serving clients etc.**	In-patient or out-patient treatment is certainly a possibility. Proper certification and DASA certified facilities is a must.
16	**Certify and audit agencies. Fund services.**	**Support services e.g; housing, mental health, medication assistance, and life skill training and life issues problem solving.**
17	Detox, longer than 30 days.	
18	Fund innovative programs. Actively seek organization. Educate organizations.	Should serve as clearing house, one stop shops. Provide a loving and caring atmosphere within the organization, take ownership of this issue and collaborate with other FBO's to foster solutions.
19	**Provide services for those who don't have insurance coverage.**	**Refer to appropriate agencies. Work for legislation to create comprehensive coverage for all.**
20	**Provide assessment; make referrals; pay for treatment.**	**Provide faith based treatment including interventions, inpatient and outpatient services.**
21*	**To financially support treatment in a sustainable fashion, using both private/community providers and state and local run facilities.**	**To provide services in a financially sustainable fashion and to collaborate with state and local government.**

*Survey 21 was received too late to be included in the analysis and survey report.

Need: Transitional housing		
#	State & local government role	FBO role
1	Establish safety standards and occupancy limits. County or state should license these homes.	Freedom to establish homes that incorporate faith but still meet licensing requirements, i.e. the requirements should not prohibit FBO-run housing.
2	**Fund Christian based housing programs.**	
3	**Provide**	
4	Not government's responsibility.	FBO's responsibility to provide.
5	**Funding for construction, operations and maintenance.**	Program operation.
6	Housing subsidy for low income clients. More available housing for all, including felons.	Co-ordination and referral.
7	**Funding, certification of agencies.**	**Provide safe housing as clients work on addiction issues. Case management.**
8	To regulate and fund.	As of now in our area there is no involvement
9	**Funding and referral services.**	Refer to services or provide housing if congregation supports.
10	**Provide space to set up housing that residents can fix up and take care of. Provide funds for full time counselors. Provide funds for job skills training.**	Act as mentors to help with education needs and job interviewing skills. Be willing to talk with people who need someone to listen.
11	Fund and certify.	**Provider**
12	**There is some subsidized funding for housing here.**	If the government would turn over existing military housing (set for closure) and turn this into housing. FBO could monitor these for shelter, housing and foster homes.
13	**Promote and secure "half-way" housing.**	Support and co-operate in setting up homes.
14	Certify agencies/fund.	Tell churches what they can do.
15	Work with treatment community and homeless providers to simplify zoning and other permitting processes. CTED could be involved with low interest loans to communities.	As long as the transitional housing is not located in a place of worship, FBO could be a valuable source.
16	**Fund pre treatment housing and license FBO programs.**	**Provide staffed licensed facilities.**
17	yes	
18	Screen agencies seeking funds. Help startup agencies navigate the red tape. Provide ready available funds in an efficient manner.	Recognize the need and help if possible. Actively seek employees who understand the issue. Actively network with other agencies.
19	**Assist with providing buildings and funding.**	If possible provide housing and assist with funding and staffing.
20	**Funding.**	**Provide transitional housing that includes for women with children.**
21*	Either run facilities or financially support the facilities in a sustainable fashion.	Run facilities where financially sustainable.

*Survey 21 was received too late to be included in the analysis and survey report.

Need: Crisis counseling – Spiritual support		
#	State & local government role	FBO role
1	Fund services through vouchers. **Establish a certification process that leaves room for counselors without MSW but screens out frauds.**	**Be able to offer these services without having to set aside religious beliefs. Again, a voucher system lets clients choose. Free market will close the doors of ineffective services.**
2	Include FBO's on all DASA referral materials like other services.	**Designated staff from FBO's should be listed with DASA as Crisis Intervention Specialists. Spirituality is very important to people during crisis.**
3		**Provide**
4	Not government's responsibility.	**FBO's responsibility to provide.**
5	None.	**With appropriate training, this would be a normal function of FBO.**
6	**An integrated crisis center for mentally ill, chemically abusing, and/or co-occurring disorders. Integrated Services!**	**Inclusive, accepting counseling and spiritual support.**
7	None	**Available to clients who are interested in receiving services.**
8	To regulate and standardize counseling in Washington state.	To serve clients.
9	**Crisis counseling.**	**Spiritual support.**
10	Provide funds for full time crisis intervention(whatever is needed on an individual basis.) Fund crisis call lines. There should be some place to go for help other than the hospital emergency room.	Perhaps ministers or chaplains do some spiritual counseling for those who express an interest.
11	Fund – do not certify!	**Lead role - provider**
12	Combine RSN efforts (offices). Better training for staff. Extended hours.	**Funding for phone trunks. Membership could supply volunteers after training completed.**
13	Co-operate with FBO's to counseling holistically each person.	**Offer and advertise spiritual counseling.**
14	Serve clients.	Provide funds and forward clients.
15	No role.	Availability of the religious communities for these services fits well with the 12 step recovery programs. My concern would be that drug and alcohol information and training be made available to counselors.
16	None	**Available at no fee to clients who qualify and sliding fee to others.**
17	yes	Open their doors for support 12 step meetings.
18	Provide funds for training.	Train employees (members). Make referrals to other agencies when needed.
19	**Goes along with medical intervention and treatment for those who don't have insurance coverage.**	**Provide short term and refer to qualified people.**
20		**Providers of this. Provide 3 sessions – refer to professional services for further help.**
21*	None	**Provide services as part of the community.**

*Survey 21 was received too late to be included in the analysis and survey report.

Need: Emergency support (clothing, car repair, utilities and others)		
#	State & local government role	FBO role
1	**Make sure** that **laws and regulations regarding charitable giving don't hamstring FBO's who depend on donations to offer these services.**	Provide such services as long as they identify themselves clearly.
3	**Provide**	Provide
4	Not government's responsibility.	**FBO'S responsibility to provide.**
5	**Funding and large-scale utility assistance programs.**	Normal FBO program.
6	Basic transportation (maybe a bus pass),basic clothing for work/treatment and basic utilities.	Referral to community resources as well as DSHS.
7	**Provide funding.**	**Provide services to address these needs.**
8	Not involved.	Very minor involvement.
9	Funding and referral services.	Provide services if congregation supports.
10	This is tricky. I have seen too many people take advantage of such programs. There has to be some way of determining real need that doesn't take more than a day or two for car repair and utilities, etc. I think a clothing bank and food bank should be set up for immediate use by those in need.	As far as I know, the FBO's in this city (Port Angeles) do an excellent job at running a soup kitchen. And most have collection baskets for food and clothing.
11	Fund	Provider.
12	Minimal government, agencies/staff, etc.	**Seem to be very involved in providing these services.**
13	Make available free support, temporarily.	Some resources offered for emergencies only.
14	Provide funding based on real need.	Provide funding.
15	No role	**Presently a very real source of assistance in our community.**
16	Emergency support as defined by basic needs, food, emergent health care.	Clothing banks, assistance with other supports as available with client participation, e.g. day labor, community service.
17	?	Could help on this.
18	Provide funds. Explore other community agencies that can utilize the funds.	Explore long term effects of their services and make changes as needed.
19	Only as a last resource.	Should be coordinated through organizations like the Salvation Army.
20		Provider of this.
21*	**Have emergency support systems in place.**	**Participate in emergency medical support.**

*Survey 21 was received too late to be included in the analysis and survey report.

Need: Alcohol and drug-free social activities		
#	State & local government role	FBO role
1	Fund through vouchers as the ATR system is doing now.	Be able to be a provider (again as the ATR system is doing). It works!
2	Monthly or quarterly updated website that list each month's activities and allows us to submit information.	FBO's should submit church activities.
3		**Provide at local levels.**
4	Not government's responsibility.	FBO's responsibility to provide.
5	None.	Should be an integral part of FBO programs.
6	No governmental responsibility.	Provide free support groups for all Mental Health, Chemical Dependency, and co-occurring disorders clients.
7	None	Provide through worship services as well as activities.
8	Not involved.	No specific involvement in our area.
9	Referrals	**As supported by congregation.**
10	**I have heard of one counseling program that sets up a community center for people with mental health and dependency problems. TV, sports, small rooms for meetings, music, free snack bar and full time counselors. I think that is a great idea!**	
11	No government involvement.	Provider.
12	Mainly through the local RSN Tobacco Prevention program, little D and A it seems.	**Many - too many to mention here.**
13	Help put on socials in local neighborhoods.	Offer socials for local natives and parishioners.
14	Certify agencies.	Provide funding.
15	No role.	Facilitation and perhaps space.
16	None	Only as they choose, no expectation. There are self help recovery groups that assist in this area.
17	Yes.	Could help with bringing them in and accepting them for social activities.
18	Offer funds to organizations.	Schedule and plan on a continuous bases.
19	Not their job.	Work with local 12-step and similar groups offering meeting space, etc.
20		Provider of this.
21*	None.	None.

*Survey 21 was received too late to be included in the analysis and survey report.

Need: Family and marriage counseling		
#	State & local government role	FBO role
1	Recognize the value of counselors who incorporate religious beliefs. Establish a certification process that lay counselors could go through. Set up a hot line or data base for complaints of misconduct that clients can see.	**Offer these services as long as their "faith" component is clearly advertised upfront.**
3		**Provide**
4	Not government's responsibility.	FBO'S responsibility to provide.
5	With the values-neutral approach taken by secular counselors, it is difficult for them to be effective.	With appropriate training, this should be a normal FBO function.
6	Women's shelters, Anger Management, and family planning are all vital services.	Counseling and referral.
7	None	Provided by church leader.
8	N/A	To have standards matching state regulations
9	Funding and referral services.	**Continue counseling by clergy.**
11	Fund and certify.	No role or small role.
12	**Licensure regulations.**	Pastoral and spiritual services through private entities.
13	**Direct persons needing advice to both state and church counselors.**	**Advertise more the counseling services available in church offices.**
14	**Promote morality of man and woman marriages rather than condoning gay marriage.**	Provide funding.
15	No role	Many FBO are treating folks from the recovery community. I believe they can play an important role.
16	**Support financially as a part of a structured treatment program.**	Make services available as long as they are not going to require a specific religious belief.
17	Yes.	Faith based generally have counselors, would be very helpful.
18		Recruit qualified staff.
19	Goes along with medical intervention and treatment for those who don't have insurance coverage.	Refer to qualified professional therapist. Assist with fees.
20		**Provider of this. Provide 3 sessions – refer to professional services for further help.**
21*	Sponsor family centers.	Provide services as financially practical.

*Survey 21 was received too late to be included in the analysis and survey report.

Need: Peer support or mentoring		
#	State & local government role	FBO role
1	Not sure that government should be involved here - it's too vague; potential for abuse of funding is huge.	Offer free of charge, funded through donations and volunteers.
3		Provide
4	Not government's responsibility.	FBO'S responsibility to provide.
5	Funding and program operation.	Values-based program operation.
6	No governmental responsibility.	Growth groups and Recovery support groups.
7	Fund mentor training.	Mentoring program; peer support offered through church programs.
8	N/A	N/A
9	Refer to services.	Provide services if congregation supports.
11	Fund. Do not certify!	**Lead role - provider.**
12	Do not revoke registered counselor license. At least support counselors can be monitored in this way!	Seems to be very active depending on the organization.
13	Help train mentors.	Promote and recruit members of church to become mentors.
15	Make funding available for training and recruiting.	**Recruiting mentors from the FBO's, offering them training on chemical dependency would be a great addition to the social service community.**
16	None	As they see fit as long as they are not going to require a specific belief or practice.
17	Yes	Peer support for families also like Naranon/Alanon.
18	Provide funds.	Make sure the organization is open to the community.
19	Only as a follow up to medical intervention and treatment.	Goes along with alcohol and drug-free social activities
20		Provider of this.
21*	Sponsor peer support.	Participate as financially practical.

*Survey 21 was received too late to be included in the analysis and survey report.

Need: Child care		
#	State & local government role	FBO role
1	Fund through vouchers. License providers.	Provide services as long as they meet licensing requirements.
4	Not government's responsibility.	FBO'S responsibility to provide.
5	Funding for low income families. No operating responsibility.	**Operation of low cost or subsidized programs to meet needs of client families.**
6	Child care while client is in treatment.	Referral to DSHS.
7	Fund agency programs for child care needed to attend treatment, meetings, and work	Provide licensed child care facility.
8	In chemical dependency agencies short term care is not regulated.	Meeting day care standards.
9	Funding and referral services.	If supported by congregation.
10		Volunteers to help man the center. Child care could be provided in the same place with an area strictly for children with someone there to watch and help them.
11	Fund and certify.	Provider.
12	Little and Bureaucratic.	Depends on availability of volunteers and space.
13	Offer more finances to cover more child care.	Preach and teach the importance of good child care.
14	Promote safe environments.	Provide funding.
15	**Continue funding** DASA child care.	Our agency holds the DASA child care contract for Clallam County. FBO's who wish to be licensed would be a welcome addition to the depleting supply of licensed child care providers.
16	Financially support and license for inpatient and outpatient programs for those with significant barriers to otherwise accessing treatment.	Offer off site services for those clients that can access.
17	Yes	Pay someone to take care of children when needed.
18	Subsidies for working parents.	On an "as needed basis".
19	**Through DSHS funding.**	Provide but meeting state guidelines for providers.
20	**Funding while parents are involved in outpatient treatment or counseling sessions.**	Provides when possible – paid staff or volunteers with background checks.
21*	Sponsor.	Participate.

Need: Other		
#	State & local government role	FBO role
2	Address and fund treatment for sexual abuse victims.	**Offer help and treatment.**
2	List Christian based agencies and other FBO's in the green book noting comment under "focus of treatment."	
2	**Allow clients to choose which treatment center they want rather than have the state designate only a select few that are approved for low income or title xx.**	**Offer all aspects of treatment to low income if state funds slots.**
6	Specialized Assessment for clients with Co-occurring disorders. **Co-Occurring Disorders Assessments take 3-4 hours to complete. They are now being reimbursed for a traditional assessment rate. Should be paid at a higher rate.**	**Complete a comprehensive Chemical Dependency/Mental Health Assessment. It is not safe or productive to place an unstable mentally ill person in a treatment group.**
8	**Co-occurring population not recognized.**	**Co-occurring population not recognized.**
8	**Take treatment agencies out of pocket of the courts for reporting purposes.**	**Take treatment agencies out of pocket of the courts of reporting purposes.**
11	Professional dental care including dentures and other cosmetic services that would make it easier for them to obtain employment. Fund.	Coordinate services for client.
11	Professional mental health services for clients with significant mental illness. **Fund and certify.**	Coordinate services for client.
11	More prevention efforts related to alcohol and Fetal Alcohol Syndrome. Start young (in schools) but also general public. **Fund.**	
11	Case management. Fund.	Provider.
13	**Family and parents supported with more parenting classes.**	**Inform more people of the importance of church attendance for better parents and stronger families.**
14	**Provide funding for tutoring agencies.**	Provide funding for churches to work with tutoring special needs kids.
14	Provide transportation for kids that want to go to private elementary schools.	
17	Definitely N.A. and A.A. meeting - regular basis.	
17	Help support groups such as NAR ANON.	
17	Teaching significant others how not to enable, and let the addict do for himself to adjust their return to society.	
17	Turn responsibility over to addict, do not take responsibility to do for them what they can do for themselves.	
18	Research small organization, for funding opportunities.	
21*	Community Education Behavioral Health – **Coordinate and sponsor community education.**	Participate.

*Survey 21 was received too late to be included in the analysis and survey report.

Part 2 – What gets in the way of FBO's supporting recovery clients? (What are the barriers you must overcome – social, bureaucracy, attitudes, stigmas, etc.?)

Barriers from the State	
1	Prohibiting faith-based treatment programs from serving as authorized representatives for food stamp clients like DASA licensed programs do. Not offering a certification process that would enable faith-based treatment providers to be "legitimate" without setting aside the faith component.
2	No funding from the state and clients are also not allowed to use the vouchers system.
3	Risk of theft. Attitudes, they are a bad influence, thus, they are not wanted NIMBY [Not in My Back Yard]!
4	Funding. Court requirements for certification of counselors on spiritual issues (anger management, domestic violence, etc.)
5	Funding limitations; conflicts within state agencies concerning the delivery of services to mentally ill individuals with substance abuse problems.
6	Title XIX coupons should be more readily available for patients with co-occurring disorders.
7	Lack of funding for programs.
8	Too many regulations and reimbursements not realistic.
9	Don't know.
10	I have no idea.
12	Documentation and accounting for services. Spiritual Elders do not want to identify who they see.
13	Bureaucracy - red tape."
15	Attitudes from some treatment providers, court staffs, that we are "fluff."
19	If paper work is required many will not do it. Fear of state intrusion.
20	Bureaucracy. Attitudes of Social Services Departments toward "faith based" providers. Stigma that FBO's are not professional – most FBO's I'm aware of are certified or licensed professionals on staff, boards, etc. even though facilities may not be licensed.
21*	Data collection cost prohibitive, under funded, "silo" thinking regarding mental health and chemical dependency.

Barriers from the local (city, county) government	
1	Our agency has not met any barriers from local authorities.
4	Funding (unwillingness to allocate resources to FBO's.)
5	City – "Chronic homelessness is not their problem!" City desire is simply to displace, not problem solve. County staff seems to have a significant bias against FBO's.
6	We need an integrated Mental Health, Chemical Dependency Crisis Center with emergency beds.
7	Lack of knowledge regarding how to address social service issues.
8	Not enough funding.
9	Don't know.
10	I have no idea.
12	Red tape - up front access, general knowledge of funding streams.
13	Unknown activities - not advertised enough.
15	None
19	Zoning is a factor in Clark County.
20	No real barriers in Yakima – city or county – all offices very helpful in FBO I am involved with.
21*	Data collection cost prohibitive, under funded, "silo" thinking regarding mental health and chemical dependency.

*Survey 21 was received too late to be included in the analysis and survey report.

Barriers from the community in general	
1	Initially in our reasoning hearing process a neighbor objected and it was clearly "not in my backyard " thinking. However, we had so many safeguards in place that the rest of the neighbors supported us.
2	Stigma. I approach churches to rent space for my agency and was surprised regarding their fears and misunderstanding of treatment.
4	Not including FBO's as partners in dealing with problems such as homelessness and substance abuse. More of an attitude of "tolerance" because of religious freedom rather than partnership.
5	**"**Those people should not be here" is the cry of the community. Bias by even organizations receiving public funds against providing housing to formerly homeless.
7	Ignorance and judgment of those in need.
8	Referral techniques and knowledge.
9	Many in the community think that treatment and support for alcoholics and addicts doesn't work.
10	I think we need to educate the public that many of the people are just that; not monsters but people who need help.
11	Funders hesitate funding Christian-based programming.
12	Involvement, cost.
13	Fear and ignorance.
15	As a respected social service agency we receive support, encouragement.
16	Fear the programs aren't regulated and therefore they pose a potential threat for an at risk population.
20	"Not in by backyard" comes across board to both FBO and non-FBO.
21*	"I don't want to pay for it!"

