

ASSEMBLIES OF GOD THEOLOGICAL SEMINARY

DEVELOPING A FAITH-BASED EARLY INTERVENTION PROGRAM FOR
ADULTS WITH ALCOHOL AND DRUG ISSUES

A PROJECT SUBMITTED TO THE
DOCTOR OF MINISTRY COMMITTEE
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF MINISTRY

DOCTOR OF MINISTRY DEPARTMENT

BY

KEVIN R. HOFFMAN

BEAVERCREEK, OHIO

MAY 2016

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ABSTRACT

A gap between prevention and treatment exists in the faith-based service continuum of care in work with adults who suffer with alcohol and other drug (AoD) problems. Faith-based mutual-help groups, such as Celebrate Recovery, exist. Treatment programs functioning from a faith-based model also occur in outpatient, intensive outpatient, residential, and inpatient treatment settings, such as those operated by Salvation Army Adult Rehabilitation Centers and Teen Challenge Centers. However, no faith-based early intervention programs are available for adults who face initial legal consequences for their use of AoD. Members of the judiciary, probation officers, applicable court administrators, attorneys, Certified Employee Assistance Programs, and professionals in the counseling field can serve their respective clients better by allowing them to participate in a faith-based early intervention program.

This project bridges the continuum care gap between prevention and treatment for people with AoD issues through the creation of a faith-based early intervention model targeting adults with alcohol and drug issues, particularly individuals with first-time alcohol and other drug offences. Initial assessment of the project indicated an effective EIP experience for three individuals. While a sample pool of three does not provide sufficient statistical data to fully substantiate the effectiveness of the EIP, it resulted in the creation of an EIP model that can be replicated in other churches and faith-based organizations.

ACKNOWLEDGMENTS

I would like to thank the Lord Jesus Christ for rescuing and saving me from a life of destruction and for calling me to the Assemblies of God Theological Seminary (AGTS) Doctor of Ministry Program. He told me AGTS would be an oasis for personal and professional development and growth. This has been my experience, for which I am extremely grateful.

I would like to express my appreciation to the leadership team of the AGTS Doctor of Ministry department for allowing me the honor and privilege of participating in the Pastoral Care and Counseling cohort. I am especially thankful to Dr. Cheryl Taylor, Director of the Doctor of Ministry (D.Min.) program, Dr. Ava Oleson, D.Min. Program Coordinator, and Dr. Lois Olena, D.Min. Project Coordinator, for believing in me, providing direction, encouragement, and support when I needed it the most. I thank God for all my wonderful professors and especially my cohort brothers and sisters in Christ. I express grateful appreciation to Barbara North, Adjunct Faculty member of Sinclair College in Dayton, Ohio who served as my editor for all coursework throughout my doctoral journey, and whose guidance empowered me to become a better writer. I want to thank my biblical adviser, Dr. Andrew Sung Park, Professor of Theology and Ethics at United Theological Seminary in Dayton, Ohio, and my project adviser, Dr. Linda Mercadante, the B. Robert Straker Professor of Historical Theology at The Methodist Theological School in Delaware, Ohio, for their depth of insight, guidance, and wisdom.

Dr. Jeff Fulks, Ph.D., Director of Adult & Graduate Studies at Evangel University, provided the required technical expertise in analyzing data. I am forever grateful to Susan Meamber, project editor, who worked many hours to refine my writing for the completion of this final project. Additionally, I would like to extend gratitude to Sara Schultz for her graphic design skills; Tina Ruble for clerical assistance; and Mark Stipich for web design. I would like to offer thanks to my colleagues, small group members, and Celebrate Recovery team members at the Vineyard Church, and to the board of directors of Three Oaks Center, Inc., the parent nonprofit organization for this project, for all their creative ideas, encouragement and ongoing prayer support.

I express heartfelt appreciation and gratitude to my dear wife, Michelle who has been my greatest cheerleader from the moment I articulated the desire to return to school—all the way through to the end of my dissertation project! You endured husbandless weeks; you faced countless household tasks and issues with other family members and handled them in stellar fashion; you sacrificed time as it was diverted to write another paper or chapter; you extended the compassion, grace, and mercy of God to me when I behaved in a snarky manner! Michelle, you have been my constant companion and forever-friend, just as we promised each other over thirty-eight years ago. I love you more than I can ever express in words.

Lastly, I want to express thankfulness to my family, especially my adult children and grandchildren—Dalynn and her husband, Will, and children, Dominick, Makayla, and Liliana; Josiah and his wife, Ashley, and children, Lucas and Logan; and Jeremiah—each of you, in your own way, provided encouragement and support, especially through the mechanism of laughter when I needed a joy-fix the most. I treasure each of you!

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CHAPTER 1: INTRODUCTION

The Context

Currently, I serve as pastor of Congregational and Pastoral Care ministry at the Vineyard Church, a multi-campus church in Dayton, Ohio. Launched in 1991 as a church plant from Vineyard Community Church in Cincinnati, Ohio, with about seven families, two of those families pioneered the Dayton church: Doug Roe, who serves as lead pastor, and Scott Sliver, who serves as associate lead pastor. Twenty-four years later, the church occupies two campuses with over 1,500 people in attendance. The largest campus covers approximately twenty-five acres with a 48,000 and a 38,000 square foot building in the suburb of Beavercreek (Greene County). The second campus, acquired eight years ago, is located in urban Dayton (Montgomery County) just north of the downtown area with one building of nearly 30,000 square feet.

A fast growing congregation, the Vineyard Church has a well-established history as an externally-focused church, conducting servant evangelism initiatives throughout the greater Dayton metroplex area. The church's leadership team estimates that more than \$1 million of goods and services have been invested in the people of the city since the church's inception. During the last few years, the food pantry at the Beavercreek Campus and its mobile food pantries on Saturdays have distributed an average of fifteen tons of food per month throughout the region. As a result of these ministries, hundreds of people have come to faith in Jesus Christ as their Savior. On average, the church baptizes nearly

100 people each year. Additionally, hundreds of people receive prayer at weekend worship services and through various outreaches on a weekly basis.

I began serving on the pastoral team in April 2003 in the area of pastoral care and discipleship. I served as executive pastor from 2005 through 2008, during which time we launched the Dayton Campus (now known as the Riverdale Community Site). Between late 2007 and 2010, I was the Riverdale campus pastor. In January 2011, I returned to the Beavercreek Campus to take the position I currently hold. As pastor of Congregational and Pastoral Care ministry, I am responsible for the development, leadership, and oversight of all pastoral care-giving teams, recovery and support group ministries, as well as the church's pre-marital preparation process. I coordinate, develop, direct, manage, and oversee programming, as well as recruit and supervise volunteer ministry partners with a goal of improving spiritual health and social functioning of individuals, couples, and families via psycho-educational and skill-based classes, pastoral counseling, interventions, and referrals to community-based resources.

Moreover, I have had a dual career working as a social worker, alcohol and drug counselor, and clinical psychotherapist spanning over twenty years and over twenty-seven years of service in pastoral ministry. I served as ministry leader for Celebrate Recovery (CR) for nearly eight years in my previous pastorate in Minnesota and for over twelve years at my present location. I also serve as a coach for leadership teams from other churches in the development of additional CR groups throughout the greater Dayton area. Presently, eight other CR groups conduct meetings on a weekly basis, four of which I assisted in a coaching capacity. I am currently credentialed as a Licensed Chemical Dependency Counselor II (LCDC-II) in the State of Ohio, as an Internationally Certified

Alcohol and Drug Counselor (ICADC) by the International Certification and Reciprocity Consortium (IC&RC), and as a Certified Pastoral Counselor and Fellow by the American Association of Pastoral Counselors (AAPC).

Problem

Because of my multi-faceted career as a social worker, alcohol and drug counselor, clinical psychotherapist, and pastor, I see a gap in the faith-based service continuum of care in work with adults aged eighteen years and older who suffer with alcohol and other drug (AoD) problems. Faith-based mutual-help groups exist, such as Celebrate Recovery. Treatment programs functioning from a faith-based model exist in outpatient, intensive outpatient, residential, and inpatient treatment settings, such as those operated by Salvation Army Adult Rehabilitation Centers and Teen Challenge Centers. However, no faith-based early intervention programs exist for adults who face initial legal consequences for their use of AoD.

These individuals are usually identified when stopped for reckless or drunk driving or for other drug offenses, such as serving as a courier of illegal drugs. A quick review of 2012 statistics published by the Ohio State Highway Patrol (OSHP) reveals 24,526 statewide arrests for Operating a Vehicle Under the Influence (OVI). This is 779 more OVI arrests (+3%) than in 2011. Statewide OVI arrests by troopers ranked third highest in Montgomery County, one of five counties accounting for one-in-four OSHP OVI arrests (6,168 or 25%). In 2012, troopers made 7,641 drug arrests. This is 1,477 more drug arrests (+24%) than in 2011.¹ As lawmakers get more serious about blood

¹ “2012 Operational Report: Statewide Activity Comparison (2008-2012),” State of Ohio, accessed September 9, 2013, http://statepatrol.ohio.gov/doc/2012_OperationalReport_Final_20130801.pdf.

alcohol content (BAC) limits, decreasing in Ohio from .15 to .10 in the 1980s and to .08 in 2003, and consider another decrease to .05 in the near future, undoubtedly more OVI arrests will occur. Adults with a first time offense are often identified through law enforcement arrest records or court records for such offenses as drunk and disorderly conduct, public intoxication, domestic violence, child abuse or neglect, breaking and entering, burglary, theft, possession of illegal substances, possession of drug paraphernalia, and drug trafficking to name a few. The negative effects of these types of offenses on society prove enormous financially, not to mention the toll on individuals' physical and mental health and the well-being of marriages and families.

Pastors and church leaders often do not know where to refer adults with AoD issues, especially a program that embraces a faith-based perspective. Scripture proclaims that Christ sets people free from the chains that enslave them—including the chains of AoD abuse and dependency. Substantial efforts have been made to provide faith-based AoD treatment for those who have developed addictions. However, no faith-based early intervention (FB/EI) models exist in the Dayton, Ohio area to bridge the gap between prevention and treatment.

The existence of a FB/EI model is important because it has the potential to impede the development of a more serious AoD problem that can lead to abuse or dependency in an individual's life. Such a model could reduce the number of repeat offenders, the numbers of people addicted to AoD requiring treatment, and the negative effects on society.

The lack of a FB/EI model limits the Vineyard Church's ability to have a kingdom of God impact on the development of AoD problems in the communities the

church serves. The opportunity exists for churches to work together to offer help that can make a difference through partnerships with Celebrate Recovery groups, Salvation Army Adult Rehabilitation Centers, and Teen Challenge Centers to bridge the gap between prevention and treatment through the creation of a FB/EI model. Additionally, the creation of a FB/EI model has the potential for applicability nationally and internationally.

Purpose

The purpose of this project is to bridge the continuum care gap between prevention and treatment through the creation of a faith-based early intervention model primarily for use with first-time alcohol and other drug offenders.

Definition of Key Terms

Addiction. An unhealthy relationship with any mood-altering experience or substance that interferes with normal daily functioning and results in harmful consequences in an individual's life.

AoD. Alcohol and other drugs.

Continuum of care. A coordinated, comprehensive plan of care to address effectively AoD problems from prevention programming through outreach, crisis intervention, screening and assessment, referral, detoxification, recovery continuum services, and aftercare.

Early intervention. Initial screening for involvement with AoDs and, if indicated, a comprehensive AoD assessment. This also includes education on the harmful effects and negative consequences of AoDs.

Faith-based. Faith-based recovery initiatives focus on spiritual and religious orientations to recovery and have received increased legitimization through President George W. Bush's 2003 Access to Recovery Program (ATR) and through the Center for Substance Abuse Treatment's Recovery Community Support Program (RCSP). Both the ATR and RCSP have encouraged the development of faith-based recovery support services in local communities around the country.

First-time alcohol and other drug offenders. Adults who face initial legal consequences for their use of AoD. During the implementation phase I expanded the terminology due to negative implications of the term offender to the more inclusive statement, adults with alcohol and drug issues.

Recovery. Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life.

Description of Proposed Project

Scope of the Project

This project will design a faith-based early intervention (FB/EI) model to bridge the gap between AoD prevention and treatment programs targeting adults with alcohol and drug issues. I will offer potential candidates the opportunity to select this program from similar weekend intervention programs provided by the municipal courts in the greater Dayton, Ohio area, specifically in the cities of Dayton, Fairborn, Kettering, Miamisburg, Oakwood, Vandalia, and Xenia. I will conduct the FB/EI model over the course of a weekend (based on availability of hotel space and contracted staff), Thursday evening through Sunday afternoon, in a residential setting (as an alternative to

incarceration at the discretion of the courts) utilizing the DoubleTree Suites Hotel in Miamisburg, Ohio.