*Survey 21 was received too late to be included in the analysis and survey report.

Other Barriers	
1	Sometimes DASA licensed treatment providers see FBO's as competition and fight any attempts to establish criteria for their certification. I know this was the case about 4 years ago when such legislation was proposed in Washington.
6	Sub-contractors for the state are badly in need of cultural diversity trainings, including race, religion, and sexual orientation.
9	Many recovering people have had negative experiences with religion and avoid FBO's.
10	I don't think that many churches have enough funds to pay their ministers or chaplains to take on this job.
11	All government funding: It is difficult to separate in time/place spiritual activities from other parts of an addiction recovery program since spiritual/emotional healing are so integral to addiction recovery. For the same reason, it is hard to make these activities" voluntary." They are the most important parts of the program. It is kind of like offering to fund hospital treatment for people, but only the portions that are voluntary and separated in either time or place from any medical activities going on.
13	Negative attitude.
14	We are interested in starting an addiction ministry. The state could send people to us and provide funds.
16	Fear of requirement to participate in the specific beliefs of the FBO.

Part 3 – Other comments or feedback

Comments/Feedback	
1	The current law requiring CDP's to be employed by a DASA-licensed agency to be able to call themselves CDP's is grossly unfair, and it discriminates against FBO's. The person is certified. Anyone who completes both the study and practical requirements and passes the Board exam should be able to use their CDP title, no matter where they work.
2	1. FBO's need to be explained further in definition. Some claim FBO without FBO actual curriculum but instead are just traditional treatment located within a FBO. 2. RCW, deferred prosecution requirements need to include church attendance or other approved church activities as replacement for 12-step, self-help groups etc. 3. **Thank you from all of us in FBO's. This is very important to people's lives and recovery.**
13	We need to know more of what is available in resources and then work together more on the needs.
20	Currently I am a licensed mental health professional, a state contracted service provider, and board president of a local FBO.

The Role of Faith Based Organizations in Chemical Dependency Recovery: A Survey

September 2006

REPRESENTATIVES OF FAITH-BASED ORGANIZATIONS (FBOs) across Washington State were surveyed about government and FBO roles in meeting the needs of clients recovering from chemical dependency. The survey was conducted in July and August 2006 by the DSHS Division of Alcohol and Substance Abuse and the Research and Data Analysis Division. Representatives of 20 FBOs responded to the survey.

The survey focused on two main areas:

- The role of government and FBOs in providing key supports for recovering clients – and suggested improvements in these processes (summarized on this page and presented graphically on pages 2 and 3).
- The barriers to effective service (presented on page 4).

What should the roles of government and faith-based organizations be in the delivery of social services?

Government Role: Survey respondents saw the most important government role as providing funding, training, certification, and regulation for programs, providers, and facilities who provide medical intervention, detoxification, inpatient and outpatient chemical dependency treatment, and transitional housing. Many respondents also mentioned a government role in funding child care, different types of counseling and emergency support. A smaller number of respondents saw a government role in providing referrals and direct services, especially emergency support.

FBO Role: The number one role for FBOs was spiritual support and crisis counseling. However, respondents saw some role for FBOs in providing almost every type of service for people recovering from chemical dependency – to include treatment, counseling and support, emergency support, outreach, alcohol/drug-free activities (often spiritual), housing, child care and family/marital counseling. Some respondents also saw FBO roles in referral and funding.

Suggestions for Change: In the course of commenting on roles, respondents also made specific suggestions for changes in the way services are provided for those recovering from chemical dependency.[1] These suggestions included:

- Allow more choice in where to get state-funded services – allowing clients to choose faith-based programs. Some respondents suggested a voucher system.
- Increase the availability of services for low-income people and those without insurance.
- Provide more recognition of, programs for, and appropriate funding for services addressing co-occurring (mental health/chemical dependency) disorders.
- Provide more funding and create more options for detoxification programs, housing, dental care, prevention and innovative programs.
- Include faith-based programs in lists of resources, and identify them as programs with a spiritual component.
- Change the law that requires certified Chemical Dependency Professionals (CDPs) to be employed by a DASA-licensed agency to be able to call themselves CDPs – so that certified employees of FBOs can use the title they have earned.
- Better define Faith-Based treatment – to distinguish between programs with faith-based curriculum and those which house a standard treatment program within an FBO.
- Allow church attendance or other approved church activities to replace 12-step programs in deferred prosecution requirements.

[1] Most of the suggestions for improvement were offered in response to the survey questions about roles, but the final three in this list were submitted in the "Additional Comments" section of the survey.

IN YOUR OPINION

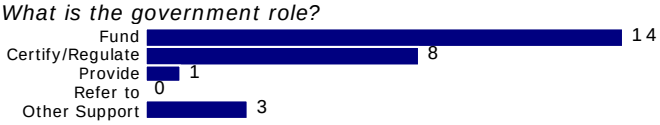
What is the government role in . . . ?

Q1 | Medical intervention, detoxification, inpatient and outpatient chemical dependency treatment

Does government have a role?

No Response = 1, No Role = 0, Role = 3, Important Role = 16

What is the government role?

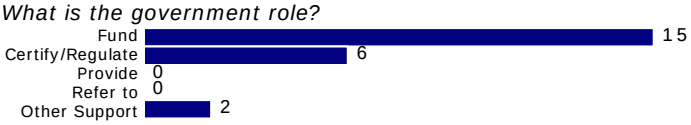


Q2 | Transitional housing

Does government have a role?

No Response = 0, No Role = 1, Role = 8, Important Role = 11

What is the government role?

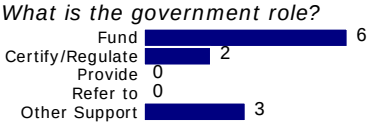


Q3 | Crisis counseling – spiritual support

Does government have a role?

No Response = 2, No Role = 5, Role = 9, Important Role = 4

What is the government role?

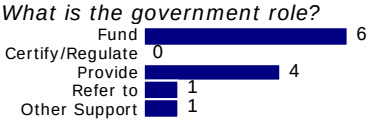


Q4 | Emergency support

Does government have a role?

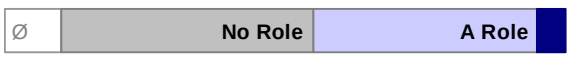
No Response = 3, No Role = 3, Role = 10, Important Role = 4

What is the government role?



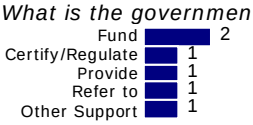
Q5 | Alcohol- and drug-free social activities

Does government have a role?



No Response = 2, No Role = 9, Role = 8, Important Role = 1

What is the government role?

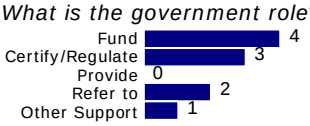


Q6 | Family and marriage counseling

Does government have a role?

No Response = 6, No Role = 3, Role = 7, Important Role = 4

What is the government role?

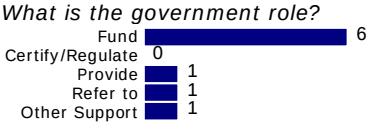


Q7 | Peer support or mentoring

Does government have a role?

No Response = 6, No Role = 3, Role = 11, Important Role = 0

What is the government role?

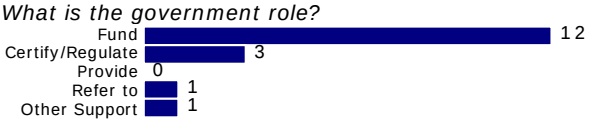


Q8 | Child care

Does government have a role?

No Response = 3, No Role = 1, Role = 13, Important Role = 3

What is the government role?

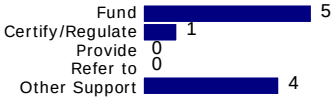


Q9 | Other

Does government have a role?

No Response = 12, No Role = 0, Role = 2, Important Role = 6

What is the government role?



IN YOUR OPINION

What is the faith-based organization role in . . . ?

Q1 | Medical intervention, detoxification, inpatient and outpatient chemical dependency treatment

Do FBOs have a role?

No Response = 2, No Role = 2, Role =8, Important Role = 8

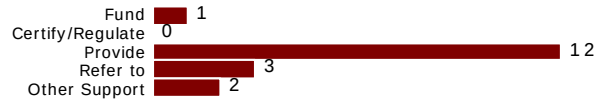
What is the FBO role?

Q2 | Transitional housing

Do FBOs have a role?

No Response = 3, No Role = 0, Role = 13, Important Role = 4

What is the FBO role?



Q3 | Crisis counseling – spiritual support

Do FBOs have a role?

No Response = 0, No Role = 0, Role = 6, Important Role = 14

What is the FBO role?

Q4 | Emergency support

Do FBOs have a role?

No Response = 1, No Role = 0, Role = 15, Important Role = 4

What is the FBO role?

Q5 | Alcohol- and drug-free social activities

Do FBOs have a role?

No Response = 1, No Role = 0, Role = 16, Important Role = 3

What is the FBO role?

Q6 | Family and marriage counseling

Do FBOs have a role?

No Response = 2, No Role = 0, Role = 13, Important Role = 5

What is the FBO role?

Q7 | Peer support or mentoring

Do FBOs have a role?

No Response = 4, No Role = 0, Role = 14, Important Role = 2

What is the FBO role?

Q8 | Child care

Do FBOs have a role?

No Response = 2, No Role = 0, Role = 17, Important Role = 1

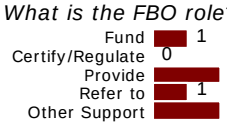
What is the FBO role?

Q9 | Other

Do FBOs have a role?

No Response = 14, No Role = 0, Role = 2, Important Role = 4

What is the FBO role?



Barriers from the State (12 respondents listed barriers*)

Limited/insufficient funding

Bureaucracy and requirements for documentation, which are seen as intrusive

Negative attitudes toward FBOs and fears about their clients

Limiting access to services available to other treatment programs

- *Not allowing faith-based programs to serve as authorized representatives for food stamp clients like DASA licensed programs do*
- *Not allowing FBO clients to use the Access to Recovery voucher system*

Insufficient resources and programming for clients with co-occurring disorders

Certification requirements that don't fit the needs of faith-based providers

Barriers from local (city, county) government (8 respondents listed barriers*)

Lack of knowledge – about social service issues, activities and funding streams

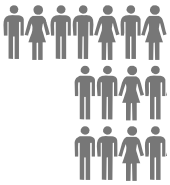
Lack of funding

Red tape and zoning issues

Negative attitudes toward FBOs and belief that chronic homelessness is not the city's problem

Need for an integrated mental health, chemical dependency crisis center with emergency beds

Barriers from the community in general (11 respondents listed barriers*)



Bias against clients (stigma, fear, misunderstanding)

Lack of knowledge about social problems and treatment

Hesitation to support/partner with FBOs - due to Christian component, lack of regulation, or cost

Other Barriers (8 respondents listed barriers*)

DASA-licensed providers – they see FBOs as competition, and need cultural diversity training re: race, religion and sexual orientation

Many clients have had negative experiences with religion; avoid FBOs; fear requirement to participate in church activities/share beliefs

Churches don't have enough money to do this big job

Difficulty separating spiritual activities from other parts of recovery programs to make voluntary and comply with government funding requirements

"Negative attitude"

*The little people shown at the left of each issue statement represent the number of respondents who mentioned that issue. The total number of little people may be higher than the number of respondents in that category because one respondent may have mentioned more than one issue.

Additional copies of this paper may be obtained from: http://www1.dshs.wa.gov/RDA/.

Washington State Department of Social & Health Services
Research and Data Analysis Division
Report Number XX.XXX

U.S. Department of Labor

COMPASSION AT WORK

The Faith-Based and Community Initiative: A Ten-Minute Overview

Jedd Medefind, Director
Center for Faith-Based and Community Initiatives
U.S. Department of Labor

The Faith-Based and Community Initiative: A Simple Conviction

The Faith-Based and Community Initiative is built on a simple conviction: America can do better for our neighbors in need when we enlist every willing partner.

Faith-Based and Community Initiative: History & Need

- America's faith-based and community-based organizations (FBCOs) have a long history of serving those in need
- FBCOs include religious and nonreligious non-profit groups that:
  - provide social services
  - vary greatly in size and resources
  - identify themselves with various:
    - community initiatives
    - religious or nonreligious traditions or philosophies

Faith-Based and Community Initiative: History & Need

- Small non-profits (including faith-based and non-faith-based groups) have for many years directed their unique strengths to address the same social problems as Federal programs
- Despite their similar goals, Federal programs and small FBCOs rarely worked together to help people in need

Faith-Based and Community Initiative: History & Need

- "Charitable Choice" provisions enacted in the 1990s were some of the first attempts to open Federal programs to non-traditional service providers, including faith-based groups
- Followed in 2001 by President George W. Bush's Faith-Based and Community Initiative (FBCI)
- Days after taking office, President Bush established the White House Office of Faith-Based and Community Initiatives *and* Centers for Faith-Based and Community Initiatives in five Federal departments
- Since that time, Centers have been established in an addition six Federal agencies

Faith-Based and Community Initiative: History & Need

- Goals of the Centers are:
  - To expand ways in which FBCOs can assist the Government in meeting people's needs
  - To ensure the equal treatment of FBCOs in the administration and distribution of Federal financial assistance
  - To protect the religious liberty of:
    - FBCOs that partner with the Federal government
    - Participants in Federally supported social service programs
  - To equip Federal agencies and other entities to work more effectively with FBCOs

Faith-Based and Community Initiative: History & Need

- Audits by Centers found that Federal agencies frequently imposed barriers to participation of faith-based groups in their programs, including:
  - Assuming that faith-based groups couldn't partner with government because of their religious identity
  - Excluding faith-based groups from certain programs
  - Conditioning assistance on a faith-based group's willingness to accept restrictions on its religious identity and activities that were not legally mandated

Faith-Based and Community Initiative: History & Need

- Barriers to small FBCOs (religious and non-religious) included:
  - On Federal agencies' part:
    - Procurement and grantmaking processes designed in ways that benefited prior grantees
    - Lack of awareness about FBCO services and capabilities
    - Limited outreach to non-traditional partners
    - Unnecessarily complex applications and reporting
  - On the part of small FBCOs:
    - Lack of knowledge and information about or experience with Federal procurement and grantmaking

DOL Before the FBCI

- Some monetary and non-monetary partnerships between DOL and large FBCOs existed
- Even the Welfare-to-Work program, which was governed by "Charitable Choice," had minimal involvement of faith-based organizations:
  - only 2% of applicants were faith-based (34 of 1,862)
  - grants to faith-based organizations made up
    - 3% of the awards (6 of 191)
    - 2% of the overall funding ($16.2 of $712 million)

FBCI In Action at DOL

- DOL has made grants more accessible by:
  - simplifying all SGAs (Solicitations for Grant Applications)
  - creating small grants for grassroots FBCOs
  - providing technical assistance for potential grant applicants
  - utilizing the intermediary grant model to extend access to DOL assistance beyond the confines of direct grant programs via sub-grants
  - publicizing grant and other partnership opportunities with FBCOs nationwide

Common FBCI Myths

Myth 1:

"The Faith-Based and Community Initiative means the government is favoring faith-based groups"

Common FBCI Myths

Reality:

- The law requires ***neutral treatment*** of groups/ individuals with regard to religion
- The Initiative is designed to:
  - remove barriers to participation by FBCOs in Federal programs
  - ensure a “level playing field” for all groups and individuals, regardless of religious affiliation or lack of affiliation

Common FBCI Myths

Myth 2:

"The Constitution strictly prohibits the government from providing funding to or partnering with any faith-based group"

Common FBCI Myths

Reality:

- The Supreme Court has "consistent[ly] reject[ed] . . . the argument that 'any program which in some manner aids an institution with a religious affiliation' violates the Establishment Clause" (Mueller v. Allen, 1983 case, citing cases as far back as 1899)
- Key issues: *the ways in which* (1) the workforce system works with FBCOs and (2) Federal assistance is provided

Common FBCI Myths

Myth 3:

"Faith-based groups that receive government assistance must hide their religious identity, limit their religious activities, restrict governing board membership, and remove religious signs, symbols and art from their facilities"

Common FBCI Myths

Reality:

- The restrictions on faith-based groups listed on the previous slide (and others) are ***prohibited*** by:
  - various Federal statutes (*e.g.*, 42 U.S.C. 290kk-1(d)(2)(B), relating to programs of HHS's Substance Abuse and Mental Health Services Administration)
  - regulations of several Federal agencies: DOL, DOEd, HUD, HHS, DOJ, USDA, USAID, and VA

Common FBCI Myths

Myth 4:

"Direct Federal funds are now paying for religious activities."

Common FBCI Myths

Reality:

- No direct Federal funding can be used for religious activities.
- Privately-funded religious activities must be kept separate in time or location from programs funded directly by the government.
- Only under “indirect funding” arrangements (i.e. when participants have a free and independent choice of the services they receive, such as vouchers) can providers incorporate faith elements.
- Organizations must serve all eligible participants regardless of the participant’s faith

FBCI at DOL: Ready4Work

- *Ready4Work* is a 3 year prisoner re-entry pilot project of the DOL and DOJ.
- Built upon partnerships with local faith-based and community organizations to help ex-offenders transition into work and life after prison.
- Operating at 11 adult sites and 6 juvenile sites until late 2006.
- *Ready4Work preliminary 1 year recidivism data indicates a recidivism rate for participants* 30-50% lower than expected BJS averages.

DOL and FBCI Resources

DOL Equal Treatment and Religion-Related Regulations
www.dol.gov/cfbci/legalguidance.htm

DOL Center for Faith-Based and Community Initiatives
www.dol.gov/cfbci

DOL Civil Rights Center
www.dol.gov/oasam/programs/crc/crcwelcome.htm

White House Office of Faith-Based and Community Initiatives
www.whitehouse.gov/government/fbci/guidance/index.html

Hello Vince,

I am responding to your inquiry about a credential for Faith Based Chemical Dependency providers. Florida does not have a credential for individual providers of faith-based addiction services, although there has been interest expressed among the Florida ATR faith-based providers. We are in the process of developing a Peer Recovery Support Specialist credential that will probably be most fitting for our faith-based providers (since this is the predominant service they provide).