I will market the program to judges, prosecuting attorneys, defense attorneys, public defenders, probation officers, Certified Employee Assistance Professionals (CEAPs), Substance Abuse Professionals (SAPs), Department of Defense/Wright Patterson Air Force Base (DOD/WPAFB), area college campus counseling centers, local churches, Celebrate Recovery groups, Salvation Army Adult Rehabilitation Centers and Teen Challenge Centers in the greater Dayton, Ohio area.

I will offer the program on a fee for service basis, with the fee established by surveying similar weekend intervention programs in the area. I will recruit staff for the weekend who will work as independent contractors. Positions will include one program director, one registered nurse to provide access to medications (as needed), one overnight hallway monitor, and at least one licensed AoD counselor per six to eight clients.

Additional resources will include videos, DVDs and various guest presenters addressing the emotional, financial, legal, medical, mental, social, relational, and spiritual effects of AoD use. I will recruit students enrolled and majoring in educational programs in the fields of chemical dependency, counseling, criminal justice, nursing, psychology, social work, and sociology from area colleges and universities (as needed) by sending notices to respective department chairpersons.

I will conduct interviews and orientations to acquaint students with duties and responsibilities in augmenting the work of professionals during the course of the weekend program, including assisting with admission and intake procedures, facilitating use of videos and DVDs, supervision of meals and snacks, monitoring hallways outside of

sleeping rooms overnight, co-facilitation of small groups, and completion of the client discharge process.

Prior to the start of the weekend program, I will establish phone contact to assess an individual's appropriateness for participation in the program. I will schedule an orientation with all clients at either the program site location, or if needed, at the Vineyard Church, approximately one week before the commencement of the EIP weekend to ensure that each participant receives and signs the appropriate consent to participate, release from liability, client rights, grievance procedure, rules and regulations, emergency telephone numbers, release of information forms as well as any additional forms mandated by the State of Ohio. I will then assign participants to a licensed AoD counselor and place them into small groups for the purpose of discussion and processing of the information presented during the weekend program.

Prior to the EIP weekend, each client will complete the Drug Use Screening Inventory-Revised (DUSI-R). At the onset of the EIP weekend, the Triage Assessment of Addictive Disorders-5 (TAAD-5) will be conducted in a client interview.² Additionally, I will administer the Discovering Your Attachment Style Questionnaire and the Reinert S-Scale during the course of the weekend in order to measure each individual's primary attachment style in relationships in general, and to God, in particular, as well as their surrender direction as it relates to spirituality. In order to secure information to help improve the program, participants will complete an evaluation form after the EIP. Each participant will receive a certificate of completion. Following each weekend program, I

² In accordance with state requirements, I will utilize two screening/assessment tools.

will perform a three-month³ follow-up utilizing the DUSI-R instrument to assess long-term changes resulting from the faith-based early intervention process.

I will center the weekend program on specific pre-planned topics that will achieve the educational purposes of increasing participants' knowledge and assisting them in making needed behavioral changes. The faith-based component will present a review of key biblical texts and themes regarding the problem of improper foundations, the danger of idolatrous false attachments, and the importance of personal responsibility.

As program director for the EIP, I will play a key role in maintaining the integrity of the program in order to meet all expectations mandated by the State of Ohio Department of Mental Health and Addiction Services (OMHAS). Recommendations consistent with the results of the screening and assessment tools and in accordance with early intervention standards will be made for each individual by AoD counselor(s) and reviewed by the program director.

The program will not provide an in-depth AoD assessment,⁴ nor serve as a substitute for AoD treatment.

Phases of the Project

Research

I will obtain information on expectations and standards for weekend intervention programs from OMHAS. I will conduct an informal phone survey to gather information

³ A similar six-month follow up has been designed but, due to the time constraints of this project,, that follow-up will be executed outside the scope of this project.

⁴ The purpose of an in-depth assessment is to gather the detailed information needed for a treatment plan that meets the individual needs of the person; it is the process for defining the nature of the problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.

and explore other weekend intervention programs in the greater Dayton, Ohio area. I will develop pre-session staffing interview content and list of potential professionals, and conduct interviews for the various contracted staff positions.

Research and reading will be conducted in preparation for writing a biblical-theological literature review. Additionally, research and reading will also be completed in order to write a general literature review.

Planning

I will order and receive training in the use of scientifically validated screening instruments—in particular the DUSI-R and TAAD-5 from eCenter Research and The Change Companies, respectively. An appropriate interactive journal will also be researched and purchased for client's use during the EIP weekend. I will secure Tim Clinton and Duane Reinert's permission to utilize the Discovering Your Attachment Style Questionnaire and the Reinert S-Scale during the EIP weekend. I will write discussion questions to accompany each DVD shown during the weekend. In addition, I will develop client and staff evaluation forms.

I will contact municipal courts as well as common pleas courts and their respective probation departments to secure support for conducting the EIP weekend program. I will make room reservations for meeting space and sleeping rooms with the management at the DoubleTree Suites Hotel. I will also create menu plans for breaks and meals, as well as arrangements for preparation, service, and clean-up.

Implementation

I will carry out the implementation or intervention phase of this project in the context of a residential setting (as an alternative to incarceration at the discretion of the

courts), utilizing the DoubleTree Suites Hotel in Miamisburg, Ohio. The goal is to conduct the FB/EI model one weekend, Thursday evening through Sunday afternoon. This will require administration of the DUSI-R instrument prior to the weekend and the TAAD-5 at the onset of the weekend. I will also administer the Discovering Your Attachment Style Questionnaire and Reinert S-Scale during the course of the weekend in order to measure each individual's primary attachment style in relationships, in general, and to God, in particular, as well as their surrender direction as it relates to spirituality. At the conclusion of the weekend, the clients and staff will complete the evaluation forms. After the EIP weekend, each client will receive a three-month follow-up utilizing the DUSI-R instrument in order to measure the effectiveness of the intervention.

Evaluation

The initial step will require the collation and tabulations of the results of the client and staff evaluation forms. Next, I will focus on collating and tabulating the results of the initial DUSI-R, which I will compare and contrast with the three-month follow-up protocol. To conclude the evaluation process, I will review the overall effectiveness of the project processes—from research to implementation to preparation for writing the chapters for the project.

Writing

After writing the biblical-theological review (chapter 2), I will submit it to the editor, biblical adviser, project adviser, and project coordinator. This chapter will review key biblical texts and theological works regarding the definition, meaning, and role of faith in the following categories: improper (Matt. 7:24-27; Rom. 1:21-24, 29-32) and proper (Ps. 89:14; 1 Tim. 6:18-19) foundations; idolatrous false attachments leading to

slavery (Lev. 19:4; Ps. 106:36; 1 Cor. 10:13-15) versus healthy true attachments leading to freedom (Isa. 48:10-12; Rom. 6:17-19); and personal responsibility in looking backward to repair (Ps. 51:1-2; Eph. 2:1-3; James 1:13-15) and looking forward to rebuild (Eph. 2:4-10; Gal. 5:1, 13) one's life.

In like manner, I will write the general literature review (chapter 3) and submit it to the editor, project adviser, and project coordinator. This chapter will review key contemporary literature in the following categories: care components in the field of addiction treatment, in particular, faith-based initiatives, and the role of early intervention in the continuum of care in the treatment of alcohol and other drug problems. I will also address the contributing factors, harmful effects, and negative consequences of alcohol and drug use and abuse, exploring mental components, psychological/emotional components, sociological/relational components, behavioral components, cultural/familial components, financial components, legal components, medical/physical components, and spiritual/theological components.

Chapter 4, "Description of the Field Project," will provide a written description of the project. I will submit it to the editor, project adviser, and project coordinator. This chapter will describe the four procedural phases of the project: (1) preparation of the project, (2) execution of the project, (3) presentation of the results of the project, and (4) reflection on the project's contribution to ministry.

Chapter 5, "Project Summary," will provide a written summary of the project and receive approval from the editor, project adviser, and project coordinator. This chapter will provide a summary of the project by evaluating the keys to the project's effectiveness and identifying the areas that need improvement. Furthermore, it will

clarify the implications of the project, make recommendations for the church, in general, regarding future implementation of the Early Intervention Program (EIP), and highlight areas for further research.

I will develop and finalize the front matter, consisting of the title page, contents, abstract, and acknowledgments. Last, I will develop appropriate appendices used to support and provide clarity for the project. In like fashion, these will be written and submitted to the editor, project adviser, and project coordinator.

CHAPTER 2: BIBLICAL-THEOLOGICAL LITERATURE REVIEW

This chapter will review key biblical texts and theological works regarding the definition, meaning, and role of faith, sin, and evil as they relate to an individual's foundations, attachments, and responsibilities. The conclusion will provide summary and synthesis of the chapter materials.

Theological Underpinnings of Faith, Sin, and Evil

This section provides an exploration of the theological underpinnings of faith, sin, and evil. Faith in Creator God provides the footings upon which the foundation of one's life is built. Sin and evil seek to destroy faith and offer substitutes in the form of false attachments and irresponsibility—characteristics upon which a life cannot successfully be built or lived.

Faith

At the outset, a basic understanding of Judeo-Christian faith is imperative in order to formulate a biblical-theological position. The essence of faith has its foundation in the Old Testament account of Abraham:

Then behold, the word of the LORD came to him, saying, 'This man will not be your heir; but one who will come forth from your own body, he shall be your heir.' And He took him outside and said, 'Now look toward the heavens, and count the stars, if you are able to count them.' And He said to him, 'So shall your

descendants be.’ Then he believed in the LORD; and He reckoned it to him as righteousness (Gen. 15:4-6).¹

S. S. Taylor in the article entitled, “Faith, Faithfulness” explains the concept of faith contained in verse 6:

Genesis 15:6 makes an apparently clear statement: ‘And [Abraham] believed (*’āman / pisteuō*) the LORD; and the LORD reckoned it to him as righteousness.’ The simplicity here is stark. Abraham took God at his word, responding in the only fitting manner to the word of Yahweh. Yahweh conferred upon Abraham the status of being rightly related to him, not on the basis of a righteous deed, but solely on the basis of Abraham’s trust in the divine promise. In its starkness, this verse is unique among OT statements concerning faith.²

God established His covenant with Abram and changed his name to Abraham, promising to make him “the father of a multitude of nations” (Gen. 17:4-6). According to Paul, this promise is based on faith: “For the promise to Abraham or to his descendants that he would be heir of the world was not through the Law, but through the righteousness of faith” (Rom. 4:13). The writer of Hebrews includes Abraham in the “hall of faith” stating clearly that it was “by faith” that the promise of God was fulfilled (11:8-12).

Taylor further explains the concept of faith in the scriptures as one rooted in relationship between God and humanity:

The biblical concept of faith/faithfulness stands at the heart of the relationship between the God of the Bible and his people, a relationship which, in its essential bi-polarity, is intensely personal, dynamic, and multiform. A characteristic terminology is employed whenever the relationship is in view. In the OT, for example, there is the Hebrew *’āman* group (**’ēminâ* and *’emet*). These are often used interchangeably, and mean ‘steadfastness’, ‘truthfulness’, ‘faithfulness’ and sometimes ‘faith’. The NT vocabulary is largely determined by the Septuagint (LXX), the Greek translation(s) of the Hebrew Bible ... But most common are those with the *pist-* root: *pistis* (‘faith’), *pistos* (‘faithful’), *pisteuein* (‘to believe’,

¹ All Scripture quotations, unless otherwise noted, are from The New American Standard Bible.

² S. S. Taylor, “Faith, Faithfulness,” ed. T. Desmond Alexander and Brian S. Rosner, *New Dictionary of Biblical Theology* (Downers Grove, IL: InterVarsity Press, 2000), 489.

‘to trust in’) and certain tenses of the cognate *peithein* (‘to trust in’, ‘to be persuaded’, ‘to obey’).³

In other words, to exercise faith in one’s relationship or covenant with God means to take action based upon belief in Him and His Word, as evidenced in the life of Abraham as recorded in the Old and New Testaments.

The New Testament provides a clear definition of faith: “Now faith is the assurance of things hoped for, the conviction of things not seen” (Heb. 11:1). Faith is the belief or confident assurance that what we hope for will actually happen; it is a fundamental trust in the existence of God, “the firm foundation under everything that makes life worth living. It’s our handle on what we can’t see” (v. 1, MSG). Further, the author of Hebrews states that, “And without faith it is impossible to please Him, for he who comes to God must believe that He is and that He is a rewarder of those who seek Him” (v. 6). In other words, it is impossible to please God without faith in Him—“Because anyone who wants to approach God must believe both that he exists and that he cares enough to respond to those who seek him” (v. 6, MSG).

In the biblical account of the deliverance and healing of an epileptic boy, and the difficulty experienced by the disciples when they attempted to help him, to have faith means to take God seriously. Christ instructed them saying: “Because you’re not yet taking God seriously,” said Jesus. The simple truth is that if you had a mere kernel of faith, a poppy seed, say, you would tell this mountain, ‘Move!’ and it would move. There is nothing you wouldn’t be able to tackle” (Matt. 17:20, MSG). Some of the benefits or results of biblical faith recorded in the New Testament include:

- Forgiveness (Matt. 9:2; Mark 2:5; Luke 5:20)

³ Taylor, 488.