The Florida ATR program does have a **program certification** process for faith-based providers to assure that they can meet the minimum standards for client safety and well-being. This in no way compares to an individual certification. It is really in lieu of program licensure that is required for all treatment agencies in Florida. The wording of this gets confusing even for people in Florida.

One resource I can share with you is the NET Training Institute in Orlando. This Christian-based organization provides training to faith-based providers who would like to achieve certification at some level for addiction counselors. This is the regular credential for addiction counselors. Here is the link to their Diploma programs:
http://netinstitute.org/diplomas.htm Their Home Study courses are very thorough.

Please let me know if you have further questions.

Pamela Waters, Director
Southern Coast ATTC
Florida Certification Board
1715 S. Gadsden Street
Tallahassee, FL 32301
850-222-6731
Visit us on the web: www.scattc.org

Report from the Florida Faith and Community-Based Treatment Committee

June 2003

SOUTHERN COAST attc

The Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

FAITH

The Energy Behind
Thousands of Providers of
Services for Floridians in Need

COMMUNITY

The Place Where Professionals
Have Evolved State-of-the-Art
Addiction Services for Florida's
People

What Happens When These

FAITH + COMMUNITY

Providers Cooperate?

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Florida Faith and Community-Based Treatment Committee (FCBT)

A group of leaders from some of Florida's Faith and Community-Based Service Organizations met informally for a number of years in order to share perspectives, build trust, and evolve methods to better meet the needs of Florida's people with addictions and/or mental health problems. These meetings took more tangible form in 2002, when the Southern Coast Addiction Technology Transfer Center (SCATTC) brought together representatives of several key groups for a facilitated dialogue. These groups include:

- Florida's Faith-Based Coalition (FFBC);
- Florida Alcohol and Drug Abuse Association (FADAA);
- Florida Certification Board (FCB); and
- Florida Substance Abuse Program (Department of Children and Families-DCF).

Members of this workgroup/committee are:

- Chet Bell, Exec. Vice President, Stewart-Marchman Treatment Center
- Cleveland Bell, Executive Director, Riverside House
- John Daigle, Executive Director, FADAA
- Rev. Bernie DeCastro, President of Florida Faith-Based Association
- Kenneth DeCerchio, Director, Florida Dept. of Children & Families, Substance Abuse Program
- Rev. John Glenn, Director of Alpha Ministries
- Dr. Jean LaCour, Director, Net Training Institute
- Charles LaCour, Net Training Institute
- Chris Yarnold, Marketing Director, Operation Par
- Neal McGarry, Executive Director, Florida Certification Board
- Pamela Waters, Director, Southern Coast ATTC
- Jim Knorp, Project Manager, Southern Coast ATTC
- Brunie Emmanuel, UniVision Group, Consultant/Facilitator

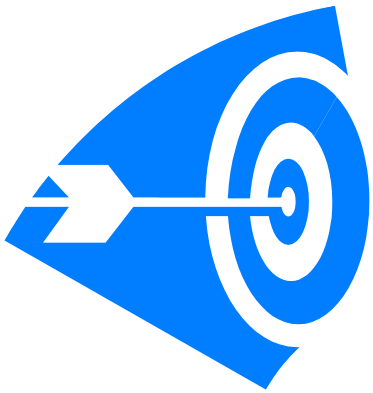
The following Report is intended to summarize the efforts of this combined working group, and hopefully serve as a model for others to emulate in achieving a level of communication and cooperation between and among Faith-Based Organizations (FBO's) and Community-Based Organizations (CBO's).

INTRODUCTION

As practitioners proceed into this 21st century, the United States' healthcare system is challenged with many emerging issues of communication and coordination. In the area of behavioral medicine, growing demand and inadequate capacity has taken on an increasingly urgent air. One of the solutions that has emerged holds both promise and concern for many of the traditional behavioral medicine players: Faith Based organization funding.

For the approximately 43 million Americans with no health insurance, and countless others with no access to existing services, the public health safety net has been shouldered by community-based providers who have had to develop dynamic ingenuity in attending to the shifting needs and increasing regulatory oversight. One consistent theme in this arena is recognition on the part of all that lasting solutions must occur within the context of community. Thus, new partnerships between previously-unaligned community players is a mandate, resulting in sharing of resources in non-traditional ways.

Concurrently, one of the cornerstones in many of these communities is their faith-based institutions. These groups have historically served parallel to but separate from the traditional community-based providers, and have established themselves as trusted community partners. This reality led to Section 104 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which encourages states to partner with independent organizations to strengthen the safety net, and forbids the exclusion of faith-based providers. This, coupled with the current administration's executive orders, and Congressional Charitable Choice mandates, has resulted in unprecedented access to federal funds for faith-based organizations. The challenge to traditional community-based organizations is palpable, thus Florida's Faith and Community-Based Treatment Committee (FCBT) developed a process that has successfully guided it into an era of unparalleled cooperation. The specific steps in that process follow, and Addendum F ("History") traces its steps from the perspective of a FBO committee member.



GOALS

Through facilitated dialogue and focused work, FCBT crafted the following **Goals** for its work together. FCBT members believe such foundational agreement in the initiation phase of activity is essential for any group hoping to achieve a high level of cooperation on sharing of funds and services. Only by having clear, tangible Goals can a group know when and if it is succeeding.

Goals for this project between Florida's Faith Based Organizations (FBO's) and Community Based Organizations (CBO's)

- *To create synergy between FBO's and CBO's in delivering addiction services **by identifying tools and best practices** for both groups.*
- *To **expand the continuum of care for addiction services** by identifying and defining Faith-based services that compliment the current (CBO) continuum.*
- *To **encourage partnerships** between FBO/CBO by finding common ground and develop ways to collaborate.*
- *To **facilitate state certification and licensure** to FBO's who want to expand their services.*
- *To **develop a separate certification and licensing process** to grass roots FBO's that is sanctioned and recognized by the FCB and DCF.*
- *To develop **new training on spirituality** as common ground for both groups.*

Guiding Principles

In addition to Goals to serve as targets for its activities, FCBT members believe it is important for group to have a set of **Guiding Principles** to use as a filter for collaboration and decision-making in their interactions. These are the standards against which the group can always turn for direction in its decisions and recommendations.

Together, the leaders of Florida's FBO's and CBO's believe:

1. *FBO's provide a wealth of resources to positively impact both the continuum of addictions services and the quality of care provided through those services.*

2. *Quality of care is the top priority and all services provided should be focused on the needs of the individuals and their families.*

3. *Effective care addresses the whole person (physical, mental, emotional and spiritual); therefore, spirituality is an integral part of treatment and recovery for many people.*

4. *All services should be subject to objective measurement.*

5. *The competencies and skills defined and articulated by state licensing bodies and professional organizations are significant aspects of quality addiction treatment.*

6. *FBO's and CBO's share a great deal of common ground on which to build synergy.*

Activity Narrative

As a step to accomplishing its Goals, FCBT members studied and used a list of addictions-related services which follows the statutorily defined services from Chapter 397, Florida Statute and Florida Department of Children and Families Administrative Rule 65D-30. They studied these definitive descriptions of the continuum of services related to addictions in the three main areas of: (1) Prevention, (2) Treatment, and (3) Recovery Support in the form of a Service Matrix. This matrix (attached as Addendum A) was used as a starting point for comparing and defining the services existing FBO's currently provide. The desire was to mirror the statutory services with similar FBO services, thus assisting interested FBOs in identifying how services they currently provide fit within this existing framework, and what recommended paths they might follow to reach eligibility for federal funds for these kinds of addiction services.

In the course of this part of its work, FCBT members arrived at three perspectives on the FBO Service matrix, reflecting the reality that:

- Some FBO's will want to seek a "separate but equal" credential for providing addictions-related services, while…
- Other FBO's will want to move towards credentialing under existing addictions-credentialing methods…and
- Others may want to continue with services that do not require any level of credentialing.

Thus, the first FBO Service Matrix (attached as Addendum B) reflects existing FBO services and how they align with existing CBO services. A separate matrix is also attached (Addendum C), which reflects different language and organizational structure for those FBO's who will seek credentialing independent from existing credentialing structures or no credentialing at all.

With support from the SCATTC, FCBT met in series of meetings in various settings around the state over the course of almost a year. They made significant progress towards the initial Goals they set, and continue to work on a series of Projects which will help realize these Goals into a phase of change implementation. Those ongoing projects and their individual status at the time of the writing of this Report are described below.

Ongoing Projects/Activities

The Committee believes many FBOs currently deliver a variety of addictions-related services in appropriate and effective ways. For these organizations to move into some of the other potentially fundable service areas offered by CBO's, however, FBO practitioners may need specific skills training and/or certification. To address this and related issues, members of the Committee have taken on several projects (on their own volition and with no additional funding), including the following:

1. **Develop and manualize an interfaith advisory counsel for CBO's.**

   FCBT members are currently providing regularly-scheduled meetings of interfaith representatives in existing CBO settings. It is the intent of these attendees to help these CBO's integrate pastoral/spiritual counseling into the fabric of their treatment assessment, planning, and service protocols. This group believes it is also important to have representatives of CBO's participate in existing FBO settings, in order to familiarize these FBO practitioners with the best practices that have evolved in those CBO settings. Interested parties can find current information on this initiative by contacting Chris Yarnold at CYarnold1@aol.com.

2. **Develop a Mentoring/Shadowing program for the staffs of FBOs and CBOs to actually work with their counterparts to learn the similarities and differences in the two service environments.**

   The Net Institute (providing addiction certification related training for persons from FBO's) has begun a Shadowing Program for its students, with the first group of four working with staff at the Center for Drug Free Living in Orlando. Mr. Charles LaCour is the contact for this program and can be reached through 407-222-9913.

3. **Develop baseline information on existing FBOs in the State of Florida and send this as a Resource Guide to both FBOs and CBOs.**

   The leadership of Florida's Faith-Based Coalition (FFBC) has developed a Resource Guide and it is available through the Florida Department of Children and Families, Substance Abuse Office and the Florida Faith-Based Coalition.

4. **Develop a Screening Instrument to assess Religiosity.**

   The first version of this instrument has been developed and is in validation testing at the time of this Report. The basis of this instrument is a series of questions, intended to identify the level of Religiosity of the respondent. Those questions are attached as Addendum D. For further information on this instrument, please contact Mr. John Glenn at 772-288-3040.

5. Begin writing up issues and options regarding education and training for both FBOs and CBOs (Addendum E).

Florida Faith and Community Based Treatment Committee (FCBT) members have begun development of a Curriculum for FBO's interested in training their personnel to work in the many FBO addictions service settings. This curriculum is in process at the time of this Report. Interested parties can find out more information by contacting Mr. John Glenn at 772-288-3040.

6. Develop a Position Paper on "moving FBO's toward licensure, certification, and credentialing."

This issue closely reflects the conversation around the fact that some FBO's desire to move their personnel towards credentialing within the established framework of addictions professionals, where others want create a separate credential for FBO's that is recognized by regulatory authorities. The Position Paper which would articulate the many issues around this issue has not yet been completed, though draft sections have been completed. There is currently no specific time frame for completion of this paper, but interested parties could contact Mr. Charles LaCour at 407-222-9913 for more information.

7. Begin to share important information with counterpart newsletters.

It is the hope of the FCBT members that this Report will serve as the basis for initial sharing of information in the newsletters of both the Florida Drug and Alcohol Association (FADAA) and Florida's Faith-Based Coalition (FFBC). These organizations can be reached through 850-878-2196 (FADAA) and 352-351-0003 (FFBC).

Recommendations
from the
Florida Faith and Community Based Treatment Committee

1. **FCBT should seek funding to continue their process.** As one member stated: "We are not coming in for a landing - we are just beginning to launch our ideas." (The state of Florida Compassion Fund was mentioned as one possible source for this funding.)

2. **FCBT should develop a mentoring/coaching mechanism that is bi-directional in its scope**, meaning that both FBO's and CBO's have much to learn from each other**.**

3. For the sake of those in need of addictions-related services, it may be most advisable for **FBO's to work on recovery support services** such as long-term housing and care for substance abusers and dependent persons.

4. It should be made clear to those FBO's seeking funds that they will have to follow the state/federal regulations re: the reception of those funds. In other words **FCBT should educate those groups as to what "strings" are attached to funding**. Because of the reality of those funding constraints, money should NOT be a main motivational operant for FBO's.

Addendum A

Traditional CBO Addiction Service Continuum of Care (Florida)

Modality	Service Description
Prevention	Prevention services are generally provided in two levels depending on the intensity, duration and target populations served. In Level 1 services are typically directed at the general population or specific subpopulations. Level 2 prevention services are typically directed toward individuals who are manifesting behavioral effects of specific risk factors for substance abuse. This level may offer counseling for non-drug treatment issues, geared at reducing risk factors and increasing protective factors. **Specific Prevention Strategies**. The following is a description of the specific prevention strategies: (**a) Information Dissemination.** The intent of this strategy is to increase awareness and knowledge of the risks of substance abuse and available prevention services. **(b) Education**. The intent of this strategy is to improve skills and to reduce negative behavior and improve responsible behavior. **(c) Alternatives.** The intent of this strategy is to provide constructive activities that exclude substance abuse and reduce anti-social behavior. **(d) Problem Identification and Referral Services**. The intent of this strategy is to identify children and youth who have indulged in the use of tobacco or alcohol and those who have indulged in the first use of illicit drugs, in order to assess whether prevention services are indicated or referral to treatment is necessary. **(e) Community-Based Process.** The intent of this strategy is to enhance the ability of the community to more effectively provide prevention and treatment services. **(f) Environmental.** The intent of this strategy is to establish or change local laws, regulations, or rules to strengthen the general community regarding the initiation and support of prevention services. **(g) Prevention Counseling.** The intent of this strategy is to provide problem-focused counseling approaches toward the resolution of risk factors for substance abuse. Such factors include conduct problems, association with antisocial peers, and problematic family relations and to enhance the protection from identified risks. This strategy does not involve treatment for substance abuse.

Modality	Service Description
Treatment	
Assessment	The assessment needs to consist of a life history inclusive of medical conditions, social history, mental health and substance abuse/chemical dependency conditions both past and present and a spirituality evaluation The assessment will be most effective should it include an accurate appraisal of strengths, needs, abilities and preferences. These will be incorporated throughout the continuum of care to gain best value in treatment. It is further recommended that a physical examination be performed to rule out any bio-medical complications.
Intervention	Intervention programs are designed to "intervene" early in the problem use patterns of individuals. Services usually incorporate a variety of specialized educational opportunities, counseling support, treatment intervention and pro-social motivational services. Often clients are deferred from criminal actions, such as in the instance of DUI offenses or other first-time misdemeanor charges, based on their participation in intervention programs. Workplace initiatives are also included in this service array.
Detoxification	Detoxification services most often occur in either an inpatient or a community-based setting. These services involve several procedures for therapeutically supervised/medically managed withdrawal and abstinence over a short term (usually 5 to 7 days but sometimes up to 21 days), often using pharmacologic treatments to reduce patient discomfort and reduce medical complications such as seizures. This modality offers a high level of structure and monitoring.
Outpatient	Outpatient AOD treatment incorporates several approaches, models, settings, and philosophies. The most obvious difference among outpatient treatment programs is level of care. Outpatient treatment ranges from traditional outpatient services to intensive outpatient treatment (IOP) programs. Traditional outpatient treatment typically involves services provided by clinical addiction professionals in organized clinical settings. This treatment occurs in regularly scheduled sessions, with usually fewer than 9 contact hours per week. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with self-help activities. Because traditional outpatient treatment involves a limited number of sessions per week, it has been described as non-intensive treatment. Outpatient services can however incorporate treatment topics and use group processes consistent with those used in more intensive service settings (e.g. residential).
Intensive Outpatient	In contrast, intensive outpatient treatment consists of regularly scheduled and structured sessions with a minimum of 9 treatment hours per week. Examples or models include day or evening programs in which clients attend a full spectrum of treatment programming while living at home or in a special residence. Within the AOD treatment continuum, intensity decreases over time if an individual meets treatment goals. For example, clients receiving AOD treatment may initially be placed in inpatient settings during withdrawal, followed by intensive outpatient treatment and continuing care. Variants of traditional outpatient treatment and intensive outpatient

Modality	Service Description
	treatment can be adapted to meet the needs of diverse client populations.
Day or Night Treatment	Day or Night Treatment is treatment provided on a nonresidential basis at least three four hours per each day and at least 12 hours each week and is intended for clients who meet the placement criteria for this component. Clients typically receive therapeutic services that include a combination of individual counseling, group counseling**,** or and counseling with families, as well as supportive therapeutic services such as substance abuse education, life skills training, education and employment support and non-verbal therapies.
Opioid Substitution Therapy	Methadone and, more recently, LAAM (levo-alpha-acetyl-methadol) and Buprenorphine are used as opioid substitutes in the treatment of opiate users. Opioid Substitution Therapy, usually called Methadone Maintenance Therapy, is designed to reduce illegal and harmful opioid use (e.g. heroin, codeine, dilaudid, oxycodone) along with the many problems associated with this addiction. The main outcome of this treatment intervention is to decrease and even eliminate opioid use to help stabilize the individual so that he/she will not return to previous substance abuse behavior patterns. Treatment consists of a prescribed daily dosage of methadone or other medications, based on patient's weight, usage, tolerance and withdrawal symptom history, and medical history. Opioid substitution medications may be used in conjunction with some combination of 12-step meetings or counselor-led recovery groups or therapy groups which take place after patients get their medication. In addition, those involved in methadone maintenance treatment receive social, vocational, legal, and educational support services.
Inpatient	The most intense levels of treatment are medically managed and medically monitored intensive inpatient hospitalization. At these levels of care, patients are hospitalized. They can receive treatment for detoxification, medical problems associated with or unrelated to addiction, and psychiatric disorders, although not all individuals need these services. Participants also engage in psychosocial treatment for addiction that can include education, group therapy, and self-help. Medically monitored intensive inpatient treatment usually provides 24-hour nursing care under the direction of a physician. In contrast, medically managed intensive inpatient treatment has 24-hour medical care in an acute medical-care setting. This approach is valuable for patients who have severe withdrawal or biomedical, emotional, or behavioral problems that require primary medical treatment.

Modality	Service Description
Residential	Residential treatment incorporates several different models, approaches, and philosophies for the treatment of AOD disorders that involve cooperative living for people receiving treatment. Specific residential treatment approaches with various lengths of stay have been designed. Residential treatment programs vary with regard to intensity of treatment. Some programs provide treatment services 8 or more hours a day, 5 to 7 days a week, with clinical staff available both days and evenings. Other residential programs are recovery homes for employed residents, with evening and weekend AOD treatment and limited onsite staff supervision. Florida has 5 levels of license categories for residential services: • Level 1 is short-term treatment with an emphasis on therapeutic services intended to stabilize clients with behavioral, emotional, and social problems associated with a substance abuse disorder and to develop recovery skills to permit placement in a less restrictive level of care. The structure of this level of treatment allows for close observation of sub-acute biomedical or psychiatric problems. • Level 2 involves a longer length of stay than level 1. Level 2 provides a controlled therapeutic environment that can be effectively used to intervene in the habitual, destructive life styles and anti-social value systems of clients while training clients in the skills of recovery. • Level 3 involves a length of stay greater than either level 1 or level 2. While offering the same types of services as level 2, it provides a slower paced treatment presentation in order to accommodate mental health problems, lower cognitive functioning, the chronic nature of the client's illness, or clients with urgent social responsibilities such as taking care of children. • Level 4 involves a length of stay appropriate to the needs of the clients served and the goals of the provider. Level 4 offers low intensity services and a setting for transitional living. Services address the maintenance of recovery skills, prevention of relapse, promotion of personal responsibility, and the reintegration of clients into the world of work, education, family life, and independent living • Level 5, as in level 4, involves a length of stay appropriate to the needs of the clients served and the goals of the provider. However, level 5 provides only housing and meals within the residential facility. Therapeutic services are provided on a mandatory basis at locations other than the primary residential facility and in accordance with operating procedures established by the provider. In this case, facilities used for room and board and for therapeutic services are operated under the auspices of the same provider. The physical environments of residential treatment programs vary greatly. The environments include hospitals, facilities on hospital grounds, institutional housing, multi-room houses, sections of apartment complexes, and dormitory-like structures. Residential treatment programs also vary in philosophical approach.

Modality	Service Description
Recovery Support	
Transitional Care/Aftercare Services	Clients who have successfully completed residential treatment, day or night treatment with host homes, day or night treatment, intensive outpatient treatment, outpatient treatment, or medication and methadone maintenance treatment are eligible for aftercare services (post primary treatment). Typical services offered are: relapse prevention, counseling sessions, identification of and referral to ancillary services and monitoring or client progress including follow-up on all referrals. Case management is often provided as a transitional or aftercare service. Case management generally can be described as a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals. Case management lends itself to the treatment of substance abuse, particularly for clients with other disorders and conditions who require multiple services over extended periods of time and who face difficulty in gaining access to those services.
Self-Help Recovery Groups	Self –help support groups such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Alcoholics for Christ, Women for Sobriety, etc. comprise additional community based supports that supplement professional treatment. Most treatment programs utilize the self-help support programs to assist in the provision of a continuum of care. This modality is often the only affordable ongoing care the individual has available once the professional therapy is discontinued.

FBO Addiction Service Continuum of Care

Modality	FBO Service Description
Prevention	
	Specific Prevention Strategies. The following describe some examples of FBO prevention strategies: (**a) Information Dissemination.** FBOs disseminate information in several ways, including: - Sermons that build awareness about addictive disorders; - Classes and written information that teach signs and symptoms; - Programs that aim to strengthen families and single parent families; and - Church bulletins and newsletters. **(b) Education**. FBOs provide a variety of addictions-related education activities including: - Parenting and family classes; - Life skills for all levels, such as: o Anger management, o Boundaries, o Co-dependency, & o Financial and debt management. - Utilizing Sunday School to provide sequential information; & - Recruiting guest speakers. **(c) Alternatives.** FBOs provide many alcohol and drug free alternative activities such as: - After school programs; - Homework assistance; - Youth groups and activities including music, drama, sports, & missions; - Vacation Bible School; - Summer Camp; - Mom's Day Out; & - Respite Care.

Modality	FBO Service Description
	(d) Problem Identification and Referral Services. Many FBOs have an assessment and/or referral service that refers to both FBOs and CBOs, plus many are affiliated with denominational treatment centers and counseling services. **(e) Community-Based Process.** CBOs directly and indirectly work with neighborhoods and communities to promote alcohol and drug-free activities and lifestyles through both denomination-based programs and as a part of nondenominational community programs. **(f) Environmental.** Many CBOs work with existing regulatory and governmental entities to establish or change laws, regulations, or rules to build the community's strength and skills regarding prevention services. Specific denominational activities include such things as letter-writing campaigns to rid neighborhoods of drug dealers, and encouraging parishioners to join and support local anti-drug and prevention agencies. **(g) Prevention Counseling.** Many FBOs have Pastoral Counseling components that work directly and indirectly with individuals and families to resolve substance abuse risk factors. NOTE: This is different than treatment of recovery support counseling services, which are described below.
Treatment	
Intervention	Many FBOs intervene both formally and informally in situations where their denomination members require assistance in getting a friend or loved one into addictions services.
Detoxification	Detoxification is a medical service that is provided in various settings. Most FBOs assist in getting individuals to detox or assisting them upon completion of this service.
Outpatient	Typically, FBO outpatient is a group setting that meets approximately once per week. It is rare that FBO pastoral services include ongoing individual addictions-related counseling.
Intensive Outpatient	Structured outpatient FBO groups rarely conform to the definition of "Intensive Outpatient" as offered in the attached Treatment Continuum.
Day or Night Treatment	FBOs rarely provide day or night treatment as defined in the Treatment Continuum.
Opioid Substitution Therapy	Opioid Substitution (or "Methadone Maintenance") Therapy (MMT) is a regulated pharmacological treatment that is inappropriate and illegal for all but certified providers.

Modality	FBO Service Description
Inpatient	These are the most intensively medically managed or monitored levels of care. These are inappropriate for any non-licensed facility.
Residential	Some FBOs provide residential treatment, which is usually seen as a transitional living situation. These are usually of two types: 1. "Deep End" programs such as Teen Challenge and Dunklin Memorial, 2. Those programs that integrate into transitional living settings with services that include such things as job placement, AA/NA, skill building, etc., and are often of 6-9 months duration.
Recovery Support	
Transitional Care/Aftercare Services	FBOs typically have two settings for transitional programs: 1. Residential: These FBO programs usually get referrals from prisons, primary treatment providers (detox, residential or outpatient), or from the community at large (homeless, dual diagnosed, families, churches, courts, etc.). The services they offer often include: a. Room & board, b. Transportation to work &/or training/education, c. Self-help support meetings, d. Bible Study (optional), e. Life Skills classes, f. Employment, g. Clothing, h. Administrative Case Management, & i. A Physical plant. 2. Non-residential: These programs usually provide such service as: a. Transportation, b. Classes and/or groups (self-help, Life Skills, Relationships, work training, relapse prevention, etc.) c. Individual and group therapy, d. Mentorship, e. Church/social/spiritual activities, f. Volunteer opportunities, g. Ancillary services, &

Modality	FBO Service Description
	h. Alumni activities.
Self-Help Recovery Groups	Many FBOs and churches offer space for 12-step meetings, plus some offer their own support groups.

FBO-Defined Addiction Services

Community Outreach (Prevention Services)

A.) Addictions Awareness
1.) Increase awareness through sermons, workshops, seminars, publications, etc. about the suffering related to addictive disorders.
2.) Strengthen families and single parent families through parental awareness and groups.
3.) Strengthen youth by building developmental assets.

B.) Educational ministries for addictions.
1.) Parenting & family classes.
2.) Connect 12 steps with spiritual goals.
3.) Life skills at all levels.
a.) Anger management
b.) Boundaries
c.) Co-dependency
d.) Financial & debt management.
4.) Utilize Sunday school to provide sequential information on recovery.
5.) Recruit/utilize guest speakers from within the recovery community.

C.) Alternatives: building developmental assets
1.) After school programs.
2.) Homework assistance.
3.) Youth activities including: music, drama, sports and missions.
4.) Vacation Bible school.
5.) Summer camp.
6.) Mom's Day out.
7.) Respite care.

Screening and Referral Services (Assessment/Intervention Services)

Pastoral Counseling
1. Recognition of signs and symptoms of addiction
2. Identification of level of recovery needed (community groups, halfway house, residential)

Pastoral Referral
1. Assistance and encouragement to enter into treatment
2. Monitoring progress with individual and family members

Self –help support groups
1. Initiate and maintain community group meetings
2. Train and oversee group leaders and facilitators of such groups.

Community Recovery (Outpatient/intensive outpatient services)
Services involving a commitment to weekly counseling sessions, recovery classes and groups in addition to traditional ministries involving Bible study, accountability groups, worship, and prayer groups.
Develop and monitor personal recovery plan that includes:

1. Individual counseling sessions
2. Weekly psycho-educational classes
3. Recovery support groups
4. Mentoring/ sponsorship
5. Family counseling

Structured Recovery (Residential treatment services)
Services involving residence in a structured program that requires outside employment, i.e. halfway houses and sober houses, clients come from self-referral, community referrals, or court referrals.
Provide a structured program for recovery that includes:

1. Residence in a group setting with others in recovery
2. Participating in assigned chores to maintain residence
3. Gainful employment in the community to pay for recovery and obligations
4. Participation in daily meetings, classes, and groups in the evenings
5. Participation in individual counseling
6. Ancillary services as needed

Residential Recovery (Inpatient treatment services)
Services involving residence in a program in which the client works and learns within the confines of the program, clients come from same referral sources.
Provide a structured program for recovery that includes:

1. Residence in a group setting with others in recovery
2. Participation in daily meetings, classes, and groups throughout the day
3. Participation in individual counseling sessions
4. Participation in assigned work crews to sustain residence and program industry.
5. Ancillary services as needed

Transitional Recovery (Transitional/ aftercare services)
Services specifically for the ex-offender with substance abuse issues, clients referred by DOC.
Provide a structured program for transition that includes:

1. Residence in a group setting with others in transition
2. Opportunity for meaningful employment within the community
3. Aftercare services for recovery and deinstitutionalization
4. Participation in individual counseling
5. Ancillary services as needed

Addendum D

Suggested Religiosity Questionnaire

1. Do you consider sharing your faith an essential part of the services your organization provides?

2. Is it mandatory for your clients to participate in religious rituals and activities of your program?

3. Is participation in religious activities and rituals considered necessary to successful recovery?

4. Are your social services a means of recruiting members into your organization?

5. Do you consider it your obligation to convert others to your religion?

6. Do you endorse the AA 12-step program of recovery?

7. Do you make a distinction between religion and spirituality?

8. Are you and your staff aware of the signs and symptoms of religious addiction?

Note: this is not a validated questionnaire, rather a set of questions that CBOs can use to determine the level of religiosity of faith-based organizations they may want to involve in partnerships. These questions were developed and recommended by the FBOs on this Florida committee.

Addendum E

Faith-Based Addiction Professional (Proposed Curriculum)

In addition to the requirements for a CAP or CAAP2 these specialists need 28 hours of special education broken into 7 four-hour blocks. An overview of the syllabus for this training is as follows:

1. **The Faith Factor**
   - The role of faith in recovery
   - The faith factor in cognitive restructuring
   - Judeo-Christian philosophy of personal worth
   - Spiritual roots of AA's 12 steps
2. **Characteristic of Toxic Faith**
   - 21 beliefs of toxic faith
   - Coercive persuasion and proselyting
   - The religious performance trap
   - Shame-based identity and the loss of hope
3. **Religious Addiction and Spiritual Abuse**
   - Symptoms of religious addiction
   - Relational dynamics of spiritual abuse
   - Religious addiction and relapse
   - Authentic faith and the hope of recovery
4. **Faith-Based verses Fear-Based Organizations**
   - Personality-driven and agency-driven organizations
   - Leadership styles and common forms of governance
   - Breaking down the barriers to collaboration
5. **Recovery as the Mission of the Faith Community**
   - Recovery as the primary mission
   - Integration of AA and the faith community
   - The synergy of partnerships in recovery
6. **Residential Recovery Support**
   - Transitional housing services
   - Full residential recovery services
   - Programs and curricula
7. **Non-residential Recovery Support**
   - Community recovery support program overview
   - Outreach, screening, and engagement activities
   - Follow-up and ongoing support ministries
   - Programs and Curricula

Addendum F

Sacred/Secular Synergy: A Commentary on Models for Collaboration

By John C. Glenn
June 27, 2003

Introduction

The sacred and the secular may seem worlds apart when it comes to many issues having to do with the American society in general and the government in particular. Yet when it comes to the area of social services, they may be much closer than we think. The president's faith initiative has focused the public eye on the distinction between the sacred and the secular, especially when it comes to supporting faith based organizations with public dollars. But can this distinction be clearly defined when it comes to serving those in need?

The charitable choice act has permitted funding certain social service providers as long as they provide "secular" services rather than the "sacred" services of "proselytizing, religious instruction, or evangelizing". While it has been relatively easy to separate out the secular from the sacred in such social services as job training, child care, transportation, and other forms of "commodity benevolence"; it is more difficult to draw the line of distinction in preventing or treating drug and alcohol addiction. The reason is that the secular and the sacred seem to come together in serving those in recovery from substance abuse and mental health issues.

For faith based organizations (FBOs) providing such important social services it becomes difficult to avoid that which may be termed "religious instruction". While they may be able to demonstrate the fact that their program does not engage in "proselytizing" or "evangelizing", the very nature of **their** tools for recovery require an understanding of religious doctrine that may be viewed as "religious instruction". To avoid such a pitfall it is necessary to make an important distinction between "religious instructions" and "spiritual" instruction. Religious instruction may be seen as coercive, threatening, other-directed, fear-based, manipulative, and self-centered in nature. The concern here is that the civil rights of those served may be somehow violated if they are somehow forced to believe or do something they do not wish to believe. For those suffering from substance abuse, this may mean that they would be somehow compelled to believe or do something they were not ready to accept in order to be "successful" in a recovery program.

But what about the treatment of substance abuse in the secular program? Do they not face the same dilemma as their faith based counterparts with those suffering from addiction? If their client is really going to recover, will it not take a radical change in their belief systems, emotions, and behavior? And do not the secular treatment programs being funded by tax dollars have coercive, threatening, fear-based methods seeking to change the clients thinking, feeling, and behavior? Remember the fear-based prevention programs sponsored by the government whose slogan was "just say no"? Graphic

depictions of brain damage due to substance abuse were illustrated by a picture of an egg in a frying pan.

Both the sacred and the secular want the same thing when it comes to preventing and treating substance abuse, a radical change from the inside out of a person's beliefs, feelings and behavior. The question is, "How do people change?" What is the agent of change for people who suffer from addiction? The stage is now being set for a partnership between the sacred and the secular approach to prevention and treatment of substance abuse and other disorders. Taking the best from both the sacred and the secular, we may discover a useful method of helping others recover without violating their civil rights by coercive techniques. This method would be holistic in the sense that it would address the physical, personal, relational, social and spiritual issues that we humans have, and offer a genuine means of change that involves the free choice of the client at every step of the program. This synergistic program may be referred to as regeneration rather than rehabilitation, since whatever change may occur is a consequence of becoming a new person (regeneration) rather than returning to the former state (rehabilitation).

The spiritual approach to prevention and treatment of substance abuse involves an individual faith that is unique to each person. That is, it cannot be forced upon another from without by various coercive means, but rather arises from within the individual as a consequence of their own realization of what they have already been given. Neither is it based upon a need to compensate for the guilt of past failures and transgressions, but focused only on divine provision rather than human effort, whether sacred or secular. A shift in focus from self-effort to divine provision brings a genuine sense of hope and confidence that allows us to actually think about others more than ourselves. The spiritual approach to recovery from all forms of dysfunction is always expressed outwardly in acts of love and compassion for others.

Real and lasting change requires more than simply recognizing the need. While all good treatment programs will spend a great deal of time bringing the client to the realization that he needs to change his thinking, feelings, and behavior; that insight alone is not sufficient for recovery. To know that we need to change is not enough to actually change us. Quality care in substance abuse treatment must also provide the client with the tools necessary for real and lasting change.

But what are these tools? What is it that actually gets the job done? The testimony of many recovering addicts indicates that it is not a "what" at all, but rather a "Who" that brings about real recovery. They insist that their own recovery is the consequence of a miracle in which God did for them what they could not do for themselves. The "tools" that were used were simply the 12 steps of AA applied personally to them within the framework of a loving social network of people who were themselves in recovery.

At the very core of the 12 step program of AA is authentic faith in the ability and willingness of God to "do for us what we cannot do for ourselves". This does not mean the individual is completely passive and just miraculously recovers, but rather that his

own self-effort to change his thinking, feelings, and behavior is not sufficient. There must be a divine intervention that is brought on by the exercise of authentic faith. While the secular program suggests faith in one's self to change thinking, feelings, and behavior; (or more likely refers the individual to AA meetings after proving that he has a problem), the spiritual program will direct that faith toward God. Learning to depend upon what God has and is doing for us to make us new, is a powerful incentive to trust him and his power to control our lives.

The best example we have today of a spiritual program that combines the best from the secular and the sacred is that of Alcoholics Anonymous. One of the clearest pictures of a faith-based organization (or maybe even a church) is what we recognize as Alcoholics Anonymous. The proliferation of AA groups around the world since 1935 has illustrated in modern history the real nature of the first century church. Led by *volunteers* who recognize their own need to serve others, AA groups illustrate many of the same characteristics that Jesus used to describe how his church was to operate. The genuine love, acceptance, and forgiveness so desperately needed by those suffering from the throes of addiction are expressed in one form or another in the various community meetings of AA. The willingness of those who are further down the road to recovery to use whatever means they have to help newcomers, reflects the genuine love Jesus required of the church and was demonstrated in the first few weeks and months of its existence in Jerusalem. The now famous 12 steps of AA is a spiritual program that applies the biblical truths necessary to lead another to the kind of faith in God that is required for personal freedom, not only from the bondage of addiction, but also from a self-centered life.

When defined in relational rather than religious-legalistic terms, a religious institution takes on an entirely different look. Perhaps the most significant expression of religious institutions in modern times apart from AA is the quiet, dedicated, and loving people employed by the state and community based organizations to serve the needs of hurting people as a calling, not for the sake of a job. Throughout the years there have been a multitude of social servants quietly ministering to the needs of others as a vocation. Because a secular agency or the government pays them, they have been summarily classified as social workers, case managers, counselors, etc., but never as "ministers."