- Healing (Matt. 9:22, 29; 15:28; Mark 5:34, 10:52; Luke 8:48, 17:19, 18:42; Acts 3:16, 14:9-10)
- Salvation (Luke 7:50; Acts 6:7, 11:24; Eph. 2:8; 2 Tim. 3:15)
- Cleansed hearts (Acts 15:9)
- Sanctification (Acts 26:18; 2 Thess. 2:13)
- Encouragement (Rom. 1:12)
- Righteousness (Rom. 3:22, 9:30; Phil. 3:9)
- Justification (Rom. 3:28, 5:1; Gal. 2:16, 3:24)
- Promise of the Spirit (Gal. 3:14)
- Sonship (Gal. 3:26)
- Fruit of the Spirit (Gal. 5:22-23)
- Boldness and confident access to God (Eph. 3:12)

Biblical faith is powerful, changing and transforming humanity into Christ's image.

Ted Peters, in his seminal work on systematic theology, postulates three dimensions to understanding the meaning of faith:

Faith has three dimensions: belief, trust, and oneness with Christ. Faith is belief that certain things are true. At its deepest personal level faith takes the form of trust, an underlying and continuing confidence in the faithfulness of God ... Christian faith also involves a union between the person of faith and Jesus Christ himself ... This third or mystical element of faith is what reconstitutes the identity of the believer; it is a result of the Spirit's presence within the soul. Our identity is changed. We become something new and different.⁴

Peter's words echo the essence of the Apostle Paul when he wrote, "This means that anyone who belongs to Christ has become a new person. The old life is gone; a new life has begun" (2 Cor. 5:17, NLT). Jean-Yves Lacoste records that "Luther in fact posits that faith is a gift of the Holy Spirit to the entire person and an offering of the entire person to

⁴ Ted Peters, *God the World's Future: Systematic Theology for a New Era*, 2nd ed. (Minneapolis, MN: Fortress Press, 2000), 69-71.

God.”⁵ Trust is the mechanism for belief to take root in a person’s soul. The Holy Spirit is the vehicle who delivers faith to each person as a gift from God.

Faith cannot consist solely of mental assent and produce life transformation. Faith in the mind, conjoined with faith in the heart, leads to transformation. Henry Emerson Fosdick, in his classical work entitled, *The Meaning of Faith*, identifies two kinds of faith:

In Scripture two kinds of faith in the personal God are clearly indicated. In the first we are dealing with the *mind’s* faith in God; the man’s intellect assents to the belief that God is and that He is one. In the second we are dealing with the *heart’s* faith in God; the whole man is here involved in an adoring trust that finds in reliance upon God life’s stimulus and joy.⁶

The whole person believes and trusts in God, thereby producing life transformation. However, one must differentiate between faith and religion. At times, people postulate that religion is humanity’s attempt to reach God, primarily by one’s own strength, will, and efforts, giving the impression that one simply follows a religious formula and produces change resulting in improvement of one’s life. On the other hand, faith, since it is a gift from God, depicts God reaching out to humanity in order to establish relationship with those whom He has created, thereby producing substantive life transformation. A clear demarcation emerges: religion leads to life improvement while faith relationship leads to a real experience of life transformation. Fosdick highlights this dilemma: “The trouble often lies not in our theories about the religious life, but in our religious life itself. The deeper difficulty is not that our thinking is unreasonable, but that our experience is

⁵ Jean-Yves Lacoste, ed., “Faith,” *Encyclopedia of Christian Theology*, vol. 1 (New York: Routledge, 2005), 556, accessed January 20, 2014, <http://www.questia.com/read/108844206>.

⁶ Harry Emerson Fosdick, *The Meaning of Faith* (New York: Abingdon Press, 1917), 90.

unreal.”⁷ The contemporary world calls for a real faith experience rather than an unreal religious experience. A faith experience that produces life transformation is the type of reality for which people yearn—an experience rooted in relationship with God in the person of His Son, Jesus Christ as Savior and Lord. God actually created people for such a relationship, as Jeffrey VanVonderen, Dale Ryan, and Juanita Ryan describe: “We seem to be hard-wired for the spiritual life—for having a relationship with God. It’s down deep in us, at the heart of things.”⁸

When an individual is arrested for an alcohol or other drug offense for the first time, it precipitates a crisis of faith, and many questions fill the quiet moments while sitting in the back seat of a law enforcement vehicle or in a holding cell of a municipal or county jail —Who am I? How did this happen to me? What am I? What is going to happen to me now and to my family? Will I still be loved? D. Mackenzie Brown records Paul Tillich raising this issue in the classic theological work entitled, *Ultimate Concern: Tillich in Dialogue*: “Tillich stressed the need for each individual to confront his existence alone, in the inwardness of his soul. Man’s fulfillment must be found through his own inner courage and vision. The fundamental question of human existence—‘What am I?’—can only be answered by the one who asks the question.”⁹ This fundamental question, raised by a crisis of faith, becomes the ultimate concern of one’s life. Tillich defines faith, and indirectly religion, as the ‘ultimate concern’ of one’s life: “Religion is

⁷ Fosdick, 100-102.

⁸ Jeffrey VanVonderen, Dale Ryan and Juanita Ryan, *Soul Repair: Rebuilding Your Spiritual Life* (Colorado Springs, CO: InterVarsity Press Books, 2008), 8.

⁹ Paul Tillich, *Ultimate Concern: Tillich in Dialogue*, ed. D. Makenzie Brown (New York: Harper & Row Publishers, 1965), xv.

direction or movement toward the ultimate or the unconditional. And God rightly defined might be called the Unconditional, the ‘Ground of all Being.’”¹⁰ An individual propelled forward, often out of a sense of desperation in the midst of his or her crisis of faith, moves forward to find answers to these questions regarding ultimate identity, the meaning of life, and where to find unconditional love.

Love is the component that drives people forward in their quest for meaning.

Tillich illuminates the answer with the following explanation:

Since we are finite creatures, we are separated from this infinite ground or foundation of our being. What overcomes this separation and brings us into communion with the ultimate ground of being, and into awareness of the meaning of our life, is love. Love is thus the most powerful and important aspect of religion ... love is the drive to bring together that which has been separated.¹¹

Individuals experiencing a crisis of faith often experience separation from the love of family and friends, yet the sense of separation from God’s love has the power to launch them into a search for the real meaning of life, found ultimately in connection with God.

Sin

H. A. G. Blocher, in an article entitled, “Sin,” introduces the biblical concept of sin as follows: “Nowhere is the vocabulary of biblical Hebrew richer than in the semantic field of ‘sin’ ... The one usually translated ‘sin’, and closely related terms of the same *ḥṭ* root, occur about 600 times. Its original meaning is that of missing the target, failing, falling short of the norm or goal (Judg. 20:16; Job 5:24; Prov. 8:36).”¹² Further, he offers

¹⁰ Tillich, 2.

¹¹ Ibid., 2-3.

¹² H. A. G. Blocher, “Sin,” ed. T. Desmond Alexander and Brian S. Rosner, *New Dictionary of Biblical Theology* (Downers Grove, IL: InterVarsity Press, 2000), 782.

a general biblical definition of sin stating, “Sin, according to the classical definition, is lack of conformity to the law of God. The testimony of Scripture, as a whole, confirms this definition.”¹³ Therefore, an accurate biblical understanding of sin has as its foundation the truth that to sin is to act unfaithfully against God; in other words, all sin is fundamentally and primarily against God even though it affects and impacts other human beings (Lev. 6:2; Ps. 41:4; Jer. 14:20; Dan. 9:8; Zeph. 1:17; Luke 15:18, 21). Some of the effects of sin noted in the Book of Psalms, include:

- Affliction and trouble (Ps. 25:18).
- Body wasting away through groaning and guilt (Ps. 32:3, 5).
- Anxiety (Ps. 38:18).
- Sense of being unclean, necessitating washing and cleansing (Ps. 51:2).

This understanding prompted David to exclaim: “Your word I have treasured in my heart, that I may not sin against You” (Ps. 119:11).

God desires humanity be freed from the power and the effects of sin. In the Old Testament He calls to His creation saying, “Come now, and let us reason together,” says the LORD, “Though your sins are as scarlet, They will be as white as snow; Though they are red like crimson, They will be like wool” (Isa. 1:18). God’s remedy for sin is salvation, thereby providing deliverance and forgiveness: “Help us, O God of our salvation, for the glory of Your name; and deliver us and forgive our sins for Your name’s sake” (Ps. 79:9). The Scripture records redemption as God’s heart towards humanity: “I have wiped out your transgressions like a thick cloud and your sins like a heavy mist. Return to Me, for I have redeemed you.” (Isa. 44:22). Blocher introduces the concept of sin in the New Testament asserting, “The vocabulary of the NT is less

¹³ Blocher, 783

abundant and varied; the standard meaning of some Greek terms has been changed, through their LXX usage, so as more closely to reflect OT concepts. *Hamartia* and its cognates form the main word-group, and closely correspond to the *ḥt* family; they even have a similar etymology, that of missing the mark.”¹⁴ John, one of the original disciples of Jesus, provides a succinct definition of sin: “All unrighteousness is sin” (1 Jn. 5:17). In other words, “All wicked actions are sin” (1 Jn. 5:17, NLT) and “Everything we do wrong is sin” (1 Jn. 5:17, MSG). James writes: “Therefore, to one who knows the right thing to do and does not do it, to him it is sin” (James 4:17). According to Jesus, sin produces its own slavery: “Jesus answered them, ‘Truly, truly, I say to you, everyone who commits sin is the slave of sin’ ” (Jn. 8:34). The Book of Romans teaches that no one is righteous and righteousness comes by faith (Rom. 3:9-31). Believers as followers of Jesus Christ are dead to sin because they are alive to God (Rom. 6). This is possible because of deliverance from the bondage of sin and slavery to sin which God has provided through Christ (Rom. 8).

The Gospels proclaim forgiveness and healing as the remedy for sin (Mt. 9:2-6; Mk. 2:1-12; Lk. 5:17-26; Lk. 7:47). God’s Son, Jesus, is the vehicle of this remedy, “The next day he saw Jesus coming to him and said, ‘Behold, the Lamb of God who takes away the sin of the world!’ ” (Jn. 1:29). In the Book of Acts, access to this remedy comes through repentance or calling on His name, demonstrated by water baptism and receipt of the gift of the Holy Spirit (Acts 2:38; 22:16). As Paul writes: “He made Him who knew no sin to be sin on our behalf, so that we might become the righteousness of God in Him”

¹⁴ Blocher, 782.

(2 Cor. 5:21). And, “For He rescued us from the domain of darkness, and transferred us to the kingdom of His beloved Son, in whom we have redemption, the forgiveness of sins” (Col. 1:13-14). John indicates that, “If we confess our sins, He is faithful and righteous to forgive us our sins and to cleanse us from all unrighteousness” (1 Jn. 1:9).

The writer of Hebrews portrays Jesus as our “high priest” who understands humanity’s struggle with sin: “For we do not have a high priest who cannot sympathize with our weaknesses, but One who has been tempted in all things as we are, yet without sin” (Heb. 4:15). Additionally, Christ is heralded as the one sacrifice who is sufficient for all time (Heb. 10). Specifically, Hebrews presents a contrast between the Old Testament system of animal sacrifices and the New Testament Savior: “For it is impossible for the blood of bulls and goats to take away sins ... He takes away the first in order to establish the second. By this will we have been sanctified through the offering of the body of Jesus Christ once for all ... Now where there is forgiveness of these things, there is no longer any offering for sin” (Heb. 10:4, 9-10, 18; cf. 1 Pet. 3:18).

Separation from God comes as a result of sin, as readily seen in 1 John 2:1: “Each sin, small and large, injures us or someone else; it imprints on our soul, makes us imperfect, and separates us from the perfect God. If we confess our sins to God each day, then He will purify our hearts and draw us closer to Him” (The Voice). Rick Warren further explains: “The Bible clearly states ‘all have sinned.’ It is my nature to sin, and it is yours too. None of us is untainted. Because of sin, we’ve all hurt ourselves, we’ve all

hurt other people, and others have hurt us. This means each of us needs recovery in order to live our lives the way God intended.”¹⁵

In postmodern culture and society, people do not view the concept of sin as popular. It no longer enters humanity’s thinking, as Karl Menninger laments:

The very word ‘sin,’ which seems to have disappeared, was a proud word. It was once a strong word, an ominous and serious word. It described a central point in every civilized human being’s life plan and life style. But the word went away. It has almost disappeared—the word, along with the notion. Why? Doesn’t anyone sin anymore? Doesn’t anyone believe in sin?¹⁶

In the absence of the use of the term “sin,” one must provide a definition. Menninger defines sin as any “behavior that violates the moral code or the individual conscience or both; behavior which pains or harms or destroys my neighbor—or me, myself.”¹⁷ This definition embraces both sins of commission (those actually committed) and sins of omission (harm caused to an individual(s) due to a lack of appropriate action, not doing something within one’s ability to do). Menninger illuminates this further:

The wrongness of the sinful act lies not merely in its nonconformity, its departure from the accepted, appropriate way of behavior, but in an implicitly aggressive quality—a ruthless, a hurting, a breaking away from God and from the rest of humanity, a partial alienation, or act of rebellion. Sin has a willful, defiant, or disloyal quality; someone is defiled or offended or hurt. The willful disregard or sacrifice of the welfare of others for the welfare or satisfaction of the self is an essential quality of the concept of sin.¹⁸

Since Menninger penned those words in 1984, society has experienced a departure from a more traditional understanding of the concept of sin to one that transfers

¹⁵ Rick Warren, “Introduction,” in *Your First Step to Celebrate Recovery: How God Can Heal Your Life*, John Baker (Grand Rapids, MI: Zondervan, 2012), 7.