Due to some stories of abuse by such agencies, however, those who truly seek to minister to the needs of others are often stereotyped as uncaring bureaucrats looking for a cushy job. Among the most critical are the religious-legalistic (toxic faith) people who see true ministry as happening only on Sunday morning in the sanctuary of a "religious entertainment center." Toxic faith people typically complain that the secular agencies are anti-religious and are not really helping people because they will not promote their particular religious agenda. In short, they believe the only way to serve people effectively is to proselyte and recruit new members into their own religious organizations. This is the give-away to their true motivation. It is focused upon recruitment not on assistance. Helping others becomes a means to an end, not the end in itself.

For this reason the issue of church-state separation has been distorted in recent times by the reaction of the *secular caregivers* to the criticism of the *religious entertainers*. If what is meant by "the church" is the "religious entertainment centers" practicing their religious rituals, then the state and community based providers need to be totally separated from such "fear-based organizations." If, however, a religious institution or church is defined as those who are actively serving the needs of others *in a practical as well as a spiritual way*, then the state needs to be grateful and supportive. True faith-based organizations are generally too busy to be religious in nature and are continually looking to serve the needs of others rather than themselves. Many of the "Para church" organizations working with society's outcasts at the community level qualify as true faith-based organizations that need to be recognized by the state as being worthy of appreciation and support.

Reaching Out For Professionalism

What this paper is about is simply a history of what has been done in Florida in a small segment of the Christian recovery community to reach out to and collaborate with CBOs and government agencies. It recognizes the tremendous synergy that will flow from genuine collaboration and partnerships between the secular and the sacred. My hope is that the reader, whether secular or sacred, will be encouraged in their own efforts, enlightened by such partnerships, and empowered to provide better care for those who are struggling with addiction.

Although Florida has enjoyed many years of recovery services by the faith community, these services have been overlooked due to the fact that they were not defined as licensable components requiring certified providers. Until recently, these services were largely viewed as simply "support" services under the church umbrella that may or may not be of help to those in recovery. Lacking any empirical data or scientific research to prove their effectiveness, the services offered by FBOs to those in recovery were not considered to be of any real value to anyone except, of course, the recipients and their families.

Two FBOs in South Florida that led the way for Christian recovery services, Faith Farm Ministries and Dunklin Memorial Camp, were founded some 40 years ago. Together these two ministries alone have provided a total of 385-400 beds for men in recovery at no cost to the state. From the historical work of these two organizations came a number of halfway houses and other residential programs that came into existence all around the state. Following their example and training these other FBOs began to offer the same sort of services for men, women, and adolescents. It is difficult to determine an accurate number of residential beds in Florida today, but a conservative estimate would be 1500 to 2000.

In addition to the residential services many FBOs have historically provided community recovery services through structured group meetings such as Overcomers, Pressing On, In Christ, Celebrate Recovery, and a host of other recovery oriented groups. It is

impossible to estimate the number of people benefited by such support groups in terms of prevention, and treatment of the addicted.

From this rich history of Christian recovery in Florida came a desire to train others to meet the state requirements for certification. Originating at Dunklin Memorial Camp a group of ministers interested in training others to be effective in recovery ministries decided to expand their training to include the course work necessary to obtain certification as an addiction professional. Two tracts were proposed, a certification tract and a ministry tract. Those students wishing to pursue certification would be required to attend courses offered by addictions professionals who were also Christian people. Those who simply wanted to minister to others without the addictions certification could simply follow the ministry training tract.

From this rich history of Christian recovery originating at Dunklin Memorial Camp came a desire for training for "The NET," a loose relational network of Christian recovery ministries that began meeting in the 1980's for mutual support and encouragement. The founding group with the vision for a more formalized training project included Rev. Ron Ross of NET Ministries, Charles and Jean LaCour, and Tom Sledd CAP who recognized the need for Christian workers to systematically access current information from the addiction field. They decided to develop the curricula based on an "external standard" of the knowledge, skills and attitudes recognized in the addiction field to complement the rich Christian recovery traditions and models already established across Florida. This pivotal decision led to a meeting in July 1995 with Neal McGarry, the Executive Director of the Florida Certification Board. Mr. McGarry graciously encouraged the group to submit sample curricula and an application to the Board to become a recognized training provider. Mr. McGarry noted that many of Florida's certified counselors were people of faith who might appreciate such a training venue.

A program of 300 hours of Christ centered instruction was developed which included recovery ministry, addiction, counseling and ethics content which would also prepare students who wanted the option of pursuing certification through the Florida Certification Board. Additional ministry courses were also available. A notable faculty was assembled of experienced recovery pastors and practicing in field professionals "with a Christian heart". Many gifted teachers with "letters" like CAP, CAPP, LMHC, LCSW, LMFT, PHD, RN, and MD eagerly stepped forward to share their clinical skills, knowledge, ethics and faith with hundreds of NET students in five Florida cities. In 2000 the NET Training Institute became a licensed career education institution under the Florida Department of Education offering home study courses as well as five registered programs including an Occupational Associates Degree in Addiction Studies with 1200 hours of study. The Institute also became a national training provider through NAADAC and internationally through the World Federation of Therapeutic Communities and provides professional faith based training in multiple nations. By 2002, 29% of NET students have achieved some level of state counselor certification. Dozens of students have been employed in various state agencies, started new recovery ministries, supported church programs and have applied their practical addiction training stateside and overseas .

The NET Training Institute, headquartered in Orlando, was birthed to serve the training needs of an informal statewide network of Christian recovery ministries and has served as a bridge in networking faith based individuals with various state agencies concerned with substance abuse. It was the initial work of Jean and Charles LaCour advocating for their students that opened the door to more serious dialog with Ken DeCerchio, Director of the Florida Substance Abuse Office, when they met in December 2000 at a dinner hosted by Neal McGarry and the Florida Certification Board. A milestone was reached in the spring of 2001 when Jean invited Ken DeCerchio to the 18th annual NET Conference at a church in Titusville so he could "see for himself" the hundreds of Christians involved in substance abuse ministry in his state. During that conference Ken met with the LaCour's, John Glenn, Rico Lamberti, Bernie DeCastro and several representatives from Teen Challenge to discuss the possibilities of FBOs being recognized by the state as providers. Although there were many more questions than answers, this meeting set the stage for more dialogue between the two systems.

It was also at that conference that the Florida Faith Based Association was first established by Bernie DeCastro, John Glenn, and Rico Lamberti. The idea of FBOs actually becoming licensed by the state and receiving public funds for services was first presented by John Glenn citing the recent contract with DCF as an example. Alpha/Lamb of God Ministries had received a contract from DCF to work with children at risk of substance abuse in Okeechobee County. The theme of this discussion was that FBOs could actually work with the government in providing social services without fear of encroachment. Important lessons concerning organizational capacity of the FBO as well as money motivation were yet to be learned, but the overall reaction of those present suggested that progress was being made.

One final outcome of this first meeting with Ken DeCerchio was the appointment of John Glenn and Bernie DeCastro to the 65D rules committee meeting to define the minimum standards of care required of all licensed providers. Over the next few months both Glenn and DeCastro had a "crash course" on the bureaucratic "nightmare" licensed providers routinely handled and questions concerning the legitimacy of FBOs receiving recognition and funding for similar services without having to face the same "nightmare". The meaning of a "level playing field" appeared to be different for the secular and the sacred. The secular defined it as simply not discriminating against a provider simply because it was a FBO. The sacred defined it as trimming down the "red tape" by lowering the minimum standards. This disparity between the two sides caused much tension and misunderstanding and raised many of questions concerning the legitimacy of FBOs providing quality services much less receiving public monies for them.

The development of the FFBA was energized by the appointment of Bernie DeCastro and Rico Lamberti to the Governor's task force on self-inflicted crimes in the summer of 2000. As a part of their duties on the task force DeCastro and Lamberti were able to arrange testimony from FBOs around the state that began a dialogue between grassroots FBOs and the various government agencies concerning how they could work together. In addition to becoming aware of the diversity and extent of services offered by FBOs, the task force was also enlightened to the potential synergy in working together on Senate

Bill 912 that would allow funding for 400 faith-based transitional beds for ex-offenders. This was viewed as a pilot project for collaborations between state agencies and FBOs. On the faith side, the actual proposal for such a partnership sparked a tremendous interest in FBOs around the state that were curious to learn more about the possibility of funding and recognition by the state government. With the passing of the bill in 2001 came a series of meetings sponsored by the Department of Corrections to find qualified FBOs for partners. The work of Richard Nimer, Pam Denmark, and Chaplain Taylor, in reaching out to FBOs interested in contracting with the department was exemplary. The standards and requirements they developed were both streamlined and sufficiently FBO-friendly to encourage the 22 providers that entered into partnership. Much has been learned from this first attempt, and much more needs to be understood on both sides.

Progress toward collaboration was made at the FAADA conference that same year. The FFBA was invited to conduct a workshop introducing the faith initiative in the State of Florida. Jean LaCour gave a brief history of faith based recovery in Florida followed by a presentation by Bernie DeCastro on the development of the FFBA. John Glenn wrapped up the workshop with a contrast between Faith Based and Fear Based organizations. The workshop was well attended by FADDA members celebrating their twenty-fifth anniversary and a tremendous interest was generated within the secular ranks to learn more about the faith initiative.

As the FFBA began to gain some momentum primarily through the work of Bernie DeCastro lobbying in Tallahassee, more individuals and agencies from both the sacred and the secular expressed a curiosity in the public debate concerning the president's faith initiative. The issues of public funds being spent for faith based services brought a tremendous amount of confusion and misunderstanding in both the sacred and the secular communities. Recognizing the need to,"level the playing field", to allow FBOs to compete for public funding through grants, the federal government issued mandates for the various social agencies to "remove the barriers" for their sacred counterparts. This action prompted a need for FBOs to also "remove the barriers" for collaboration and partnerships with their secular partners. The following were identified by John Glenn as "sacred barriers" to collaboration:

Money Motivation. The underlying reason for the faith initiative is simply that the government does not have the money to meet all the social needs. The reason for the curiosity of the faith community is to see what, if any, money they can receive from the government to provide their services. Thus, the two groups come together in a "tic on a dog" relationship in which both are looking to receive rather than give. To break down this barrier FBOs were encouraged to:

1. take the initiative to trust The Funder, our sovereign God, to provide the resources in many other ways besides grants
2. Use what resources they have at hand to minister to the needs of others.
3. Develop and promote a "giver mentality" rather than a "taker" mentality.
4. Look for creative ways to collaborate with CBOs instead of "reinventing the wheel".

Spirituality not Religiosity. FBOs need to know and declare the difference between authentic faith and toxic faith along three dimensions:

1. Authentic faith originates within the individual as a response to love, whereas toxic faith is forced on and individual by fear and shame.
2. Authentic faith is focused on divine provisions whereas toxic faith is focused on self-effort.
3. Authentic faith is expressed in an attitude of tolerance, acceptance, and unconditional love, whereas toxic faith is expressed in an attitude of manipulation and control leading to religious addiction and spiritual abuse.

Recognition of True Mission*:* True FBOs are unique social service providers in that their motivation for their services is first and foremost faith, not monetary reward. Their most powerful asset is the collective compassion of an army of volunteers who are willing to extend a helping hand just because they can. They are to be distinguished from religious organizations by the social services they provide as a result of authentic faith. Where true faith exists there will be hope. And when hope is present, there will be love in action. The true mission of the FBO is not to be a "holy huddle" for the religious elite, nor is it to be a "religious entertainment center" that spends the majority of its resources on the comfort and applause of those who watch the weekly show. The true mission of the FBO is to express compassion and recovery to the broken and wounded of our society.

This message was repeated to the various FBO meetings conducted by the FFBA around the state and seemed well received by most FBOs. The famous statement by former president, JFK, was adopted as a motto for this message, "Ask not what your country can do for you, but what you can do for your country".

In the spring of 2002 John Daigle of FADAA submitted to the Southern Coast ATTC a draft of a concept paper entitled "Joining Hands: A collaboration between the FFBA and FAADA" in which he outlined sever goals to enhance the dialogue between FBOs and CBOs. The ATTC was approached to provide technical assistance to bring a formal workgroup together to help achieve the goals set forth in this paper. John Glenn responded to this paper with excerpts from the latest draft of the vision for a faith based coalition of service providers and it was distributed at the Governor's Drug Summit of that year. The following is a copy of the initial work. John Glenn's responses are italicized.

Original Concept Paper/Technical Assistance Request to SCATTC

"Joining Hands": A Collaborative Effort Between The Faith-Based Coalition and the Florida Alcohol and Drug Abuse Association (FADAA)

Introduction

At both the national level and here in Florida, the stage is now set to harness the tremendous potential of the faith-based "armies of compassion." Both President Bush and Florida's Governor Bush have expressed their commitment and leadership to this initiative. Furthermore, here in Florida, in the area of substance abuse, we are particularly fortunate to have in existence a solid foundation of collaboration between Florida's community-based addictions treatment and prevention programs and Florida's faith-based organizations. Over the past year and a half, Florida's Faith-Based Coalition and the Florida Alcohol and Drug Abuse Association have developed a positive, cooperative working relationship based on mutual respect and common goals. The leadership of both organizations is committed to furthering this partnership for the sake of those individuals and families in need of a wide variety of services. As a result of this fledgling partnership, Florida is uniquely positioned to move the dialogue forward regarding the need for a real and productive collaboration between these two areas of service.

Proposal

Florida's Faith-Based Coalition and the Florida Alcohol and Drug Abuse Association (FADAA) propose to develop a model for an effective partnership between community-based substance abuse treatment and prevention programs and faith-based organizations. The model would include identification of agreed-upon roles of faith-based organizations in the area of substance abuse, as well as opportunities for collaboration and partnership between faith-based organizations and licensed community–based treatment and prevention programs. This 1-year project will involve representatives of both faith-based organizations and licensed treatment and prevention agencies in the following activities:

Development of Guiding Principles

Through a structured, facilitated process, "common ground" would be identified which would guide the model development.

Guiding Principles of the Faith Based Coalition

1. Because personal recovery requires a change in personal identity, faith-based organizations are able to address social ills using a set of tools not available to other government and community-based entities.

2. Faith-based organizations are, in some way or another, presently working to restore health and hope to Florida residents, and have much to offer in enhancing and expanding their services.

3. Performance standards must be identified in order to guide and empower faith-based organizations in providing excellent and professional services; performance standards for all services/programs/ministries that will maintain the integrity of their programs, yet improve and increase the delivery of services.
4. In order to reach desired successful outcomes, faith-based organizations must be allowed to continue to provide their services in their own style; services that are guided by spiritual principles and led by those who have experienced recovery themselves.
5. In order to address Florida's social problems, a comprehensive and coordinated effort by public/government, private and faith-based organizations is imperative.
6. Government needs to sanction efforts by faith-based organizations; allowing for less-restrictive operating standards, greater opportunities for funding and implementing necessary legislative actions.
7. Much has already been done by public/government, private and faith-based groups to address social ills. The best practices need to be combined and collaboration between all groups must be a priority.
8. It is time…in fact, imperative…to be able to document the success of faith-based programs and to quantify and measure, and ultimately plan future programs/services, through the collection of empirical data.

Identification of Resources and Competencies

-Identification of resources and strengths that faith-based organizations bring to the problem of substance abuse as well as limitations
-Identification of opportunities for and challenges to the involvement of the faith-based organizations in the area of substance abuse

Faith-Based Resources and Strengths

Perhaps the single most important resource faith-based organizations offer is the people who are willing to give freely of their time, energy, and money to fulfill and support the mission of loving others. Volunteers who are trained to deliver various services we call "ministries" are invaluable to helping others in recovery. It is the service of volunteers and donors that make faith-based treatment of substance abuse so cost effective.

Because faith-based providers are "licensed exempt" they enjoy a certain freedom from the bureaucratic demands to rationalize their existence and justify their services. While this does not mean they are not accountable for the quality of their services and the manner in which they manage their finances, their liberty from excessive documentation allows more of their resources to be channeled into direct services.

Since those served by faith-based organizations freely choose to enter such programs, faith-based providers have the liberty to fully utilize their unique tools for recovery in addition to the best practices and models identified in the field of recovery. Historically, the most effective tool for recovery from all kinds of dysfunction has been repeatedly demonstrated to be the 12-step program originated by AA. In addition to the twelve steps many faith-based organizations are using the Alpha Series, a biblically based psycho-educational class offering the client a new identity and set of personal, communication, and relational coping skills. These and other spiritual tools used by faith-based

organizations have been found to be highly effective in bringing about recovery from substance abuse and other forms of dysfunction.

Limitations and Challenges for Faith Based Organizations

Faith-based organizations could benefit greatly from commonly agreed upon performance standards and professional qualifications among those working in the field of substance abuse. The following goals of the newly formed Faith Based Coalition reveal the desire to overcome these limitations and challenges.

***Goal #2**: Identify methods, strategies and legislative measures necessary to empower faith-based organizations to continue, improve and expand human services delivery.*

1. *Provide the oversight necessary to insure small faith-based providers are in compliance with state requirements for church/non-profit status.*
2. *Inform and encourage faith-based providers to seek state funding for services. Teach the leadership of faith-based providers how to recognize their ministries as services that can be recognized and funded by the State.*
3. *Provide up to date and crucial information to both the government and the faith-based providers for future funding and program development needs.*

***Goal #3**: Identify performance standards and professional qualifications for faith-based organizations, as well as a credentialing organization for same.*

1. *Set minimum standards of care for each component of the continuum of care identifying specific goals designed to meet and maintain personal needs.*
2. *Set minimum qualifications for those who would seek to provide the services including ordination, experience and certification.*
3. *Establish accreditation criteria for faith-based organizations.*

Assessment of Service Needs

This process would involve a review of the gaps in Florida's treatment and prevention efforts to combat substance abuse, using existing service continuum models.

***Goal #4:** Meet the ongoing education, training and technical assistance needs of faith-based organizations. Organize, coordinate and develop a comprehensive and seamless continuum of care to meet the needs of residents.*

***Goal #5:** Act as the Information and Referral source for all faith-based services available in the state, and the intermediary between faith-based organizations and government agencies and/or community service providers.*

Matrix Development

The outcome of the above process would the development of a matrix that matches service needs with resources available through faith-based organizations.

The activities necessary to accomplish the above would include:

- a structured, facilitated retreat to launch the initiative
- a review of the research literature related to existing effective service models
- a series of workgroup meetings
- writing capacity to develop the proposed matrix

Summary

This project seeks to build upon existing proven leadership that has already established a foundation for collaboration. The result would be not only the furthering of this collaboration in Florida, but the development of a practical and useful tool for others interested in moving the current dialogue from a concept to reality.

Credentialing Procedures for Faith-Based Organizations and Nontraditional Service Providers

Access to Recovery (ATR) is a three-year grant awarded to Missouri in August of 2004 by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Funding will be administered by the Department of Mental Health's Division of Alcohol and Drug Abuse. All substance abuse assessment, clinical treatment, and recovery support services under this program are to be provided pursuant to a voucher or vouchers given to a client by the State or its designee. Eligible service providers for the voucher program may include public and private, nonprofit, proprietary, as well as faith-based and community organizations, as approved by the State.

Program Overview

Research has established that there are many paths to recovery from substance abuse or addiction. Some people are able to resolve their problems without outside intervention. Others recover with the support of self-help groups such as Alcoholics Anonymous, the faith community, or other community organizations. Some require clinical treatment interventions along with recovery support services.

ATR has three broad goals:

- To engage faith-based and nontraditional community providers in providing a broader spectrum of treatment services and recovery supports.
- To ensure genuine, free, and independent client choice for substance abuse clinical treatment and recovery support services.
- To improve access and increase capacity for substance abuse treatment and recovery support services.

In order to meet these goals, the Division of Alcohol and Drug Abuse will expand and enhance its existing substance abuse service delivery system by recruiting, training, and enrolling faith-based and nontraditional service providers on a statewide basis to provide an array of recovery support services, or ***recovery supports***. The ATR voucher program will be a collaborative effort between the recovery support service providers and the clinical treatment providers.

Recovery supports are often provided by paid staff or volunteers familiar with how their communities can support people seeking lives free of alcohol and drugs, and are sometimes peers of those seeking recovery.

Important things to know about participant rules for Access to Recovery:

- The ATR project is for adults only, ages 17 years and older, unless otherwise noted.
- The federal funding for this grant is allocated to the state on a year-to-year basis. Funding cannot be guaranteed beyond the term of the grant, which is August 1, 2007.
- Faith-based and other community-based organizations that receive federal funds through this grant are subject to basic audit and reporting requirements of the grant. These requirements are necessary in order to ensure that federal dollars have been spent properly on legitimate costs. It is important to keep accurate records of all transactions conducted with federal funds.

ATR Services and Qualified Providers

Clinical Treatment Services

- Clinical treatment services must be provided by agencies that are certified by the Department of Mental Health in accordance with requirements under 9 CSR 30-3.100 through 9 CSR 30-3.199.
- Faith-based or non-traditional organizations desiring to provide clinical substance abuse treatment must be certified by the Missouri Department of Mental Health in accordance with requirements under 9 CSR 30-3.100 through 9 CSR 30-3.199. *Attaining "certified" status does not guarantee receiving a contract to provide ATR clinical treatment services.*

Recovery Support Services

- Programs currently certified by the Division of Alcohol and Drug Abuse to provide clinical substance abuse treatment services are not eligible to provide recovery supports as defined in this document.
- Faith-based organizations desiring to provide recovery support services through ATR must be credentialed by the Department of Mental Health, Division of Alcohol and Drug Abuse and Committed Caring Faith Communities (CCFC), an independent statewide 501(c)(3) interfaith corporation. The credential will remain in effect for three years, pending passage of an annual review
- Nontraditional service providers desiring to provide recovery support services through ATR must be credentialed by the Department of Mental Health, Division of Alcohol and Drug Abuse. The credential will remain in effect for three years, pending passage of an annual review.

Requirements for Credentialed Status

Program Administration and Organization

This section describes the administrative and organizational requirements that faith-based and nontraditional service providers must have in place in order to participate in the ATR program.

1. Produce proof of and maintain documentation of good standing under the requirements of the Office of Secretary of State of Missouri.
2. Maintain a policy and procedure manual that contains, at a minimum, the organization's purpose, philosophy, Articles of Faith, and Entity Creed.
3. A governing body (e.g., a board of directors) that meets according to their bylaws to provide fiscal planning and oversight, ensure quality improvement in service delivery, establish policies to guide administrative operations of the organization, ensure responsiveness to the community and individuals being served, and delegate operational management to a program manager in order to effectively operate its services.
4. Maintain copies of all staff meeting and board meeting minutes and other required documentation to demonstrate full compliance with the ATR credentialing requirements.
5. Credentialed key staff or volunteers shall provide supervision of the recovery support services for which the organization is credentialed.
6. A plan of action for continuity of services in the event the organization can no longer perform services due to facility incapacitation or loss of key personnel.
7. A written policy to prevent conflict of interest which states that no employee or volunteer may use his or her official ATR position to secure privileges or advantages of any client.
8. The organization shall maintain a work and/or service environment that is free from sexual harassment and intimidation.
9. The organization shall not subcontract services it is credentialed to provide under the ATR program unless a previous agreement has been arranged with the Division of Alcohol and Drug Abuse.
10. The organization must conduct a client satisfaction evaluation as required by the Center for Substance Abuse Treatment.
11. Organizations that provide transportation for clients must present proof of a chauffeur's or CDL license (more than 15 passengers) and shall maintain auto insurance coverage, in adequate form and amount, throughout the time period they are providing ATR services. It is recommended as a best practice that the organization secure and maintain adequate insurance to protect against other liabilities as deemed necessary based on the services being provided.

Personnel

1. The organization shall ensure that staff possesses the training, experience, and credentials to effectively perform their assigned services and duties related to the ATR program. Key personnel and volunteers assigned to supervise the organization's ATR program must successfully complete the Addictions Academy, a 32-hour substance abuse course designed for clergy, lay leaders, congregation members, and other community volunteers.

2. Organizations that choose to utilize the Department of Mental Health's electronic client admission and invoicing systems must receive training on these systems.

3. ATR staff are encouraged to participate in the annual Spring Training Institute sponsored by the Department of Mental Health for its service providers.

4. The organization shall conduct an orientation for all new staff and/or volunteers within the first ten days of employment. Orientation must include, but is not limited to, components of the ATR program and policies and procedures of the organization.

5. The organization shall conduct at least three (3) hours of annual refresher training for all ATR staff and volunteers about the policies, procedures, and services of the agency.

6. Credentialed staff and volunteers shall participate in at least three (3) clock hours of relevant training during a one-year period. Annual refresher training provided by the organization does not fulfill this requirement. The organization shall maintain a record of participation in training and staff development activities.

7. The organization shall conduct a complete caregiver background check for all staff and volunteers who have contact with ATR clients. Service providers may secure background screening information in a variety of ways including the "Family Care Safety Registry" maintained by the Missouri Department of Health and Senior Services which may be downloaded at: http://www.dhss.mo.gov/FCSR/inquiry.pdf. Providers may also use the "Caregiver Background Screening" program managed by the Missouri State Highway Patrol which can be accessed at the following website: http://www.dmh.mo.gov/hr/careback/caregive.htm

8. The organization shall maintain complete, confidential, and current personnel records for each staff or volunteer assigned to the ATR program.

9. The organization shall establish and maintain a written standard of conduct for all staff and/or volunteers.

10. The organization shall maintain a staffing pattern that guarantees full delivery of credentialed services.

11. The organization shall not permit an employee or volunteer to enter into a business relationship with an ATR client or ATR client's family (e.g., selling, buying, or trading personal property) or employ them while the ATR client is receiving credentialed services.

12. The organization's employees and/or volunteers shall not engage in any conduct which is criminal in nature or that would bring discredit upon the contractor, CCFC, or State of Missouri. The organization shall ensure the conduct of all ATR credentialed employees and/or volunteers are above reproach or the appearance of misconduct.

13. The organization shall ensure that each employee or volunteer is legally eligible to work and reside in the United States.

Physical Plant and Safety

1. All individuals shall be served in a safe facility.
2. All buildings used for ATR program activities must provide proof of compliance with the Life Safety Code of the National Fire Protection Association and local/state codes.
3. The organization shall maintain documentation of all inspections and correction of all cited deficiencies to assure compliance with applicable state and local fire safety and health requirements.
4. A currently credentialed organization that relocates any program into a new physical facility shall ensure that the new facility complies with these requirements in order to maintain credentialed status. Any additions or expansions to existing physical facilities must also meet these requirements. Relocation or additions to existing facilities must be approved by the credentialing body (CCFC or the Division of ADA) prior to the delivery of ATR services.
5. The organization shall provide proof of occupancy and zoning permits in cities, counties, and towns where this is required.

Fiscal Accountability

1. The organization shall operate according to an annual written budget of anticipated revenues and expenditures that is approved in a timely manner by the governing body. Fiscal reports should be prepared at least annually and shared with the governing body and show a comparison of the budget to actual expenditures.
2. The organization shall have fiscal management policies, procedures, and practices consistent with generally accepted accounting principles and, as applicable, state and federal law, regulation, or funding requirements.
3. The organization shall utilize financial activity measures to monitor and ensure its ability to pay current liabilities and to maintain adequate cash flow.
4. Fiscal records shall be retained for at least five years or until any litigation or adverse audit findings, or both, are resolved.

Documentation

1. The organization shall have an organized record system for each client that receives recovery support services.
2. Client records shall be maintained in a manner which ensures confidentiality and security. The organization shall abide by all local, state, and federal laws and regulations concerning the confidentiality of records.
3. If records are maintained on computer systems, there must be a backup system to safeguard records in the event of operator or equipment failure and to ensure security from inadvertent or unauthorized access.
4. The organization shall retain individual records for at least five (5) years or until all litigation, adverse audit findings, or both, are resolved.
5. The organization shall assure ready access to the records by authorized staff and other authorized parties including Department of Mental Health staff.

6. All entries in the individual record shall be legible, clear, complete, accurate, and recorded in a timely fashion. Any errors shall be marked through with a single line, initialed and dated. Documentation shall be made with indelible ink or print.

7. All recovery support services shall, at a minimum, include the following documentation:

   Title of the service provided;
   Brief description of the service provided;
   The date and actual time (beginning and ending times) the service was rendered;
   Name and title of the person who rendered the service.

   The following individual recovery support services shall be documented with a case note in the client record:

   Care Coordination
   Family Engagement
   Pastoral Counseling
   Recovery Support –Individual
   Work Preparation

   Documentation of other recovery support services may be maintained in group program records.

Data Collection and Reporting

1. All faith-based and community-based organizations that participate in the ATR program must comply with reporting requirements of the grant.
2. Recovery support providers may submit manual client admissions/discharges for the Client Tracking, Registration, Admission and Commitment (CTRAC) system and Purchase of Service Invoices in accordance with established policies and procedures.
3. Organizations that choose to utilize the Department of Mental Health's electronic client admission/discharge and billing systems must meet the work station requirements listed below to access this system. Staff from the organization must be trained on use of the CTRAC and Purchase of Service Invoice systems.
4. Workstation requirements include:

Category	Required
Operating System Version	*Windows XP Pro*
Computer Processor	450Mhz or higher
Memory	256MB or higher
Browser Version	Internet Explorer 6.0 or higher, with current service packs.
Virus Protection	Required. Virus definitions must be kept current.
Monitor	Capable screen resolution of 1024 x 768
Printer	Required for printing reports
E-mail	Internet e-mail address
Bandwidth	Fastest network connection available and economical to you. Recommend DSL or cable modem.

Rights, Responsibilities, and Grievances

1. The organization shall demonstrate through its policies, procedures, and practices an ongoing commitment to the rights, dignity, and respect of the individuals it serves.
2. Each client shall be informed and oriented as to what will happen as recovery support services are provided. Information shall include applicable program rules, participation requirements or other expectations.
3. The organization shall have in place an internal procedure for handling client complaints and grievances in an expedient manner.
4. Each client shall be given the name, address, and phone number of the Division of Alcohol and Drug Abuse District Administrator in their area and informed that they may be contacted directly regarding a complaint of abuse, neglect, or violation of rights.

Report of Complaints of Abuse, Neglect, and Misuse of Funds/Property

1. Any employee or volunteer who has reasonable cause to believe that a client has been subjected to physical abuse, sexual abuse, misuse of funds/property, class I neglect, class II neglect, or verbal abuse while under the care of a recovery support program shall immediately make a verbal or written complaint to the organization's ATR Administrator.
2. The organization shall immediately report any complaints of abuse, neglect, and misuse of funds or property in a recovery support program that is credentialed by the Department of Mental Health, Division of Alcohol and Drug Abuse or Committed Caring Faith Communities and funded by the ATR program. Complaints should be reported to the appropriate Division of Alcohol and Drug Abuse District Administrator within one business day of the alleged incident.
3. The organization shall follow State regulations for reporting incidents of child abuse and/or neglect.
4. Failure to report shall be cause for disciplinary action, criminal prosecution, or both.

Client Confidentiality/HIPAA

1. All faith-based and community-based organizations that handle or maintain confidential alcohol or drug abuse treatment client information shall follow the federal confidentiality regulations (42 CFR Part 2) related to the release of alcohol and drug abuse records.
2. All organizations that have been determined to be a covered entity as defined by HIPAA shall adhere to the policies and procedures that the HIPAA privacy rule requires for each covered entity.

RECOVERY SUPPORT SERVICES – ACCESS TO RECOVERY

Vouchers for recovery support services may be issued to clients following assessment and enrollment into a PR+ level of care.

Recovery Support Limit – Initial authorization per client: **$1,000** per treatment episode

Extended Residential Support: $400 per client per treatment episode.

Recovery support vouchers will be generated by the clinical treatment agency, based upon the client's informed choice of provider. In the event the client will be receiving services from multiple providers of recovery supports, separate vouchers will be issued for each service. The amount of service the client is authorized to receive will be identified on the recovery support voucher. **Additional recovery supports may be requested through the Division of Alcohol and Drug Abuse Clinical Review Unit.** Prior to requesting additional recovery supports, staff of the recovery support agency and the clinical treatment agency should jointly make a determination as to the level of additional services needed, based on the client's progress in treatment. The request for additional recovery support services will be submitted to the Division of Alcohol and Drug Abuse by the clinical treatment provider.

The voucher represents a commitment on the part of the State of Missouri, Division of Alcohol and Drug Abuse, to pay for services while funding is available and the client remains eligible. If at any point in the fiscal year funds are exhausted, all subsidies end for that year without regard to the existence of vouchers that have not expired.

RECOVERY SUPPORT SERVICE DEFINITIONS– ACCESS TO RECOVERY			
39RS31	1. Care Coordination	*Unit of Service:* ¼ Hour	*Firm, Fixed Price:* $5.00
	Helping individuals engaged in clinical treatment access the network of services and other community resources available to them in order to facilitate retention in treatment and sustained recovery. This may include consultation with their PR+ treatment provider, procurement of psychiatric or other medications through charitable programs, assistance in finding and securing permanent housing, and developing an informal support system. Regular contact with the client's clinical treatment provider in order to evaluate client progress is required. Services are to be provided by a graduate of the Addictions Academy or a staff person who is supervised by a graduate of the Academy.		
39RS12	2. Child Care	*Unit of Service:* 1 hour	*Firm, Fixed Price:* $3.85
	Licensed (or license waived) child care while client (parent/guardian) is participating in clinical treatment or recovery support services.		
39RS33	3. Drop-In Center	*Unit of Service:* 1 Day	*Firm, Fixed Price:* $10.00
	Facility that offers personal recovery planning, educational sessions, social and recreational activities, recovery support sessions, and assistance in obtaining health, social, vocational and other community services. Normally hosts twelve-step meetings throughout the week. Organization staff must complete the Addictions Academy and supervise the activities of the program.		
39RS14	4. Emergency/Temporary Housing	*Unit of Service:* 1 Day	*Firm, Fixed Price:* $25.00
	Housing that meets local occupancy/safety requirements and has 24-hour staff supervision. Length of stay in emergency/temporary housing is limited to five days and is intended for clients in a crisis situation who have been assessed and enrolled in a PR+ clinical treatment program and are waiting for a residential support bed to become available.		
39RS34	5. Extended Residential Support	*Unit of Service:* 1 Day	*Firm, Fixed Price:* $20.00
	Housing that meets local occupancy/safety requirements and has staff supervision when clients are present. To be eligible, clients must be participating in Level II or Level III of any PR+ program or Level I of a PR+ program that does not offer residential support. Total expenditures for Extended Residential Support shall not exceed $400 per client per treatment episode.		
39RS1J	6. Family Engagement	*Unit of Service:* ¼ hour	*Firm, Fixed Price:* $6.25
	Family Engagement is a service that helps to engage the client's family in treatment and enhance their understanding of the treatment and recovery process in order to assist the primary client in working toward treatment goals. Family engagement should provide the structure to support stabilization in the family and to assist the entire family in making changes that support the recovery of the client and all members of the family. Family Engagement services are provided by a qualified substance abuse professional or duly ordained minister or their equivalent such as a rabbi or imam who is also a graduate of the Addictions Academy.		
39RS2L	7. Pastoral Counseling	*Unit of Service:* ¼	*Firm, Fixed Price:* $10.00
	Pastoral Counseling incorporates faith in the substance abuse recovery process. This may include, but is not limited to, assisting clients and their family members in various crises as a result of substance abuse. Pastoral counseling is delivered by a duly ordained minister or their equivalent such as a rabbi or imam who is also a graduate of the Addictions Academy.		
39RS35	8. Recovery Support-Individual	*Unit of Service*: ¼ Hour	*Firm, Fixed Price:* $5.00
	Face-to-face interaction between an experienced recovery support person and an individual who is engaged in clinical treatment. Recovery support is intended to help clients remain engaged in treatment and identify and shift their destructive patterns that may lead to relapse. The provider must be recognized by the agency's governing authority as being qualified to provide this service. The service provider must be a graduate of the Addictions Academy or supervised by a graduate of the Academy.		
39RS36	9. Recovery Support-Group	*Unit of Service:* ¼ Hour	*Firm, Fixed Price:* $2.00
	Group facilitator and at least two persons who are engaged in clinical treatment. The purpose of the group is to provide support for individuals in recovery by offering mutual encouragement and becoming connected with others who share similar experiences. The facilitator must be a graduate of the Addictions Academy or supervised by a graduate of the Academy.		