¹⁶ Karl Menninger, *Whatever Became of Sin?* (New York: Bantam Books, 1984), 16.

¹⁷ *Ibid.*, 19-20.

¹⁸ *Ibid.*, 22.

some behaviors into the realm of addiction. Linda Mercadante elucidates this departure: “Behavior that was once called sin is often today called addiction . . . In America the word *addiction* has become a euphemism to describe problematic, excessive, or repetitive behavior.”¹⁹ In other words, the idea of addiction has been popularized in contemporary culture and society to the extent that some have actually conjectured that addiction has become synonymous with sin and offers a more comfortable spirituality than the traditional Christian doctrine of sin. This amazing shift, occurring over nearly eight decades, has roots in the formation of Alcoholics Anonymous (AA) and the subsequent Alcohol and Other Drug (AOD) treatment industry.

Nevertheless, the problem of sin exists, as does the problem of evil. One must identify how sin and evil factor into the understanding of human behavior and the human predicament, yet include the grace of God. Mercadante provides the following perspective:

Sin is holistic, affecting body, mind, and spirit, and salvation is much more about healing and newness than about retribution and punishment . . . Sin is not primarily about right and wrong behavior. Sin is first about orientation. One’s *telos*, direction, primary attachment—rather than beliefs or behavior—is what is most radically affected by sin.²⁰

Clearly stated, sin effects the entire human being—body, mind, and spirit—not just behavior. Therefore, the primary focus of attention in terms of healing and recovery must target one’s orientation, not simply one’s behavior. To simply target one behavior creates an over-simplification of the true problem, often resulting in “switching addictions” as

¹⁹ Linda Mercadante, *Victims & Sinners: Spiritual Roots of Addiction and Recovery* (Louisville, KY: Westminster John Knox Press, 1996), 5, 7.

²⁰ *Ibid.*, 27-28.

one moves from one problematic behavior to another because the underlying issue has not been addressed—the problem of one’s orientation.

All human beings have the power of choice in their orientation—either movement toward God or movement away from God. All sin is primarily a turning from the source of our being, God. It is too simplistic to describe sin as putting oneself in the place of God. Sin is more accurately described as “a refusal to find the self through the only sure reality, a perverse rejection of the true ground of the self, God. In other words ... sin is a refusal or an ignoring of the reality and claims of God”²¹ Rejecting God’s claims means not recognizing that God loves all people (John 3:16), because humanity was created in the Trinity’s own image for relationship (Gen. 1:26-27; Rom. 5:11). God sent Christ to die for all of humanity to redeem and reclaim them as His own (Isa. 43:1; Rom. 5:18; 1 Pet. 1:17-19, NASB), to adopt them into His family as children (Rom. 8:14-17), and to call them friends (John 15:14-16).

Many people question whether a connection exists between sin and addiction. In addressing this concept, Mercadante provides insight:

Sin is disorder, disorientation, disinclination. God intends integrity, order, and right orientation. This quandary—deciding whether addiction is sin—comes primarily from confusion over, distortions of, and increasing ignorance of sin ... and from confusion over and misuse of the term *addiction*. The term *addiction* has been used too widely, too loosely, too easily.²²

Sin and addiction represent an orientation that moves human beings away from God, rather than toward God. Right relationship with God results in wholeness for humanity.

²¹ Mercadante, 35-37.

²² *Ibid.*, 43.

Humanity can become partakers of biblical wholeness through God’s grace—a free gift from God. This grace-gift provides the redemption and rebirth that humanity so desperately needs—thereby creating the reorientation and movement towards God. Grace ushers in the possibility for healthy, positive, and true spirituality. The person and work of Jesus Christ, through the gift of God’s grace, empowers humanity to choose movement toward God and biblical wholeness.

Evil

The notion of evil permeates the bible; multiple words attempt to capture its various meanings. Blocher in an article entitled, “Evil” notes some of the most common:

The Hebrew *ra‘* occurs about 640 times, and 40 per cent of these cases refer to some calamity ... In NT Greek, the word *kakos* has a wide application ... The other common NT words for evil are *ponēros* and *ponēria* (derived from *ponos*, toil or pain, Col. 4:13; Rev. 16:10–11), which occur 85 times; these refer to physical evil ... but more often to that which is wicked and worthless, the store from which men and women, being evil, draw the evil things they do and say (in Matt. 12:35 *ponēros* is used three times; *cf.* v. 34).²³

Jesus drew attention to the fact that words reveal character, “the tree is known by its fruit” (Mt. 12:33). Living one’s life firmly rooted in Christ is the best way to combat evil.

According to Blocher, there are two biblical insights relevant to the idea of evil in the scriptures:

(1) Evil is real, drawing its reality from created things; it is the *perversion* and *corruption* of the good ... The Genesis narrative separates the origin of evil from the act of creation: evil entered the world later, as a ‘foreign body’ and parasite; it was not present in the beginning. Evil entered history in the abuse of created freedom (**cf.* Matt. 19:8; Rom. 5:12); and (2) If evil is perversion, its original

²³ Blocher, 465.

locus is the perversion of freedom: the primary evil is sin ... Paul agrees that death entered the world through sin (Rom. 5:12).²⁴

In order to provide a more comprehensive perspective regarding the effects of sin as it relates to evil, closer scrutiny needs to include the impact on the victims of sin.

Andrew Sung Park raises this concern and leads the way in consideration of this topic:

Throughout its history, the church has been concerned with the sin of people, but has largely overlooked an important factor in human evil: the pain of the *victims* of sin. The victims of various types of wrongdoing express the ineffable experience of deep bitterness and helplessness. Such an experience of pain is called *han* in the Far East. *Han* can be defined as the critical wound of the heart generated by unjust psychosomatic repression, as well as by social, political, economic, and cultural oppression. It is entrenched in the hearts of the victims of sin and violence, and is expressed through diverse reactions as sadness, helplessness, hopelessness, resentment, hatred, and the will to revenge. Sin and *han* must be treated together, if we are to grasp a more comprehensive picture of the problems of the world than that delineated by the doctrine of sin alone.²⁵

Park presents a veracious indictment regarding the failure of the church at large to include the victims of sin in its understanding in the larger doctrine of sin and evil.

To focus on the behavior of the perpetrators of sin without inclusion of their impact on the thoughts, feelings, and experience of the victims of sin perpetuates an incomplete portrait of the human predicament. Mercadante sheds additional light regarding the victims of sin and *han*: "When one's core problem is truly a turning from God, a disorientation from our proper source, this can come about through inordinate self-loss as much as through inordinate self-will."²⁶ Therefore, the victims of sin who

²⁴ Blocher, 466.

²⁵ Andrew Sung Park, *The Wounded Heart of God: The Asian Concept of Han and the Christian Doctrine of Sin* (Nashville, TN: Abingdon Press, 1993), 10.

²⁶ Mercadante, 39.

experience *han*, need to be empowered to give voice to their experience and face their perpetrators, facilitating a deeper and fuller restorative healing.

An understanding of evil, therefore, becomes necessary in the picture of the human predicament. M. Scott Peck offers one perspective: “Evil, then, for the moment, is that force, residing either inside or outside of human beings, that seeks to kill life or liveliness. And goodness is its opposite. Goodness is that which promotes life and liveliness.”²⁷ The power to choose to move towards the goodness that resides in God or evil exists within each human being. Peck provides keen insight: “There are only two states of being: submission to God and goodness or the refusal to submit to anything beyond one’s own will—which refusal automatically enslaves one to the forces of evil. We must ultimately belong to either God or the devil.”²⁸

An important clarification on the origin of evil is necessary, especially as it relates to human will. Conceptualization of the connection between evil, human will, and sin reveals that:

Humans do not originate evil, they yield to it. We are tempted and overcome, and yet we also allow evil to drown out our own reservations. One needs a properly directed, motivated, and functioning will in order to resist. Thus will in itself—even self-will—is not the source of the problem. Although our wills may be drawn and yield to evil, the capacity of will in itself is not equivalent to evil. The will is distorted by sin, but it is capable of reformation through relationship with God.²⁹

²⁷ M. Scott Peck, *People of the Lie: The Hope for Healing Human Evil* (New York: Simon and Schuster, 1983), 43.

²⁸ *Ibid.*, 83.

²⁹ Mercadante, 29.

The gospel message provides the ultimate solution to the problem of sin and evil in the context of faith in Christ's work on the cross. "The gospel declares that the powers of evil have been defeated by the blood of Christ's cross (Rev. 12:11; Col. 2:15). For God's people the burden of guilt is lifted and the bondage of sin broken. On Calvary faith beholds both God's hatred of sin (radical evil) and his sovereignty over it, which issues in victory."³⁰ In other words, the ultimate solution to the problem of evil, sin, and human will has its locus in one's faith or right relationship with God, which includes a firm grip on one's foundations, attachments, and responsibilities. A brief definition of biblical theology will provide the necessary framework for an in-depth understanding of these concepts.

Biblical Understanding of Foundations, Attachments, and Responsibilities

Biblical theology seeks to ascertain what the biblical writers, under God's guidance, believed, described, and taught in the context of their culture, society, and times. Robert W. Yarbrough offers the following definition for biblical theology:

An attempt to articulate the theology that the Bible contains as its writers addressed their particular settings. It labors to arrive at a coherent synthetic overview ... and factors in the progressive and historical dimension of the Bible's theology. Biblical theology moves forward as its practitioners know, love, and submit to the God of the Bible rather than the ideologies of the age. God is not a composite of the latest critical theories.³¹

In other words, one must not cave in to any one prominent philosophical position in the

³⁰ Blocher, 467.

³¹ Robert W. Yarbrough, "Biblical Theology," in *Baker's Evangelical Dictionary of Biblical Theology*, ed. Walter A. Elwell, accessed January 29, 2014, <http://www.biblestudytools.com/dictionaries/bakers-evangelical-dictionary/biblical-theology.html>.

discussion of the relationship between sin, evil, and addiction, and thereby succumb to the “ideologies of the age.” A thorough exploration and understanding of the biblical concepts of foundations, attachments, and responsibilities creates the pathway for the ultimate solution to the problem of sin and evil—a love relationship with God, the creator of all humanity.

Foundations

Utilizing a building motif, footings and foundations undergird an entire structure. The strength of the whole structure depends upon the solidness of its foundation. The Bible presents an understanding of improper and proper foundations.

Improper Foundations

Jesus describes two possible foundations for one’s life and their corresponding mental frameworks of wisdom and foolishness (Matt. 7:24-27). The wise person builds his or her house upon rock, and when the storms of life come, it withstands them because of the formidableness of its foundation. However, the foolish person builds his or her house on the sand; when the storms come; it disintegrates due to the instability of its foundation.

William D. Mounce defines the Greek word for *foundation* (*themelios*) as “the supporting groundwork or base of a building or city, suggesting the permanence and strength of what is built on it.”³² As illustrated in Matthew 7:24, 26, Johannes P. Louw

³² William D. Mounce, *Mounce’s Complete Expository Dictionary of Old & New Testament Words* (Grand Rapids, MI: Zondervan, 2006), 269-270.

and Eugene Albert Nida connect understanding and wisdom with obedience in contrast to the connection between foolishness and disobedience.³³

Another perspective on the Matthew 7 passage contrasts true and false discipleship (cf. Luke 13:24 with 6:43-46; and 13:25-27 with 6:47-49). D. A. Carson, R. T. France, J. A. Motyer, and G. J. Wenham describe the contrast:

Both *wise* and *foolish* are depicted as hearing *these words of mine*; the difference is in putting them *into practice* (cf. the ‘fruit’ of vs. 16-20). This whole concluding section of the discourse leaves Christians with the uncomfortable demand to consider not just what they profess but whether it is based on a genuine relationship with Jesus and issues in the life of a true disciple.³⁴

In other words, wise individuals build their houses upon the rock of true discipleship, genuine relationship, and subjection to Christ. When the storms of life come, the house stands because its foundation is the rock (Ps. 18:2, 31:3, 62:2).

The attitude of disciples is obedience, contrasted with the foolish, whose lives, built on empty profession and mere external services, cannot withstand the storms of life and fall in ruin. Robert Jamieson, A. R. Fausset, and David Brown note the relevance of this word picture: “How lively must this imagery have been to an audience accustomed to the fierceness of an Eastern tempest, and the suddenness and completeness with which it sweeps everything unsteady before it!”³⁵ The only sure way to withstand all the

³³ Johannes P. Louw and Eugene Albert Nida, *Greek-English Lexicon of the New Testament: Based on Semantic Domains* (New York: United Bible Societies, 1996), 383, 386.

³⁴ D. A. Carson, R. T. France, J. A. Motyer and G. J. Wenham, eds., *New Bible Commentary: 21st Century Edition*, 4th ed. (Leicester, England; Downers Grove, IL: InterVarsity Press, 1994), 914.

³⁵ Robert Jamieson, A. R. Fausset, and David Brown, *Commentary Critical and Explanatory on the Whole Bible* (Oak Harbor, WA: Logos Research Systems, 1997), Matt. 7:24-27.

challenges of life is to build one's foundation solidly on a relationship with God through faith in the person of Jesus Christ.

Intrinsic blockages and barriers exist, which contribute to the foolishness of humanity. The Apostle Paul notes that when people do not build their lives on the solid foundation of a relationship with God, they become “futile in their speculations, and their foolish hearts darkened ... and they exchange the glory of the incorruptible God for a false image ... due to the lusts of their hearts ...” and propel themselves towards all kinds of sin (Rom. 1:21-24, 29-32, NASB).

Rarely does the word “heart” in Scripture refer to the actual physical heart in one's body. According to Louw and Nida, the biblical concept of heart (Gr., *kardia*) refers to “the causative source of a person's psychological life in its various aspects, but with special emphasis upon thoughts—‘heart, inner self, mind.’”³⁶ The Hebrew concept of heart, as explained by B. O. Banwell, incorporates a holistic perspective:

The Hebrews thought in terms of subjective experience rather than objective, scientific observation ... It was essentially the whole man, with all his attributes, physical, intellectual, and psychological, of which the Hebrew thought and spoke, and the heart was conceived of as the governing centre for all of these.³⁷

In the New Testament, Paul writes that individuals comprehend the love of God through Christ's dwelling in the heart by faith (Eph. 3:17). Leland Ryken, Jim Wilhoit, and Tremper Longman provide a contemporary understanding of this Hebrew concept: “The heart is used in the Bible to describe ‘what makes us tick,’ or, human personality ... The

³⁶ Louw and Nida, 320.

³⁷ B. O. Banwell, “Heart,” in *New Bible Dictionary*, ed., D. R. W. Wood, I. H. Marshall, A. R. Millard, J. I. Packer, and D. J. Wiseman (Leicester, England; Downers Grove, IL: InterVarsity Press, 1996), 456.

heart is the seat of desire ... and chooses a course of action.”³⁸ The concept of heart in Scripture refers to the totality of one’s inner life—emotional, intellectual, psychological, and volitional—which directs the trajectory of one’s life.

One must identify why human beings experience a disorientation creating movement away from God. Paul asserts that those whose “foolish hearts were darkened” exchanged the real for the false—a real relationship with God for a false substitute (Gr., *allassō*) of an idol—creating a downward spiral in their lives.³⁹ Ryken, Wilhoit, and Longman explain, “Idolatry [can be interpreted] as desires even without [physical] idols. Idolatry eventually comes to designate lawless living in general (Col. 3:5; 1 Pet. 4:3). Ultimately, any violation of God’s law is idolatry, and idols may serve as an image and label for all that is anti-Christian (1 John 5:21).”⁴⁰

The difficulty in the heart of humanity concerns desire. In Greek, *epithymeō* means “to desire earnestly, long for something, lust, covet. It always describes the inner motivation rather than focusing on the object of desire. The Greek noun *epithymia* means ‘an urge’ or ‘passion.’ In Jewish thought, the sinful motivation of the heart is to be condemned as strongly as the sinful act itself.”⁴¹ “Foolish hearts” that choose a false substitute—an idol—rather than, in wisdom, choosing a real relationship with God, enter a downward spiral away from God. Carson, France, Motyer, and Wenham notes the

³⁸ Leland Ryken, Jim Wilhoit, and Tremper Longman, *Dictionary of Biblical Imagery* (Downers Grove, IL: InterVarsity Press, 2000), 368-369.

³⁹ Louw and Nida, 573.

⁴⁰ Ryken, Wilhoit, and Longman, 418.

⁴¹ Mounce, 172-173.

spiraling effect: “Rather than glorifying God or giving him thanks, they turn from the truth to embrace idolatry ([Rom. 1] vs. 21-23). It may be that Paul implies a sequence in these sins, the basic sin of idolatry—putting something in God’s place—leading to all other kinds of sin (vs. 29-31).”⁴²

In summary, Scripture contrasts a solid foundation with an unstable one. The solid foundation is built upon wisdom from and obedience to God and is marked by true discipleship, which flows out of a genuine relationship with and subjection to Jesus Christ. The unstable foundation is built upon the foolishness of disobedience to God and is marked by a false discipleship, which flows out of no relationship with God. The unstable foundation allows the individual to live in subjection to oneself and whatever idol he or she chooses to place at the center of one’s life.

Proper Foundation

A proper foundation has God as its architect (Prov. 8:29-31, NLT; Heb. 11:10). The Psalmist writes, “Righteousness and justice are the foundation of Your throne; Lovingkindness and truth go before You” (Ps. 89:14). This passage declares four attributes of God as foundational to who God is: righteousness, justice, loving-kindness, and truth. Paul J. Achtemeier provides the following synopsis:

God’s righteousness offers hope for redemption from sin ... Justice is founded in the being of God, for whom it is a chief attribute ... Lovingkindness, a characteristic of God in the OT contains the idea of devotion, loyalty, and covenant faithfulness (see Exod. 34:6; Neh. 9:32) ... Truth, generally used means ‘constant, permanent, faithful, reliable.’ God above all is true, that is, real and

⁴² Carson, France, Motyer, and Wenham, 1122-1123.

reliable (Isa. 65:16; Jer. 10:10); for the Hebrews, truth was moral and relational, not intellectual.⁴³

B. A. Milne, on the connection between God’s righteousness and humanity’s relationship with God, conveys a crucial foundation:

One basic ingredient in the OT idea of righteousness is relationship, both between God and man (Ps. 50:6; Je. 9:24) and between man and man (Deut. 24:13; Jer. 22:3). When we move from relations between men to those between God and men ... righteousness implies a correct relationship to the will of God which was particularly expressed and interpreted by Israel’s covenant with God.⁴⁴

In other words, God expresses the fullness of His righteousness in the context of covenantal relationship, a connection that calls humanity into alignment with God’s will through the vehicle of obedience—an impossibility without a proper foundation.

A believer demonstrates a solid foundation through obedience to God and right relationships with God and other people. Paul admonishes believers to “work hard to show the results of your salvation, obeying God with deep reverence and fear” (Phil. 2:12). He elucidates the ingredients of obedience that help form a proper foundation for one’s life: “Instruct them to do good, to be rich in good works, to be generous and ready to share, storing up for themselves the treasure of a *good foundation* for the future, so that they may take hold of that which is life indeed” (1 Tim. 6:18-19, emphasis added). These good deeds should benefit others. According to Jamieson, Fausset, and Brown, “Believers live—so ‘rich in faith’ they produce good works (Jam 2:5). They live not cleaving to possessions, but ready to impart to others. The result produces a good

⁴³ Paul J. Achtemeier, ed., *The HarperCollins Bible Dictionary* (San Francisco: Harper & Row, 1985), 871, 519-520, 581, 1100.

⁴⁴ B. A. Milne, “Righteousness,” in *New Bible Dictionary*, ed. D. R. W. Wood and I. Howard Marshall (Leicester, England; Downers Grove, IL: InterVarsity Press, 1996), 1020.

foundation—earthly riches *scattered* in faith lay up in store a sure *increase* of heavenly riches. We gather by scattering (Prov. 11:24; 13:7; Luke 16:9).⁴⁵ Jesus paints a great word picture through His story of the two foundations. The foolish man built his house on the sand while the wise man built his house on a rock (Matt. 7:24-27). VanVonderen, Ryan, and Ryan illustrate the consequences of a lack of a solid spiritual foundation: “No one sets out to build a spiritual house on sand. Rather than building on the stable rock of God’s love and grace, many build on the unstable soil of fear and shame. When self-reliance and religious striving are driven by fear and shame, one’s life shows predictable patterns of spiritual dysfunction.”⁴⁶ Ultimately, a proper foundation demonstrates right relationship with God and others.

Rebuilding requires a thorough assessment of the extent of damage to the existing structure and its foundation. Idolatrous attachments serve as a major contributing factor for inadequate spiritual foundations: “Foundational spiritual problems ... come from living in relationship with gods who are different from the God of love and grace who has been revealed to us in Jesus ... idolatrous attachments rooted in distorted images of God: abusive, abandoning, emotionally distant, passive, god of impossible expectations.”⁴⁷ The best plan or blueprint for rebuilding spiritual lives begins with a relationship with God that is characterized by intimacy and loving respect. Grace awakens the deepest longing within human beings—a longing to love and be loved.

⁴⁵ Jamieson, Fausset, and Brown, 1 Tim. 6:18-19.

⁴⁶ VanVonderen, Ryan, and Ryan, 10-12.

⁴⁷ *Ibid.*, 93-94.

The right tools encourage effective and efficient progress in the rebuilding process. Spiritual disciples serve as useful tools for building a solid foundation, “The most useful tools for spiritual growth are those found in Christian tradition: surrendering and listening to God ... tools that increase our capacity for honesty and humility ... such as those of inventory, making confession, making amends, and telling our stories or testimony.”⁴⁸ Traditional spiritual disciplines comprise a valuable toolbox creating the opportunity for personal reflection and a mechanism for connecting with God and others in the rebuilding process.

Community represents another important component in the rebuilding process. The bible provides a glimpse of the power of community, “If you forgive the sins of any, their sins have been forgiven them; if you retain the sins of any, they have been retained” (Jn. 20:23). A paradox often stated in recovery circles states: “No one can do recovery for you and you can’t do it alone.” More aptly stated, one heals and recovers most fully in the context of community. Utilizing a construction motif, other individuals serve as building inspectors to assist in assessing the true condition of foundations and offer support in the rebuilding process. Participating in community reminds individuals that they do not face their spiritual brokenness alone. In the context of community, one person’s story intersects with another individual’s story. Community provides the environment, “where we can practice honesty and humility, and where we can give and

⁴⁸ VanVonderen, Ryan, and Ryan, 111-113, 132-133, 137, 142, 150-151, 154-156.

receive gifts of strength and hope.”⁴⁹ It is in the context of community that forgiveness of sins is realized and the best rebuilding of damaged spiritual lives occurs.

Ultimately, the development of a proper foundation entails growth in one’s capacity to receive God’s love and grace, “these gifts of love and grace are not for us only. They are given to us so that we can pass them on through the spiritual disciplines of forgiveness and service.”⁵⁰ With the establishment of a firm foundation rooted in right relationship with God, one’s attention shifts and can focus on attachments.

Attachments

Having the foundation of one’s life firmly established in right relationship with God, one must also make a thorough examination of one’s attachments. Paul issues a warning about one’s attachments: “Those who weep or who rejoice or who buy things should not be absorbed by their weeping or their joy or their possessions. Those who use the things of the world should not become attached to them. For this world as we know it will soon pass away. I want you to be free from the concerns of this life” (1 Cor. 7:30-32a, NLT).

The possibility of beginning in a right relationship with God, yet needing to remove barriers and blockages (2 Cor. 10:3-6, MSG) in order to grow in that relationship necessitates such examination, “Our problems today often spring from interior emptiness, trivialization, and internal chaos, all due to the lack of a true center. Intensive, internal self-examination will be frustrating and fruitless without a careful guided integration of a

⁴⁹ VanVonderen, Ryan, and Ryan, 162.

⁵⁰ Ibid., 174-175.

true center in God.”⁵¹ The prophet Ezekiel warns, “For everyone who separates himself from me and takes his idols into his heart, thus setting in front of himself the stumbling block that leads to sin, and then comes to the prophet, asking him to consult me for him, I myself, *Adonai*, will answer him” (Ezek. 14:7, CJB). Proverbs cautions, “He who willfully separates *and* estranges himself [from God and man] seeks his own desire *and* pretext to break out against all wise *and* sound judgment” (Prov. 18:1, AMP). In other words, attachments to anything outside of a relationship with God that becomes the central focus of one’s life can become an idol—an unchecked desire that forms a stumbling block and leads to disconnection or sin (separation from God and others; Ezk. 14:4-5; Gal. 5:19-21).