39RS3L	10. Spiritual Life Skills (Individual or Group)	*Unit of Service*: ¼ hour	*Firm, Fixed Price:* $2.50
	Helping an individual or group of at least two persons to develop spiritually which might include, but is not limited to, establishing or reestablishing a relationship with a higher power, acquiring skills needed to cope with life changing incidents, adopting positive values or principles, identifying a sense of purpose and mission for one's life, and achieving serenity and peace of mind. Responsible decision-making, social engagement and family responsibility may also be addressed. Spiritual Enrichment is to be provided by an individual who is recognized by the agency's governing authority as being trained and qualified to provide this service, a graduate of the Addictions Academy, or is supervised by a graduate of the Academy.		
39RS02	11. Transportation (Mileage)	*Unit of Service:* Per Mile	*Firm, Fixed Price:* $0.48
	Transportation is to and from treatment or recovery support services. Organizations that provide transportation for ATR clients must present proof of a chauffeur's or CDL license (more than 15 passengers) and proper auto insurance. Mileage is limited to a maximum of 50 miles one way, per client, per trip.		
39RS0W	Transportation (Public Transportation)	*Unit of Service:* Per Trip	*Firm, Fixed Price:* As Prescribed
	Transportation is to and from treatment or recovery support services. The contractor may purchase bus passes (daily, weekly, or monthly) for clients who are engaged in clinical treatment and recovery support services. Bus passes shall not exceed two monthly passes per client during the treatment episode.		
39RS38	12. Work Preparation	*Unit of Service:* ¼ Hour	*Firm, Fixed Price:* $5.00
	Assisting an individual in finding or maintaining employment during the course of treatment. This may include, but is not limited to, developing a resume, arranging job interviews, work skills development, and on-the-job training. Services are to be provided by a graduate of the Addictions Academy or a staff person who is supervised by a graduate of the Academy.		

Application Procedures

1. Open enrollment will be held for faith-based organizations and nontraditional service providers that are interested in participating in the Access to Recovery program as a provider of recovery support services. Open enrollment will be conducted in accordance with the State of Missouri, Office of Administration, Division of Purchasing, policies and procedures.

   Information about the application process will also be posted on the Division of Alcohol and Drug Abuse website at http://www.dmh.mo.gov/ada.

2. Application packets can be obtained by contacting:

   - Committed Caring Faith Communities, (314) 951-1033
   - The Division of Alcohol and Drug Abuse, (573) 751-4942 (please reference the ATR Project)
   - The Division of Alcohol and Drug Abuse website at http://www.dmh.mo.gov/ada (Access to Recovery Project)

3. An applicant can withdraw its application at any time during the credentialing process.

4. Organizations may apply to provide all of the recovery support services included in the service package or specific components. Exceptions to participation in the Addictions Academy may be granted for entities that apply to provide material services only, such as transportation.

5. All applications will be reviewed by staff of Committed Caring Faith Communities and the Division of Alcohol and Drug Abuse and will be rated as follows:

   a. Credentialed
   b. Provisional, pending on-site survey, submission of required documentation, or completion of Addictions Academy
   c. Technical assistance needed
   d. Ineligible

6. Organizations will be notified of their status within 30 days of receipt of application.

7. The Division of Alcohol and Drug Abuse and Committed Caring Faith Communities reserves the right to conduct a site survey at an organization to assure compliance with standards of care and other requirements. The credentialing body (the Division and/or CCFC) shall determine which standards and requirements are applicable based on the application submitted and the on-site visit.

8. The Division and/or CCFC, at its option, may visit the organization's program site(s) solely for the purpose of clarifying information contained in the application and its description of programs and services, and/or determining those programs and services eligible for credentialed status.

9. The applicant agrees, by act of submitting an application, to allow and assist Division and/or CCFC representatives in fully and freely conducting these on-site survey procedures and to provide representatives reasonable and immediate access to premises, individuals, and requested information.

10. The Division and/or CCFC may conduct a scheduled or unscheduled site survey of an organization at any time to monitor ongoing compliance with these requirements.

11. Credentialed status will be awarded for a three-year period to an organization that is found to meet all criteria relating to quality of care and safety, health, and welfare of persons served in the ATR program.

12. An annual follow-up review will be conducted with all credentialed providers to ensure continued compliance. This review may include a site visit or telephone conference call.

13. A contract will be issued to all credentialed providers and providers will be required to adhere to the terms and conditions of this contract. Any changes in the scope of work will require prior approval from the Division of Alcohol and Drug Abuse and Committed Caring Faith Communities.

14. All recovery support providers will be required to submit progress reports twice per year to their credentialing body (CCFC or Division of Alcohol and Drug Abuse) that indicates the number of clients served, success rates, problems, or other pertinent information related to the program.

Terms and Definitions

Unless the context clearly indicates otherwise, the following terms used in reference to the Access to Recovery project shall mean:

1. **Assessment –** systematically collecting information regarding the individual's current situation, symptoms, status and background, and developing a treatment plan that identifies appropriate service delivery.
2. **CAGE-AID Screening –** four-question screening instrument that has been designed to identify individuals who have or are at risk for developing alcohol- or drug-related problems and need assessment to diagnose their substance use disorders and develop plans to treat them.
3. **Charitable Choice –** the general term for several laws that were enacted during the period 1996-2000. These laws are designed to give people in need choices among charities offering them services and apply to projects funded by four Federal agencies including the Substance Abuse and Mental Health Services Administration. These laws clarify the rights and responsibilities of faith-based organizations that receive Federal funds.
4. **CIMOR –** Customer Information Management, Outcomes, and Reporting System; under development by the Department of Mental Health to replace current information systems and will allow better access to data with meaningful and accurate reports; anticipated implementation is July 1**,** 2006.
5. **Clergy and other Pastoral Ministers –** a citizen of the United States and in good standing and duly recognized as an ordained minister or equivalent, such as a rabbi or imam, with any church, mosque, or synagogue in the State of Missouri.
6. **Client –** this term many be used interchangeably with individual (see definition of individual).
7. **Community-based organization –** an agency or organization that is incorporated and in good standing under the requirements of the Office of Secretary of State of Missouri and is providing services that are part of the ATR program.
8. **Congregation –** local, specific religious institution; a particular church, synagogue, temple, or mosque whether or not there is a specific, permanent physical edifice associated with the institution.
9. **Crisis –** an event or time period for an individual characterized by substantial increase in symptoms, legal or medical problems, and/or loss of housing or employment or personal supports.

10. **CTRAC –** Client Tracking, Registration, Admission, and Commitment system; the Department of Mental Health's information system that provides a single set of comprehensive client demographics and diagnostic classification information on all DMH clients.
11. **Discharge –** the time when an individual's active involvement with the primary program concludes in accordance with treatment plan goals, and/or program rules; conclusion of billable service units. Primary programs, for purposes of the ATR grant, are clinical treatment providers. Recovery support providers cannot discharge clients from treatment.
12. **Drop-In Center –** facility that offers personal recovery planning, educational sessions, social and recreational activities, recovery support sessions, and/or assistance in obtaining health, social, vocational, and other community services. Normally hosts twelve-step meetings throughout the week.
13. **Faith-based organization –** entity having a distinct legal existence that is organized and operated exclusively for religious or other charitable purposes.
14. **Family/family members –** persons who comprise a household or are otherwise related by marriage or ancestry and are being affected by the substance abuse problems or another member of the household or family.
15. **House of Worship –** place of worship such as a church, mosque, synagogue, or temple.
16. **Individual –** a person/consumer/client receiving services from a program.
17. **Individual choice –** for purposes of this grant program, individual choice is defined as a client being able to select from at least two agencies qualified to provide the necessary services, with at least one to which the client has no religious objection.
18. **Nontraditional service provider –** secular organization whose primary mission is not to provide traditional clinical substance abuse treatment; rather, the organization offers an array of recovery support services.
19. **Outcome –** a specific measurable result of services provided to an individual or identified target population.
20. **Pastoral care –** the religious or spiritual care of individuals.
21. **Pastoral counseling –** individual or family work related to treatment and recovery delivered by clergy who are licensed or degreed by an accredited institution of higher learning, credentialed by CCFC, and a graduate of the Addictions Academy.
22. **Peer support –** mutual assistance in promoting recovery offered by other persons who have experienced similar substance abuse challenges.
23. **Program –** an array of services designed to achieve specific goals for an identified target population in accordance with designated procedures and practices.
24. **Qualified Substance Abuse Professional (QSAP) –** a person who demonstrates substantial knowledge and skill regarding substance abuse by being either: 1) a counselor, psychologist, social worker or physician licensed in Missouri who has at least one (1) year of full time experience in the treatment or rehabilitation of substance abuse; 2) a graduate of an accredited college or university with a master's degree in social work, counseling, psychology, psychiatric nursing, or closely related field, who has at least two (2) years of full time experience in the treatment or rehabilitation of substance abuse; 3) a graduate of an accredited college or university with a bachelor's degree in social work, counseling, psychology, or closely related field, who has at least (3) years of full time experience in the treatment or rehabilitation of substance abuse; or, 4) an alcohol, drug, or substance abuse counselor certified by the Missouri Substance Abuse Counselors Certification Board, Inc.
25. **Recovery –** continuing steps toward a positive state of health that includes stabilized symptoms of substance abuse, meaningful and productive relationships and roles within the community, and

a sense of personal well-being, independence, choice, and responsibility to the fullest extent possible.

26. **Recovery supports –** an array of activities, resources, relationships, and services designed to assist an individual's integration into the community, participation in treatment, improved functioning, or recovery.
27. **Recovery support group –** group facilitator and at least two persons who are engaged in clinical treatment.
28. **Reimbursement –** payment for services rendered upon providing required documentation to payor.
29. **Relapse –** recurrence of substance abuse in an individual who has previously achieved and maintained abstinence for a significant period of time beyond detoxification.
30. **Reuse –** any use of a substance after a prolonged period of abstinence.
31. **Relapse prevention service –** assisting individuals to identify and anticipate high risk situations for substance use, develop action steps to avoid or manage high risk situations, and maintain recovery.
32. **Spiritual –** the quality of any activity which drives the human being forward towards some form of development -- physical, emotional, intuitional, social -- in advance of his present state.
33. **Staff member –** an employee or volunteer who is credentialed to provide ATR services.
34. **Substance –** alcohol or other drugs, or both.
35. **Substance abuse –** a broad term referring to alcohol or other drug abuse or dependency in accordance with criteria established in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.
36. **Traditional treatment provider –** Department of Mental Health certified organization whose primary mission is to provide clinical treatment services.
37. **Voucher –** provided to eligible clients to pay for assessment and other clinical treatment and recovery support services from a broad network of eligible providers. Vouchers can be time-limited and are issued based on availability of ATR grant funds.

3/1/05

Committed Caring Faith Communities
The Missouri Department of Mental Health Division of Alcohol and Drug Abuse
&
The U.S. Drug Enforcement Administration

present the

2006 Fall Addictions Academy

a 32-hour course on substance abuse designed specifically for faith leaders, congregation members, staff of faith-based community organizations, and other non-traditional service providers

October 23-27, 2006

To Be Held In Jefferson City or Columba – Exact Location To Be Announced

The kick-off for the Academy will be October 23 and will feature guest lecturer **Rev. Edwin Sanders II**, BA, senior servant and founder of the Metropolitan Interdenominational Church of Nashville, Tennessee. Rev. Sanders' lecture is entitled *Spirituality as an Essential Component of Effective Substance Abuse Prevention, Education & Treatment Initiatives*.

Other classes to be offered include:

Alcohol, Tobacco, and Other Drug Abuse: Challenges and Responses for Faith Leaders	**Special Agent Shirley Armstead, BA** U.S. Drug Enforcement Administration
Addiction 101	**Sharon Ema, RN, CSAC** Committed Caring Faith Communities
Science-Based Drug Abuse Prevention	**Alysia Harris, BA** National Council on Alcoholism and Drug Abuse – St. Louis
History and Interpretation of the Twelve-Step Model	**Raymond D. Little, Sr. RASAC** Committed Caring Faith Communities & Missouri Institute of Mental Health
How to Approach the User	**Scott Doty, BA, CSAC II** Gibson Recovery Center of Cape Girardeau
"I Lift My Eyes Unto the Mountain: From Where Will My Help Come?" *Finding and Accepting Help for the Helpers*	**Valerie Atkins, M.Ed, MA, CASAC** The Empowered Church – St. Louis
Co-Dependency & the Family Dynamics of Addiction	**JoAnn Stovall, BA, CASCA, CCGC, ICADC, CADCII** National Council on Alcoholism and Drug Dependence of Greater Kansas City
Concept of Co-Occurring Disorders: A Brief Introduction	**Elayne C. Davis, BA, LCSW** Committed Caring Faith Communities
Setting Up a Faith-Based Substance Abuse Program	**Daphne Walker-Thoth, M.Ed & Raymond D. Little, Sr., RASAC** Committed Caring Faith Communities & Missouri Institute of Mental Health
Screening & Appropriate Referrals, Certification/Licensure	**Michelle Smart, MSW** Consultant
The Access to Recovery (ATR) Grant: Building on a Foundation of Rock	**Jonathan Smith** Missouri Division of Alcohol and Drug Abuse
ATR Collaboration, Standards, and Outcomes	**Mark Shields, M.Ed, LPC, CASAC** Missouri Division of Alcohol and Drug Abuse
ATR Information Systems	**Mark Shields, M.Ed, LPC, CASAC** Missouri Division of Alcohol and Drug Abuse
Recovery Revival Demonstration	**Rev. Isaac C. McCullough, BA, BS** Committed Caring Faith Communities

Registration information is attached. For additional information, call (314) 951-1033.

32 contact hours from Missouri Substance Abuse Counselors' Certification Board will be issued.
Participants must complete the entire Academy to receive contact hours.
Classes will be held daily from 9 a.m. to 5 p.m.

2006 Fall Addictions Academy Registration Form & Information

Academy Required for Faith-Based & Non-Traditional Organizations to be Credentialed for ATR

Faith organizations and other non-traditional providers interested in providing recovery support services under the Access to Recovery program are required to have a **minimum of two staff or volunteers** complete the Addictions Academy. Due to space and budget constraints, organizations may not send more than **three** participants. Graduates of the 2002, 2003, and 2004 Academy are not required to retake the entire Academy, but will be required to attend the Access to Recovery class on Friday.

Fees

Aside from transportation to Jefferson City or Columbia, there is no cost for faith organizations to send representatives to the Academy. Free double-occupancy lodging and meals will be provided. Participants who desire a private, single room will have to pay for lodging. A **$25 refundable deposit must be submitted with each application**. The deposit will be returned to participants immediately upon completion of the Academy. The deposit will not be returned to registrants who do not show up or who leave the Academy before it is over.

Registration Deadline

The registration deadline for the Academy is October 1, 2006, registration forms must be received at the CCFC office by this date. Late registrations will not be accepted, no exceptions. Space is limited, so registrants are encouraged to register early.

2006 Addictions Academy Registration Form

Please print or type and mail completed form along with $25 deposit to: CCFC, Addictions Academy, 5400 Arsenal, Room A-314, St. Louis, MO 63139. *Use separate registration form for each registrant. Make copies if necessary. Questions about the Academy should be directed to CCFC at (314) 951-1033.*

Name _____ Telephone ( ) _____

Faith Organization or Non-Traditional Provider Organization _____

Your Position at Your Religious Institution/Non-Traditional Provider _____

Denomination _____

Your Mailing Address _____

City/State/Zip _____

E-mail Address _____

Emergency Contact Name _____ Telephone ( ) _____

Are you associated with an ATR program? ❑ **Yes** ❑ **No**

Lodging & Meal Information: (Please check one)

Gender: ❑ Male ❑ Female
Meal Preference: ❑ Regular meals ❑ Vegetarian meals

❑ Reserve a double-occupancy room for me. I have already selected a roommate and his/her name is

_____

❑ My spouse and I will room together. My spouse's name is _____

❑ Reserve a double-occupancy room for me. I need to be matched with a roommate.

❑ I prefer to pay for a private room. I will take care of making my own reservations.

❑ I live in or near Jefferson City and will not need overnight accommodations.

Check here if you need special assistance: ❑ (Please specify the type of assistance needed):

_____

Deposit Payment Method: *Payment may be made by check or money order only. Credit card payments cannot be accepted. Please make check or money order payable to CCFC.*

Pre-registration is required. Registration will not be accepted at the door.

PREPROPOSAL STATEMENT OF INQUIRY

CR-101 (June 2004)
(Implements RCW 34.05.310)
Do **NOT** use for expedited rule making

Agency: Department of Social and Health Services, Economic Services Administration

Subject of possible rule making:

The department is amending WAC 388-408-0040, *How does living in an institution affect my eligibility for Basic Food?*

Statutes authorizing the agency to adopt rules on this subject:
RCW 74.04.050; 74.04.055; 74.04.057; and 74.08.090.

Reasons why rules on this subject may be needed and what they might accomplish:

Changes proposed to this rule will be to allow persons living at certain drug and/or alcohol treatment centers to receive Food Stamp benefits under the Washington Basic Food Program.

Currently, persons must be living at a nonprofit facility certified by the Washington State Division of Alcohol and Substance Abuse in order to be eligible for basic food benefits. Under new guidance provided by the U.S. Department of Agriculture, Food and Nutrition Service – Someone residing in a nonprofit drug or alcohol addiction treatment facility may participate in the food stamp program if the facility meets one of the following three conditions:

- The facility receives funding under part B of title XIX of the Social Security Act;
- Eligible to receive funding under part B of title XIX of the Social Security Act even if the facility does not receive these funds; or
- Operating to further the purposes of part B of title XIX of the Social Security Act.

The Department's Division of Alcohol and Substance abuse will determine which nonprofit facilities meet the criteria listed above.

Changes proposed to this rule will be consistent with policy information provided under Food Stamp Program Administrative Notice 06-08 dated April 10, 2006.

Identify other federal and state agencies that regulate this subject and the process coordinating the rule with these agencies:
The United States Department of Agriculture, Food and Nutrition Service (FNS) publishes federal regulations for the food stamp program in the Federal Register. Rules published in the federal register are incorporated into the U.S. Code of Federal Regulations. FNS also issues administrative notices to inform states of new program requirements that are not yet in the U.S. Code of Federal Regulations.

DSHS incorporates these regulations and exercises state options by adopting administrative rules for food assistance benefits in Washington State.

Process for developing new rule (check all that apply):

- ☐ Negotiated rule making
- ☐ Pilot rule making
- ☐ Agency study
- ☒ Other (describe)

DSHS welcomes the public to take part in developing the rules. Anyone interested should contact the staff person identified below. At a later date, DSHS will file a proposal with the Office of the Code Reviser with a notice of proposed rule making. A copy of the proposal will be sent to everyone on the mailing list and to anyone who requests a copy.