Idolatry parallels addiction because it sets up a false attachment. Addiction often intersects with the ideas of disconnection and disorientation:

The fear of being unconnected can prompt ... relationships that tend toward the disorienting, the idolatrous. Addiction can be sin when it springs from these false orientations. It can be sin when it is primarily a refusal to orient self and will to God ... Even when addiction eventually takes on a biological life of its own, it may well have begun in a turning from God ... All sin is ultimately ignoring or turning away from God, a disinclination to be centered in the only Absolute.⁵²

Addiction contributes to disconnection and disorientation due to the disloyalty and disinclination of one’s heart and entire life away from centralization in God. As the following section portrays, the Scriptures provide instruction about idolatrous false attachments leading to slavery and healthy true attachments leading to freedom.

⁵¹ Mercadante, 38.

⁵² Ibid., 38, 42.

Idolatrous False Attachments Leading to Slavery

When communicating God’s Torah to the people of Israel, Moses clearly addresses the issue of idolatry: “Do not turn to idols or make for yourselves molten gods; I am the LORD your God” (Lev. 19:4). J. A. Motyer, writing about idolatry, contends, “The OT views idolatry as a decline from true spirituality—the idol is whatever claims that loyalty which belongs to God alone (Isa. 42:8).⁵³ False spirituality occurs when one lives in loyalty to an idol that takes God’s rightful place as the center and focus of one’s life.

Idolatry, comprised of yielding to the influences of evil and embracing sin, wreaks havoc in one’s life. Brian S. Rosner agrees with this claim:

Just as keeping the first commandment was expected to lead one to obey all the commandments, so idolatry was thought to lead to other sins (Rom. 1:18–32; cf. Wisdom of Solomon 14:27: ‘The worship of idols ... is the beginning and cause and end of every evil’). Sin consists of placing such a high value on something that in effect it replaces God.⁵⁴

In creating false attachments, loyalty disintegrates into disloyalty, one’s true identity in God fragments into a false identity, and one’s disorientation leads to other wrongdoing or sin.

A fundamental question of theology emerges: what constitutes a god? Alexander and Rosner, after considering Martin Luther’s answer response based on the first commandment in his larger catechism, make the following conclusion: “Whatever your

⁵³ J. A. Motyer, “Idolatry,” in *New Bible Dictionary*, ed. D. R. W. Wood and I. Howard Marshall, (Leicester, England; Downers Grove, IL: InterVarsity Press, 1996), 495-496.

⁵⁴ T. Desmond Alexander and Brian S. Rosner, eds., *New Dictionary of Biblical Theology* (Downers Grove, IL: InterVarsity Press, 2000), 571.

heart clings to and relies upon, that is your God; trust and faith of the heart alone make both God and idol.”⁵⁵ Alexander and Rosner further contemplate both diagnosis and cure:

In one sense idolatry is the diagnosis of the human condition to which the gospel is the cure. The root problem with humans is not a horizontal ‘social’ problem (like sexual immorality or greed [or addiction]), but rebellion against and replacement of the true and living God with gods that fail (which lead to these destructive sins). If the story of the human race is a sorry tale of different forms of idolatry, the height of human folly, the good news is that God reconciles his image-bearers back to himself in Christ.⁵⁶

False attachments come because of rebellion against God; they serve as a replacement of the true God with gods—idols, if you will, who fail miserably in comparison to the God who loves humanity and provides for its redemption and reconciliation.

Attachment to idols becomes a snare: “And [they] served their idols, which became a snare to them” (Ps. 106:36). Achtemeier indicates that a snare is “a trap ... which capitalized on surprise, a feature often noted (Luke 21:34), and caused its victims to enmesh themselves while struggling to get free (Prov. 22:25).”⁵⁷ This accurately portrays improper attachments related to the nature of addiction—deeper enmeshment occurs as individuals struggle on their own to get free from their false attachments.

Scripture portrays idolatry and sin, in general, as entrapment. Ryken, Wilhoit, and Longman impart additional clarity to this imagery:

The image of trapping is linked to unrighteous practices as a snare to those who practice them. Idolatry was thus one of the chief sins that trapped God’s people. For biblical writers, sin in general is a snare to the sinner; sin blinds and weighs

⁵⁵ Alexander and Rosner, 575.

⁵⁶ Ibid.

⁵⁷ Achtemeier, 961.

down sinners until they are so vulnerable and weakened that they essentially self-destruct.⁵⁸

Spiritual peril occurs when one engages in unrighteous practices leading to ensnarement.

Clearly, idolatry is both sin and snare; attachment to either leads to self-destruction.

The Apostle Paul imparts valuable instruction regarding the role of temptation:

“No temptation has overtaken you but such as is common to man; and God is faithful, who will not allow you to be tempted beyond what you are able, but with the temptation will provide the way of escape also, so that you will be able to endure it. Therefore, my beloved, flee from idolatry” (1 Cor. 10:13-14). Mounce provides insight into the meaning of the Greek verb for temptation (Gr., *peirazō*):

Being “tempted” to do or think something wrong or contrary to God’s will (Gal. 6:1; Jas. 1:13) ... God does not induce anyone to sin, and in fact we are to admit our dependence on God as we pray for protection from temptation. However, trials and sufferings will occur so that our faith can be purified, shown to be true—all of which enables us to grow up into Christian maturity.⁵⁹

God does not induce anyone to sin. The Bible exposes the raging battle between good and evil, as depicted vividly by Ryken, Wilhoit, and Longman:

For people living in a fallen world, life at every moment is at a transcendent crisis in which a person’s allegiance is claimed by God and counterclaimed by Satan and evil. No one is forced to succumb to temptation. People choose to do so ... people have a power of choice when confronting temptation—despite all the external circumstances and agents that elbow their way into a person’s consciousness and beckon toward evil, they do not *cause* anyone to give in to temptation; they merely provide *the occasion for* moral choice—the enemy is within (James 1:14-15). The antidote therefore is to guard one’s inner heart and

⁵⁸ Ryken, Wilhoit, and Longman, 885-887.

⁵⁹ Mounce, 714-715.

soul: “keep your heart with all vigilance; for from it flow the springs of life” (Prov. 4:23, RSV).⁶⁰

In the midst of one’s crisis of faith, each individual retains the power to choose one’s allegiance or attachment. The good news that Paul declares to his hearers champions God as the source of the effectual power to choose. According to Robert B. Hughes and J. Carl Laney, “Paul assured the Corinthians of God’s faithfulness to give initial endurance and a path of escape from falling into sin (1 Cor. 10:13). God in his faithfulness always arranges a way of escape from temptation (lit., “a way out”) and before that, gives strength to endure it.”⁶¹ God grants the power to endure temptation when it arrives and the power to choose a way of escape.

Paul also teaches believers to actively flee from any and all forms of idolatry. John Peter Lange, Philip Schaff, and Christian Friedrich Kling affirm Paul’s instructions: “By this he [Paul] enjoins the avoidance of everything, which, however remotely, would imply participation in idol worship. This includes two things: first, avoiding whatever is questionable and, second, avoiding the occasions and temptations to sin.”⁶² Mounce points out that the Greek verb *pheugō* primarily means “to flee, but also can mean to escape, elude, and run off/away.”⁶³ Paul uses *pheugō* to command his readers to “flee from idolatry” (1 Cor. 10:14). He also exhorts Timothy, his son in the faith, to “flee the

⁶⁰ Ryken, Wilhoit, and Longman, 852-854.

⁶¹ Hughes and Laney, 554.

⁶² John Peter Lange, Philip Schaff, and Christian Friedrich Kling, *A Commentary on the Holy Scriptures: 1 Corinthians* (Bellingham, WA: Logos Bible Software, 2008), 209.

⁶³ Mounce, 257-258.

evil desires of youth, and pursue righteousness, faith, love and peace” (2 Tim. 2:22) and to “flee from unrighteousness completely” (1 Tim. 6:11).

Healthy True Attachments Leading to Freedom

The healthiest attachment is one’s attachment to the Creator God who hard wired humanity to connect in relationships, especially to the One who created them. Healthy true attachments lead to freedom. God refines and purifies individuals, thereby creating the freedom to establish healthy true attachments, rather than false attachments. The prophet Isaiah writes, “Behold, I have refined you, but not as silver; I have tested you in the furnace of affliction. For My own sake, for My own sake, I will act; For how can My name be profaned? And My glory I will not give to another” (Isa. 48:10-12). Most often, God refines humanity through the afflictions experienced throughout life that give individuals the opportunity to examine their attachments—what is really important and valued—and their connection to God, who will not share His glory with those who create false attachments. Mounce indicates that the Hebrew verb *šārap* “is commonly used to denote the testing or refining of both metals and human beings” (Isa. 48:10).⁶⁴ John D. Barry, Michael R. Grigoni, Michael S. Heiser, Miles Custis, Douglas Mangum, and Matthew M. Whitehead, in the *Faithlife Study Bible*, note the purpose of the refining and who receives the credit: “The refining should remove the impurity of their past sins and restore their relationship with God (see [Isa.] 1:22, 25). Yahweh alone deserves the credit

⁶⁴ Mounce 718-719.

for the salvation He has planned.”⁶⁵ The refining process strengthens healthy attachments, which lead to greater freedom.

God desires life for humanity, not death. Even in the midst of the refining process, God’s salvation provides life. John Peter Lange, Philip Schaff, and Carl Wilhelm Eduard Nägelsbach reaffirm this reality: “The LORD desires not the death of the sinner, but that he should repent and live.”⁶⁶ The New Testament bears this truth as Paul pens the words, “If God is for us, who can ever be against us” (Rom. 8:31)? In fact, nothing can separate humanity from God’s irresistible love (vv. 31-39).

Paul addresses the issues of slavery to sin, obedience from the heart, and freedom as slaves of righteousness, resulting in sanctification (Rom. 6:17-19). Paul implies freedom from sin requires obedience to God from the heart. A person’s slavery transitions from destructive sin to righteousness—or right living—as he or she yields to God’s power, released by the Holy Spirit. One must first get free from the negative influences of sin. A familiar tone rings true in Peter’s writings: “They promise them freedom while they themselves are slaves of destructive habits—for we are slaves of anything that has conquered us” (2 Pet. 2:19, GNT). The New Living Translation renders the last part of this verse, “For you are a slave to whatever controls you,” while the God’s Word translation renders the phrase as, “A person is a slave to whatever he gives in to.” Peter provides astute clarity: individuals become slaves of destructive habits when they become attached to something other than God. In turn, this misappropriated attachment

⁶⁵ John D. Barry et al., *Faithlife Study Bible* (Bellingham, WA: Logos Bible Software, 2012), Isa. 48:10-11.

⁶⁶ John Peter Lange, Philip Schaff, and Carl Wilhelm Eduard Nägelsbach, *A Commentary on the Holy Scriptures: Isaiah* (Bellingham, WA: Logos Bible Software, 2008), 520-521.

conquers or controls them because they give in to or yield to its power rather than embracing God's power.

A right relationship with God, plus right attachments in one's life, produces right living. Hughes and Laney echo this idea: "Paul appealed to a familiar principle: you are a slave to the one you serve. People are either slaves to sin resulting in death, or slaves to righteousness resulting in life. Sin ends in death, and grace ends in eternal life. Death is earned as a consequence of sin; eternal life is received as free and unmerited favor."⁶⁷ In other words, whatever an individual chooses to serve becomes the central focus of one's life; whatever one focuses on, grows. If an individual has a right relationship with God, attaches to biblical principles that support and deepen that relationship, an abundant and full life follows in this life as well as in eternity. Carson, France, Motyer, and Wenham succinctly summarize the issue: "Like Jesus, Paul insists that true 'freedom' is to be found only in a relationship to the God who created us (John 8:31-36)."⁶⁸ Therefore, a right relationship with God, plus healthy attachments and implementation of God's principles, yields right living.

Conversely, false attachments and a focus on sin produce slavery. Barry, Grigoni, Heiser, Custis, Mangum, and Whitehead capture the concept of slavery leading to spiritual bondage and eventual death in their overview to Paul's passage in Romans 6:

Paul uses the term "slave" to describe a person under the complete control of someone or something. Prior to faith in Christ and baptism, believers were enslaved to sin. Paul presents salvation as deliverance from spiritual bondage. He illustrates it as a transfer from one master to another—from sin to God. In this context, the word *hamartia* refers to the destructive power of sin. The word

⁶⁷ Hughes and Laney, 534.

⁶⁸ Carson, France, Motyer, and Wenham, 1136.

thanatos refers not only to spiritual or physical mortality, but to separation from God. Paul cautions the Roman believers that their obedience to sin results in death. ‘Slaves to sin’ describes being under the complete control and power of sin. Paul emphasizes obedience because it functions as the only tangible expression of faith.⁶⁹

In other words, just as obedience to sin produces death (separation from God), obedience to righteousness in the person of Jesus Christ produces life.

Another portrayal of slavery to righteousness emerges from the pages of Scripture. Ryken, Wilhoit, and Longman explain, “Slave of Christ is Paul’s Christological restatement of Moses’ first command: one is not to have compromising relationships with any other masters (cf. Lev. 25:55; Deut. 6:4; Matt. 6:24). Yet it is only temporary. Advancement is also possible; indeed, slaves of God are adopted as sons by God (John 8:35-36; Gal. 4:1-9).”⁷⁰ Individuals move from a slave to sin, to a slave of righteousness, to adopted sons and daughters of God. True attachments yield the opportunity for freedom to materialize when people realize their destiny as part of God’s family and embrace His plans and purposes for their lives.

The Scriptures teach that the influence of evil plays a role in one’s tendency toward false attachments. “But the Scriptures declare that we are all prisoners of sin, so we receive God’s promise of freedom only by believing in Jesus Christ” (Gal. 3:22; NLT). False attachments birthed by sin, by their very nature, are seductive: “The Bible presents evil as a power that lures or seduces. Once one lets this evil in or responds to it, its insidious work begins on the inside. A craving or desire (‘concupiscence’) is set up,

⁶⁹ Barry et al., Rom. 6:16-17.

⁷⁰ Ryken, Wilhoit, and Longman, 798-799.

which ultimately becomes a bondage.”⁷¹ In order to deal with the false attachment, one must address the seductive nature of evil.

The remedy for the human predicament of sin, influence of evil, addiction, and false attachments battling against healthy true attachments is to remove everything that obscures the divine image of God in a person’s life. The author of Hebrews instructs humanity to lay aside every hindrance and sin, and fix one’s eyes on Jesus as “the author and perfecter of faith” (Heb. 12:1-2). This requires fully embracing the transformative power of God so that partnership with God yields fulfillment of the plans, promises, and purposes of God; embracing the role of salvation as offered to humanity by God:

Salvation is not primarily a matter of shedding our past, disavowing former connections and preferences, living in fear, and guarding against all incursions or previous pleasures. But it is also a life meant to reflect the divine image from start to finish. It is both a refocus of and a maturing into our potential for partnership with God ... God’s intention to raise us beyond the status of ‘slaves’ to the status of ‘friends.’ To accomplish this, complete healing is necessary ... complete wholeness and health, that is, a total transformation.⁷²

Freedom from sin and true life in Christ only occurs as an individual appropriates God’s free gift of salvation. In order to maximize the freedom from bondage that Christ provides, one must seriously consider the role of responsibilities.

Responsibilities

After establishing a solid foundation built upon the bedrock of a right relationship with God and guarding the attachments of one’s heart to ensure continuance in that sacred relationship, an individual must take responsibility for all the issues in his or her

⁷¹ Mercadante, 133.

⁷² Ibid., 166.

life. With the rise of the disease model of addiction, not taking responsibility for one's choices often gets blamed on the disease.⁷³ Ultimately, a person must guard his or her heart and take full responsibility for personal actions. Before moving forward into the rebuilding process, an individual must look backward to repair the broken areas of one's life.

Backward to Repair

King David penned one of the most powerful reflections of a contrite sinner's prayer for pardon and forgiveness in all of Scripture. Nathan the prophet confronted David, who murdered Uriah and committed adultery with Uriah's wife, Bathsheba (2 Sam. 12:1-15). Later, upon reflection, David writes, "Be gracious to me, O God, according to Your loving kindness; According to the greatness of Your compassion blot out my transgressions. Wash me thoroughly from my iniquity and cleanse me from my sin" (Ps. 51:1-2). Mounce indicates that the Hebrew noun *peša'* usually translated as "rebellion, offense, sin, transgression, normally denotes intentional disobedience, especially against God's law. In all occurrences of *peša'* the common thread is the breach of a covenant responsibility [relationship]."⁷⁴ God desires to heal the brokenness caused by sin; a repentant heart and a moldable will are necessary ingredients in this healing process, as humanity cannot achieve this healing without God's involvement.

Restoration only comes because of a contrite heart, as illustrated in Psalm 51. Hughes and Laney further support this scriptural concept:

⁷³ See page 100, in Chapter 3, regarding ASAM's working definition of addiction.

⁷⁴ Mounce, 655-656.

There was only one acceptable act to restore David after his adultery and murder—having a broken spirit and contrite heart (51:17). David’s contrition was genuine; therefore, he was accepted by God. He made his appeal on the basis of God’s “unfailing love” and “great compassion” (Ps. 51:1). David sinned against Bathsheba and Uriah, but all sin is ultimately an offense against God (51:4; cf. Gen. 39:9).⁷⁵

Brokenness, a contrite heart, and humility, together with a repentant heart and a moldable will, comprise the necessary elements for repairing the damage wrought by sin in one’s life. David models the components of good repair work: a broken and contrite heart, a moldable will, humility, personal confession, and repentance.

As clearly stated in James 1:13-15, sin comes as a result of giving in to temptation:

Let no one say when he is tempted, “I am being tempted by God;” for God cannot be tempted by evil, and He Himself does not tempt anyone. But each one is tempted when he is carried away and enticed by his own lust. Then when lust has conceived, it gives birth to sin; and when sin is accomplished, it brings forth death. (James 1:13-15).

God does not tempt people to do evil but rather temptations come as a result of what is in each individual’s heart. Louw and Nida provide clarification regarding the origin of temptation: “A person is tempted when he is drawn away and trapped by his own desires.”⁷⁶ The propensity toward sin flows from what comprises one’s heart. David recognized the wickedness of his own heart and repeatedly prayed for God to search his heart: “Put me on trial, Lord, and cross-examine me. Test my motives and my heart” (Ps. 26:2), and “Search me, O God, and know my heart; test me and know my anxious

⁷⁵ Hughes and Laney, 215.

⁷⁶ Louw and Nida, 374.

thoughts” (139:23). The wisdom literature encourages individuals to “Keep your heart with all diligence, for out of it spring the issues of life” (Prov. 4:23).

When one does not guard the heart, desires arise that either provide the opportunity to move towards God or away from God. Gerhard Kittel, Geoffrey W. Bromiley, and Gerhard Friedrich discuss the process of temptation as it relates to sin: “Man’s own desire urges him to the concrete act which destroys him. Sin is never caused by God, but is always man’s own act. The desire and the deed are both his own. When accomplished the deed brings as its fruit death. Nevertheless, Paul is also of the opinion that desire leads the will of man to sin.”⁷⁷ Desires urge one toward sin, especially when coupled with one’s own will and choice to move away from God.

God is not to blame. Not only is God not the focus of blame, neither can individuals shirk their own personal responsibility and blame the devil or evil. Carson, France, Motyer, and Wenham reflect on the proper locus of responsibility: “It is *desire* within one which makes the test a test. This *desire* is what the Jews called the ‘evil impulse’ in people, or what psychologists call ‘drives’ or what Paul in Romans 7 calls ‘sin’; it is quite simply the undifferentiated ‘I want.’”⁷⁸ A person’s own interior desires, unchecked, lead towards sin, as noted by Jamieson, Fausset, and Brown:

Every man, when tempted, is so through being drawn away of his own lust. The cause of sin is in ourselves. Even Satan’s suggestions do not endanger us before they are made *our own*. Each one has *his own peculiar* lust, arising from his own

⁷⁷ Gerhard Kittel, Geoffrey W. Bromiley, and Gerhard Friedrich, eds., *Theological Dictionary of the New Testament* (Grand Rapids, MI: Eerdmans, 1964), 760-762.

⁷⁸ Carson, France, Motyer, and Wenham, 1358.

temperament and habit. Lust flows from the original birth-sin in man, inherited from Adam. Nip sin in the bud of lust.⁷⁹

The locus of sinful desires resides in the heart of humanity, unique to each individual; an area of difficulty for one person may not present an issue for another person. Barry, Grigoni, Heiser, Custis, Mangum, and Whitehead capitalize on the analogy of human conception and birth to describe sin:

God is not responsible for temptation or for the sin that might result from it. Desire is “conceived” when a person yields to temptation, which results in the “birth” of sin. As sin “matures” and becomes “complete,” this ultimately leads to God’s judgment of death. With this analogy, James asserts that God’s judgment against sin is the result of people’s own choices. All sin ultimately originates in individuals, not in any other source. According to James, desire (the negative, destructive kind) is the source of temptation, which explains the presence of sin and death in the world (compare Rom. 7:17-23; Gal. 5:16-21; Eph. 2:3).⁸⁰

Each person must take personal responsibility for sin rather than blaming God, Satan, others, a disease, or circumstance. Roger Ellsworth concurs, indicting the true culprit:

“We are individually responsible for sin. We sin because we are sinners. But the truth of the matter is that Satan could not have any success with us at all if it were not for the stuff of which we are made. We rather possess a nature that readily inclines us towards it.”⁸¹

Assuming personal responsibility for sin serves as a crucial step toward healing.

The Apostle Paul creates a portrayal of humanity’s condition prior to a relationship with God through faith in Jesus Christ. Though alive, people live as those “dead in trespasses and sins ... living out of the lust of their flesh indulging the desires of

⁷⁹ Jamieson, Fausset, and Brown, James 1:13-15.

⁸⁰ Barry, et al., James 1:13-15.

⁸¹ Roger Ellsworth, *Opening up James*, Opening up Commentary (Leominster, UK: Day One Publications, 2009), 41-43.

the flesh and of the mind” (Eph. 2:1-3). Mounce further affirms the concept of the living dead: “In the spiritual sense, *nekros* pertains to being so morally or spiritually bankrupt as to be in effect dead ... Persons even though alive are described as ‘dead’ in this sense (Eph. 2:1; cf. 2:5; Col. 2:13).”⁸² The repair work requires each individual to take responsibility for his or her condition of living as one who is morally and spiritually bankrupt and invest one’s life in a faith relationship with Jesus Christ.

Reflecting on the Pauline passage in Eph. 2:1-3, Williams presents this perspective:

Here, Paul addresses our fivefold problem. First, we are spiritually dead in transgressions and sins [we suffer from generational sin—from birth there is a hole in the soul, making our lives unmanageable]. Second, we follow the ways of this fallen world [we are subject to environmental sin—we conform and live in a culture separated from God]. Third, the devil—“the ruler of the kingdom of the air” or “the prince of the power of the air”—dominates us [we live in the illusion that we are in control, but we are really out of control, spiritually oppressed]. Fourth, we gratify the cravings of our sinful nature, its desires and thoughts [we choose to live in the cravings of our bodies and minds]. Fifth, we are the objects of God’s wrath. God says no to our total corruption. The result of total rejection—death in life—is a deep wound in the soul, a ‘being-wound,’ which is the source for our shame-based lives ... [it is the hole in the soul].⁸³

Paul indicates that humanity, apart from a relationship with God in the person of Jesus Christ, although physically alive, is spiritually dead in trespasses and sins. Paul characterizes individuals who live as they “formerly walked” [i.e. behaved]—as those rejecting belief in God. This creates a deep wound in the soul for which one must give attention to in the rebuilding process.

⁸² Mounce, 159, 772.

⁸³ Williams, 44-48.

Forward to Rebuild

Having looked backward to repair, one can move forward to rebuild. In Ephesians 2:4-10, Paul vividly contrast humanity's condition prior to a relation with God as having moved from being "dead in transgressions" to being "alive together with Christ." The new believer, because of God's mercy and compassion, is saved by grace (Eph. 2:4-7). Alexander and Rosner, acknowledge the connection between mercy and compassion in the New Testament: "Mercy forms the foundation of the communion God desires with humankind. Not surprisingly, the New Testament interprets God's mercy largely in the light of the Christ event, the supreme expression of love, mercy and grace."⁸⁴ The most important part of the repair process is repairing one's broken relationship with God, damaged by sin and healed by the provision of Christ's substitutionary death on the cross—the most incredible expression of God's love evidenced through the attributes of mercy, compassion, and grace.

Salvation is by grace, as Paul admonishes: "For by grace you have been saved through faith; and that not of yourselves, it is the gift of God; not as a result of works, so that no one may boast. For we are His workmanship, created in Christ Jesus for good works, which God prepared beforehand so that we would walk in them" (Eph. 2:8-10). According to Mounce, "The Greek noun *charis* means 'grace, favor'—the acceptance of and goodness toward those who cannot earn or do not deserve such gain—manifested most clearly in the sacrificial, substitutionary death of Jesus Christ (Rom. 3:24-26; Heb. 2:9) ... The Greek noun *dōron* means a 'gift' or 'present.'"⁸⁵ Clearly, salvation is a gift

⁸⁴ Alexander and Rosner, 661.

⁸⁵ Mounce, 303-304, 283.

from God that a person cannot earn and does not deserve; consequently, God alone receives the glory and praise (Eph. 1:4-14).