How interested parties can participate in the decision to adopt the new rule and formulation of the proposed rule before publication:
(List names, addresses, telephone, fax numbers, and e-mail of persons to contact; describe meetings, other exchanges of information, etc.)

Contact: John Camp, Policy Analyst
Division of Employment and Assistance Programs
PO Box 45470
Olympia, WA 98504-5470
Phone: (360) 725-4616 **Fax:** (360) 493-3493 **TTY:**
E-mail: campjx@dshs.wa.gov

DATE 6-5-06

NAME (TYPE OR PRINT)
Andy Fernando

SIGNATURE

TITLE
Manager, Rules and Policies Assistance Unit

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United States Department of Agriculture

Food and Nutrition Service

3101 Park Center Drive

Alexandria, VA 22302-1500

MAR - 8 2006

SUBJECT: Drug Addiction and Alcoholic Treatment and Rehabilitation Programs

TO: All Regional Administrators
Food and Nutrition Service

Recently questions have been raised regarding Food Stamp Program (FSP) authorization and reauthorization policy for drug and/or alcohol (DAA) treatment centers and rehabilitation programs. These questions pertained to whether residents of faith-based and community DAA recovery programs in several States were being denied the ability to participate in the FSP because of some confusion over whether State licensing is required for such participation. **Such licensing is not required**, and this memorandum serves as guidance to clarify that policy while the Food and Nutrition Service (FNS) proposes an amendment to the current regulations. The specific statutory and regulatory language that this memorandum will address includes:

Statute: Section 3(f) of the Food Stamp Act of 1977 {7 USC 2012 (f)}: Defines drug addiction or alcoholic treatment and rehabilitation programs as any such program conducted by a private non-profit organization or institution, or a publicly operated community mental health center, under part B of title XIX of the Public Health Service Act (42 U.S.C. 300x et seq.) to provide treatment that can lead to the rehabilitation of drug addicts or alcoholics.

Regulation: 7 CFR 271.2: The term "Under part B of title XIX of the Public Health Service Act" is further defined as meeting the criteria which would make a program eligible to receive funds even if it does not actually receive funding under part B of title XIX.

In order for the residents of a DAA center to be certified to receive food stamps under 7 CFR 273.1(b)(7)(vi)(B), the DAA must provide evidence that it is:

1) (a) Tax exempt; **and,**

(b) Certified by the State agency responsible for the treatment and rehabilitation of drug addicts or alcoholics (the State Title XIX Agency) as:

(i) Receiving funding under part B of title XIX; **or**
(ii) Eligible to receive funding under part B of title XIX even if no funds are being received; **or**
(iii) Operating to further the purposes of part B of title XIX, to provide treatment and rehabilitation of drug addicts and/or alcoholics.

OR

2) Authorized as a retailer by the FNS.

The State food stamp agency must clearly communicate the above requirements to any DAA center making application on behalf of its residents. The State food stamp agency must make it clear that the residents may be eligible if the DAA center meets any of the FSP standards for certification listed above.

The State food stamp agency must verify that the DAA center meets the above requirements before it determines any residents of the DAA center eligible for food stamps. DAA centers may provide verification of this status to the State food stamp agency as follows:

1. By way of a copy of a letter, license or other certification issued by the State Title XIX agency that shows that the DAA center meets the FSP standards for certification listed above. It should also be noted that such "certification" need not rise to the level of State licensure.

2. If a DAA center cannot provide documentation that it meets the FSP standards for certification listed above, the State food stamp agency should take the necessary steps to facilitate contact between the DAA center and the State Title XIX agency. Where the DAA center in question offers an alternative model of treatment or rehabilitation not eligible for licensing by the State, the State's Title XIX agency should still make a determination as to whether or not the facility is operating to further the purpose of part B of title XIX, to provide treatment and rehabilitation of drug addicts and/or alcoholics. FNS will be satisfied with a simple letter from the appropriate State agency acknowledging that the facility is operating for this purpose. FNS understands that Secretary Johanns of the United States Department of Agriculture and Secretary Leavitt of Health and Human Services recently addressed a letter to State governors encouraging State Title XIX agencies to adhere to the guidance addressed in this memorandum. As such, FNS strongly encourages State food stamp agencies and State Title XIX agencies to work together to make this determination.

   Where faith-based DAA facility participation in the FSP is concerned, States should take care not to impose additional burdens.

3. If the FNS has authorized the DAA center as a retailer, the State food stamp agency may rely on that for verification. FNS will ensure that DAA centers it authorizes as retailers meet the required standards at authorization and at periodic reauthorization every 5 years.

FNS Regional Offices need to encourage the State agencies in their regions to maintain lists of DAA centers that meet the FSP standards for certification listed above. At the very least, local food stamp offices need to know how to obtain such information from the appropriate State agency. For ease of reference, we are providing a link to the Substance Abuse & Mental Health Services Administration website, which lists the State Title XIX agencies. The URL is: http://findtreatment.samhsa.gov/ufds/abusedirectors.

Finally, it is important to note that faith-based treatment and rehabilitation facilities are not required by law or FNS regulations to allow residents to opt-out of religious programming or activities in order to participate in the FSP. Federal law prohibits direct funding of inherently religious activity. However, food stamps are a benefit to the resident, not the facility, and are thus considered indirect funding.

Where a resident has made a genuine and independent private choice to enter a faith-based facility, participation in the FSP does not amount to direct funding of inherently religious activities. Where Federal funding is indirect, as in the FSP, a facility may incorporate inherently religious activities into its program and require food stamp beneficiaries to participate in such activities. Recognition from the appropriate State agency that a faith-based program furthers the purpose of part B of title XIX to provide treatment and rehabilitation of drug addicts and/or alcoholics is sufficient for FNS to authorize a faith-based program as a retailer and for the State food stamp agency to issue food stamp benefits to individuals. Such facilities do not have to make their inherently religious activities voluntary.

FNS staff may call the regional office contact in the Certification Policy Branch with questions. State officials should call their respective FNS regional office.

Clarence H. Carter
Deputy Administrator
Food Stamp Program

United States Department of Agriculture
Food and Nutrition Service

Western Region

Reply to: FSP-2-General — April 10, 2006

Attn of: FSP – Administrative Notice 06-08

Subject: Policy Guidance for Drug and Alcohol Treatment Centers

To: ALL WESTERN REGION FOOD STAMP PROGRAM COORDINATORS

As a follow-up to information previously sent to State Food Stamp directors over the past months and weeks, this is to reiterate guidance on Food Stamp Program (FSP) policy for drug and or alcohol (DAA) treatment centers and rehabilitation programs for individuals residing in faith-based (FBO) and community-based (CBO) DAA centers.

The regulations at 7 CFR 273.11(e), *Residents of drug and alcohol treatment and rehabilitation programs,* provide rules for individuals residing in DAA treatment centers. These rules include guidance regarding household composition, authorized representatives, and using the Food Stamp EBT cards. The recent FNS memo on FBO and CBO treatment centers found at http://www.fns.usda.gov/fsp/rules/Memo/06/030806.pdf did not change any of the rules for DAA centers. Rather, the memo provides clarification for one single exception; what kinds of DAA centers are acceptable for certifying residents.

As noted in 7 CFR 273.11(e), prior to certifying *any* DAA residents for food stamps, the State agency must verify that either:

The DAA center is authorized by FNS as a retailer in accordance with §278.1(e), **or**

The DAA center comes under part B of title XIX of the Public Health Service Act, 42 U.S.C. 300x *et seq.,* (as defined in "Drug addiction or alcoholic treatment and rehabilitation program" in 7 CFR 271.2).

It is with this second criterion that FNS has provided additional guidance. If the DAA center meets the first criterion, having been authorized as a retailer, the State food stamp agency may rely on verification from FNS. If the DAA center is not an authorized retailer the State food stamp agency must verify that the center meets the second criteria; the title XIX part. The DAA center must provide evidence that it is:

(a) Tax exempt; **and**,
(b) Certified by the State agency responsible for the treatment and rehabilitation of drug addicts or alcoholics (the State Title XIX Agency) as;
- **(i)** ***Receiving*** funding under part B of title XIX; **or**
- **(ii)** ***Eligible to receive*** funding under part B of title XIX even if no funds are being received **or**
- **(iii)** ***Operating to further the purposes of Part B of title XIX,*** to provide treatment and rehabilitation of drug addicts and/or alcoholics.

The State food stamp agency may verify that the DAA center meets (i), (ii), or (iii) by

viewing documentation issued by the State Title XIX agency confirming which criteria is met. The State Title XIX agency documentation can include any one of the following:

a) a simple letter acknowledging that the facility is operating for the purpose of Part B of title XIX, to provide treatment and rehabilitation of drug addicts and/or alcoholics,
b) a license, or
c) other certification documentation.

If the DAA center cannot provide the State Title XIX documentation, the State food stamp agency must facilitate contact between the DAA center and the State Title XIX agency. As long as the DAA facility is recognized by the State's Title XIX agency as furthering the purpose of rehabilitating drug addicts and/or alcoholics and documentation is provided, the residents meet the criteria. We believe this policy of recognition, without requiring licensing, is equitable and consistent with objectives and regulations calling for the equal treatment of FBO and CBO organizations.

FNS strongly encourages State food stamp agencies and State Title XIX agencies to work together. The link to the Substance Abuse and Mental Health Services Administration website, which lists the State Title XIX agencies, is found at: http://findtreatment.samhsa.gov/ufds/abusedirectors.

State agencies should also maintain lists of DAA centers that meet the standards for certification. Maintaining lists will ensure FBO and CBO DAA centers do not have additional burdens imposed on their residents who seek food assistance. Should a State food stamp agency require further assistance in working with the Title XIX agency, states may also contact the FNS regional office for assistance.

Finally, while Federal law prohibits direct funding of inherently religious activities, it is important to note that faith-based treatment and rehabilitation facilities are not required by law or FNS regulations to allow residents to opt-out of religious programming or activities in order to participate in the Food Stamp Program.

Participation in the Food Stamp Program does not amount to direct funding of inherently religious activities. The food stamps are a benefit to the resident of the DAA facility, and are thus considered indirect funding. When Federal funding is indirect, as in the Food Stamp Program, the facility may incorporate inherently religious activities into its program and require food stamp beneficiaries to participate in such activities. The facility does not have to make their inherently religious activities voluntary.

If you have questions, please contact your State Program Officer.

DAVID H. BAILEY, Section Chief
Program Operations and Investigations
Food Stamp Program
Western Region

Effective January 1, 2007

WAC 388-408-0040 How does living in an institution affect my eligibility for Basic Food?

1. For Basic Food, an "institution" means a place where people live that provides residents more than half of three meals daily as a part of their normal services.
2. Most residents of institutions are not eligible for Basic Food.
3. If you live in one of the following institutions, you may be eligible for Basic Food even if the institution provides the majority of your meals:
    a. Federally subsidized housing for the elderly;
    b. Qualified drug and alcohol treatment centers when an employee of the treatment center is the authorized representative as defined under WAC 388-460-0010;
    c. Qualified DDD group homes for persons with disabilities;
    d. A shelter for battered women and children when the resident left the home that included the abuser; or
    e. Nonprofit shelters for the homeless.
4. A qualified DDD group home is a nonprofit residential facility that:
    a. Houses sixteen or fewer persons with disabilities as defined under WAC 388-400-0040(6); and
    b. Is certified by the Division of Developmental Disabilities (DDD).
5. A qualified drug & alcohol treatment center is a residential facility that:
    a. Is authorized as a retailer by the US Department of Agriculture, Food and Nutrition Service; **or**
    b. Is operated by a private nonprofit organization; **and**
    c. Is certified by the Division of Alcohol and Substance Abuse (DASA) as:
        i. *Receiving funds* under part B of title XIX of the Social Security Act;
        ii. *Eligible to receive funds* under part B of title XIX, but does not receive these funds; or
        iii. *Operating to further the purposes* of part B of title XIX to provide treatment and rehabilitation of drug addicts or alcoholics.
6. Elderly or disabled individuals and their spouses may use Basic Food benefits to buy meals from the following meal providers if FNS has approved them to accept Basic Food benefits:
    a. Communal dining facility; or
    b. Nonprofit meal delivery service.
7. If you are homeless, you may use your Basic Food benefits to buy prepared meals from non-profit organizations the department has certified as meal providers for the homeless.

CLARIFYING INFORMATION

1. **Federally subsidized housing for the elderly:**

   For someone to be eligible for Basic Food based on living in federally subsidized housing for the elderly, the housing must meet **both of** the following two conditions:

   a. The facility must be *expressly for the elderly*; and

   b. The facility must be federally subsidized.

2. **Optional meal plans:**

   If a residence offers an **optional** meal plan as a part of their normal services, we only consider a resident to be living in an institution for Basic Food if they choose to get their meals through the optional plan.

   If someone chooses to get the majority of their meals through an optional meal plan, the person is living in an institution. For this person to be eligible for Basic Food benefits, the institution must meet the requirements of WAC 388-408-0040.

3. **When someone in an ineligible institution may get Basic Food:**

   A person who lives in an institution that provides meals may be eligible for Basic Food benefits when:

   a. The person living in the institution can't eat the institution's meals because they need a special diet; and

   b. The institution is unable or unwilling to provide the special diet.

4. **Release from a hospital or other institution:**

   a. A person in a hospital or other ineligible institution is not eligible for Basic Food until they are released from the institution.

   b. If someone applies for Basic Food while in an ineligible institution and they are released within 30 days, we use the date of release as their date of application for Basic Food.

5. **Group living arrangements that are not Qualified Group Homes:**

   Some group living arrangements are not qualified group homes, but we don't consider them institutions, because the facility doesn't prepare the majority of meals for the persons living there. In this case, we look at the client's living arrangements and whether or not they buy and fix food together to determine who must be in the AU under WAC 388-408-0035.

6. **Supported Living Providers / ITS Homes:**

   A Supported Living Provider (formerly Intensive Tenant Support Services or ITS Home) provides services to DDD clients and is licensed by DDD.

   a. Most clients who receive services through one of these providers receive home

persons are not living in an institution. We look at requirements under WAC 388-408-0035 to determine who must be in a client's AU.

b. Some Supported Living Providers also run qualified DDD group homes. Since these clients are living in a qualified DDD group home, they can receive Basic Food**.**

NOTE	Knowing that a client gets services from a Supported Living Provider does not tell you if the client is in a qualified group home. To determine if the institution is eligible for Basic Food, review the group home files in ACES.

7. **Nonprofit Drug and Alcohol Treatment Centers Authorized as FNS retailers:**

Drug or alcohol treatment centers certified by FNS as eligible for Basic Food: (Nonprofit facility authorized as a retailer under 7 CFR §278.1(e))		
Placeholder Facility A Seattle, WA	Placeholder Facility B Vancouver, WA	Placeholder Facility C Spokane, WA
Placeholder Facility D Tacoma, WA	Placeholder Facility E Lacey, WA	Placeholder Facility F Yakima, WA

8. **DASA certification of nonprofit drug and alcohol treatment facilities:**

We do not need to determine that DASA has licensed a nonprofit drug or alcohol treatment facility to verify that the facility meets the criteria under section (5)(b) of WAC 388-408-0040.

Drug or alcohol treatment facilities certified by DASA as eligible for Basic Food: (Receiving funds / Eligible to receive funds / Furthering the purposes of part B of title XIX)		
Placeholder Facility G Seattle, WA	Placeholder Facility H Vancouver, WA	Placeholder Facility I Spokane, WA
Placeholder Facility J Tacoma, WA	Placeholder Facility K Lacey, WA	Placeholder Facility L Yakima, WA

a. If someone lives in a non-profit drug or alcohol treatment facility that is on the above list, DASA has certified that the facility meets the criteria under WAC 388-408-0040. Residents may receive Basic Food while at this facility.

b. If the facility is not licensed by DASA isn't on the above list, take the following actions to determine if residents can receive Basic Food while at the facility:

i. ??? How would you like this contact to work?

ii. ?? By phone / e-mail / Campus Mail??

iii. ?? Do you want the inquiry to go to a specific person, position, or unit at DASA??

9. **Authorized Representatives for clients in a qualified DASA or DDD facility:**
    a. If a client is in a qualified DASA facility, a representative of the facility must be the client's authorized representative for Basic Food.
    b. If a client is in a qualified DDD group home, the client may:
        i. Have a facility representative as an authorized representative;
        ii. Choose another person as an authorized representative under WAC 388-460-0005; or
        iii. Choose not to have an authorized representative.
10. **Facilities who are suspended as authorized representatives:**

    FNS may decide to suspend an eligible institution's status as an authorized representative for Basic Food. If this happens, the clients may still apply for and receive basic food on their own behalf.

11. **Homeless shelters who provide communal meals:**

    If a client lives in a non-profit homeless shelter, they can receive Basic Food while in this institution even if the shelter provides **all** of the client's meals.

12. **Organizations that provide meals to homeless people:**

    To accept Basic Food benefits for prepared meals, non-profit organizations that provide meals to homeless people must be approved by the Division of Employment and Assistance Programs and certified by Food and Nutrition Service (FNS).

    a. If a public or private non-profit organization asks about approval to accept Basic Food for prepared meal, refer them to the Program Policy & Planning unit in the Division of Employment & Assistance Programs at (360) 725-4604.
    b. Organizations that provide meals to homeless people cannot be authorized representatives for Basic Food.

13. **Communal dining and home delivered meals:**

FNS does not provide a list of facilities that they approve for communal dining or home-delivered meals. Clients must ask the food service organization if they accept Basic Food benefits for payment.

FBOs qualifying for food stamps work plan

Changes in federal rules allow for FBOs to receive food stamps in behalf of persons residing in their programs to deal with issues of alcohol and drug addictions. The following steps will be taken by DSHS to facilitate the rule changes and to help FBOs successfully partner with DSHS in supporting persons in recovery.

1. DASA will meet with prospective FBO representatives to review proposed criteria for "endorsement" of FBOs as organizations supporting client recovery. (October 18, 2006)

2. ESA will publish changes in WAC effective **January 1, 2007,** allowing for FBOs to access the food stamp program.

3. DASA will notify FBOs known to be interested in qualifying for food stamp of the process for requesting DASA's endorsement. ESA will include this information in the Food Stamp manual for CSO staff, who may be contacted directly by FBOs. (December 15, 2006)

4. Community Services Division within ESA will provide training to CSO staff of the changes and anticipated applications from FBOs and the persons supported by FBOs. (Initial training to begin in December, 2006, with publishing of new WAC.)

5. ESA/DASA will compile an information packet to send to FBOs throughout the state regarding the changes in the food stamp program. (January 1, 2007)