Since salvation comes by grace, one cannot acquire salvation through good works. Despite Paul's negative view of works of righteousness, which cannot save, he does encourage good works that constitute the fruit of a redeemed life (Rom. 13:3; 2 Cor. 9:8, Eph. 2:10; Phil. 1:6; Col. 1:10; 1 Tim. 2:10; 5:10; 6:18; 2 Tim. 2:21; 3:17; Tit. 2:7, 14).⁸⁶ With regard to good works, Craig S. Keener provides a succinct statement: "Good works flow from what God does in us, rather than God's work in us flowing from our works."⁸⁷ In summary, the basis of salvation is God's grace most clearly demonstrated through Christ's sacrifice on the cross and commensurate resurrection. In this act, Christ purchased humanity's deliverance from the power of sin and death, and infused humanity with resurrection power and new life.

Paul contrasts Ephesians 2:4-10, which refer to the believer's present and future, with verses 1-3, which refers to their past. Those who demonstrate the salvation of God represent God's "workmanship" and reveal themselves as co-creators, making "works of art" of their lives.⁸⁸

In Galatians 5:1, 13, Paul provides a solemn warning: "It was for freedom that Christ set us free; therefore keep standing firm and do not be subject again to a yoke of slavery ... For you were called to freedom, brethren; only do not turn your freedom into

⁸⁶ Mounce, 807-808.

⁸⁷ Craig S. Keener, *The IVP Bible Background Commentary: New Testament* (Downers Grove, IL: InterVarsity Press, 1993), Eph. 2:4-10.

⁸⁸ Kenneth Barker, ed., *NASB Study Bible* (Grand Rapids, MI: Zondervan, 1999), Eph 2:10.

an opportunity for the flesh, but through love serve one another.” According to Mounce, the Greek noun *eleutheria* refers to “freedom, the state of being free. It describes the state of a person no longer enslaved by an oppressive force. In the New Testament, freedom focuses primarily on the release from the bondage of sin.”⁸⁹ Thus, the rebuilding process includes both a release from something—from sin—to something, a new freedom in love to serve others.

The rebuilding process means making a transition from living as slaves, serving the brokenness of sin, to living as bond slaves, serving the One who is the “light of the world” (John 8:12) and “the way, the truth, and the life” (John 14:6). Ryken, Wilhoit, and Longman make an interesting observation: “The important figurative jump is not from slavery to freedom, but from slavery to sin to slavery to God, darkness to light, falsehood to truth—the issue is whether one’s master is God or sin (Rom. 6:15–23).”⁹⁰ Believers continue as slaves, but slaves to a new master—Christ. Mounce states this beautifully: “Christ redeems his people from the bondage of sin so that we may lead lives of service and abandonment to that one who is worthy of slave-like devotion (Rom. 12:1-11; 1 Thess. 1:9).”⁹¹ Slavery to Christ releases the believer from the oppressive bondage to sin and results in a life of love.

The biblical process of transitioning from slavery to sin toward slavery to Christ is through repentance. According to Mounce, there are two primary words for repentance in the Old Testament: “The verb *nāḥam* bears two distinct but related meanings, ‘to

⁸⁹ Mounce, 272-273.

⁹⁰ Ryken, Wilhoit, and Longman, 798.

⁹¹ Mounce, 634.

comfort, console’ and ‘to relent, repent, change one’s mind, be grieved.’ The verb *šûb* [means] ‘to turn, return, repent, go/come back.’ In the moral-spiritual realm, *šûb* can describe the human act of repentance (turning away from sin or idolatry and turning to God).⁹²

Further, he identifies three Greek words in the New Testament (NT) for the biblical concept of repentance. “The noun *metanoia* and the verb *metanoēō*; both denote a radical, moral turn of the whole person from sin and to God. When *metanoēō* and *epistrephō* appear together in the NT, the former emphasizes the turn from sin and the latter emphasizes the turn to God (see Acts 3:19, 26:20).⁹³ Therefore, biblical repentance includes turning from sin and turning to God.

Borrowing from the dynamics of mission therapy, repentance involves four stages. Howard Clinebell identifies these stages as “crisis, preparation, surrender-acceptance, and consolidation.”⁹⁴ Often crisis serves as the catalyst to move one towards the need for repentance. God prepares humanity through the circumstances of life, which can lead to surrender-acceptance if one chooses, resulting in consolidation of renewed heart and mind with right living (or God-produced righteousness).

In order for true biblical repentance to occur, one needs to journey through the steps of repentance. Park enumerates six steps of repentance on this journey:⁹⁵

⁹² Mounce, 580.

⁹³ Ibid., 580–581.

⁹⁴ Howard Clinebell, *Understanding and Counseling Persons with Alcohol, Drug, and Behavioral Addicts: Counseling for Recovery and Prevention Using Psychology and Religion*, rev. and enl. ed. (Nashville: Abingdon Press, 1984), 176.

⁹⁵ Park, *From Hurt to Healing*, 76-77.

1. Repentance begins with contrition for one's own sin. It is an internal transformation; it means having the heart of remorse, regret, and sorrow for what one has done. It is to decide before God not to repeat the sin.
2. Confession involves admitting or acknowledging the exact nature of the sin before God and before his or her victim [or society].
3. Repentance means changing one's behavior, turning back from sin and walking in the right way.
4. Repentance requires acts of recompense—any repentance without compensation [to the victims or society] is not genuine repentance.
5. Repentance involves asking for forgiveness from the wronged—not asking for the events of the injustice to be forgotten, but to give the wrongdoer new opportunities [for right behavior].
6. Repentance seeks reconciliation—it leads the penitent and the one who forgives him or her to reconciliation.

Three portraits of repentance in Scripture illustrate the aforementioned stages and steps: one depicts repentance from pressure, one from pity, and the last from persuasion based upon passion and truth.

The Old Testament book of Exodus contains the first portrait. Moses is called by God to go to the Pharaoh of Egypt to bring God's people the Israelites out of Egypt because of their suffering incurred as slaves (Exod. 3:7-10). Moses' initial appeals did not result in freedom, and Pharaoh's heart became hard and he would not listen (7:13).

God's intention to multiply His signs and wonders in Egypt brought forth ten plagues: blood, frogs, gnats, flies, death of livestock, boils, hail, locusts, darkness, and death of all the firstborn sons (Exod. ch. 7-12). After the death of his own firstborn son in the middle of the night, Pharaoh summoned Moses and Aaron and said, "Up! Leave my people, you and the Israelites! Go, worship the Lord as you have requested" (12:31, NIV). However, after Moses and the Israelites departed, "Pharaoh and his officials *changed their minds* about them and said, "What have we done? We have let the Israelites go and have lost their services!" (14:5, NIV). The Hebrew word for the change of one's mind here is not the verbs *nāḥam* nor *šûb* as defined above; but *hāpāk* which

means to overthrow, overturn, turn around, or change.⁹⁶ In other words, Pharaoh's repentance or change of mind was from pressure most likely from his advisors, friends and family, not true biblical repentance. Pharaoh's hardened heart led him to pursue the Israelites even to the point of chasing them as they fled into the Red Sea—then the water flowed over all Pharaoh's chariots, horses, officers and his entire army—none of them survived; yet all the Israelites walked through the sea on dry ground (vv. 8, 23, 28; 15:4, 19).

The second portrait presents in the NT Gospel of Matthew. The story unfolds depicting the betrayal of Jesus by Judas Iscariot (Matt. 26:14-16, 47-50). "When Judas, who had betrayed him, saw that Jesus was condemned, he was *seized with remorse* and returned the thirty pieces of silver to the chief priests and the elders ... So Judas threw the money into the temple and left. Then he went away and hanged himself" (27:3, 5; NIV).

The remorse that seized Judas led to despair. Craig Keener explains:

Some Jewish teachers held that even the recantation of a false witness for the prosecution could not reverse the verdict ... Those who dealt in bribes were accursed under the law and a false witness was liable to the punishment appropriate for the alleged crime of the accused. Having innocent blood on one's hands meant that one was guilty of murder; Judas's suicide is an act of despair⁹⁷

This portrait depicts repentance from pity resulting from despair and misplaced remorse.

The final portrait is the parable of the lost son contained the Gospel of Luke in the NT. The younger of two sons demands his share of the estate from his father, who divided his property between them (Luke 15:11-12, NIV). Soon after he gathers all he has

⁹⁶ Mounce, 104, 924.

⁹⁷ Craig S. Keener, *The IVP Bible Background Commentary: New Testament* (Downers Grove, IL: InterVarsity Press, 1993), Mt 27:3–5.

and leaves for a distant country, and squanders his wealth in wild living, spending all his money, and losing all his so-called friends. A great famine ensued, forcing him to get a job—in the fields feeding pigs—not the dream job of a Jewish young man! He became so desperate that “he longed to fill his stomach with the pods that the pigs were eating, but no one gave him anything” (vv. 13-16, NIV). Finally he comes to his senses and knows he must return home: “I will set out and go back to my father and say to him: Father, I have sinned against heaven and against you. I am no longer worthy to be called your son; make me like one of your hired servants.’ So he got up and went to his father” (vv. 17-20). The prodigal son’s repentance depicts repentance from persuasion based upon passion; complete in that it goes all the way to the point of acknowledging and recognizing the truth of his heart and mind before God—he knew that he had sinned against God as well as his earthly father. It is this type of repentance—persuasion based upon passion of the heart and the truth of Scripture—that ushers one into slavery to Christ.

As slaves of Christ, believers should serve one another out of love (Gal. 5:13b). Carson, France, Motyer, and Wenham identify the right use of freedom: “Serve [lit. be slaves to] one another in love. The entire law is summed up in a single command: ‘Love your neighbor as yourself.’ The kind of conduct that flows from communion with the Holy Spirit consists primarily of attitudes and actions that enhance personal relationships.”⁹⁸ The freedom one gains through slavery to Christ does not lead to riotous or immoral living, as Barry, Grigoni, Heiser, Custis, Mangum, and Whitehead note:

⁹⁸ Carson, France, Motyer, and Wenham, 1218-1219.

The freedom given by Christ liberates believers from having to earn God's favor through the law (legalism), having their life governed by the law (nomism), and living under the control of sin and the desires of the 'flesh' (licentiousness). It is possible that the agitators twisted Paul's gospel message to imply that freedom from the law meant freedom to behave immorally, or that grace provides a license to sin.⁹⁹

To the contrary, healthy relationships will flow from a heart devoted as a slave to Jesus Christ, as demonstrated through loving actions. As Jesus said, "If the Son makes you free, you will be free indeed" (John 8:36). In the rebuilding process, one must take personal responsibility for engaging in a transformational journey that leads to a deep abiding faith in God, resulting in a new trajectory away from the brokenness of sin toward the abundant life promised by God for all followers of Jesus Christ (John 10:10).

Conclusion

A strong Judeo-Christian faith, yielding a close connection to God in the person of Jesus Christ, is imperative in the healing of addictions. Separation from God comes as a result of sin. When separated from God, humanity yields to evil, thereby producing increased brokenness that flows from sin.

The necessary healing of addictions begins by replacing improper foundations with proper foundations. An orientation toward wrongdoing produces false attachments leading to greater slavery to sin. However, an orientation toward God, through the vehicle of a right relationship with God, produces healthy true attachments leading to freedom.

In order to maximize the freedom from bondage that Christ provides, one must seriously consider the role of responsibilities. The importance of having a solid

⁹⁹ Barry et al., Gal. 5:13.

foundation built upon the bedrock of a right relationship with God, along with guarding the attachments of one's heart to ensure continuance in that sacred relationship includes the necessity of taking responsibility for all the issues in one's life. It is imperative to guard one's heart and take full responsibility for all of one's actions and relationships—including a look backwards with a view to repair damage, followed by moving forward to rebuild by journeying through the steps of true biblical repentance—once a commitment to such a process dominates daily living, a person can experience a transformed trajectory for life.

CHAPTER 3: GENERAL LITERATURE REVIEW

Introduction

This chapter will review key contemporary literature in the following categories: care components in the field of addiction treatment, in particular, faith-based initiatives, and the role of early intervention in the continuum of care in the treatment of alcohol and other drug problems. It will also address the contributing factors, harmful effects, and negative consequences of alcohol and drug use and abuse.

Care Components in the Field of Addiction Treatment

This section provides an introduction to the concept of faith-based initiatives and the important role of early intervention. Additionally, it will address the concept of attachment theory and its connection to the role of faith within the construct of faith-based initiatives. It will not provide a comprehensive description of the myriad of care components in the field of addiction treatment.

Faith-based Initiatives

Historical Background

At the outset, a basic history of the concept of faith-based initiatives serves to lay a foundation for understanding its importance in this dissertation project. Jay Poole reports that the White House Office of Faith-Based and Community Initiatives (OFBCI) was created on January 29, 2001 by President George W. Bush. Its purpose focused on discovering barriers that prohibit Americans in need from receiving effective social services. By August of 2001, the OFBCI issued a report entitled, “Unlevel Playing

Field,” which identified regulatory and administrative barriers discriminating against faith-based and community groups in the Federal grant process. Congress failed to come to a consensus on proposed legislation. President Bush, through executive order in December 2002, directed federal agencies to revise their policies so that “equal treatment” principles are followed in grant making. This order paved the way to allow religious and faith-based organizations to apply for federal grants through several federal departments without having to “secularize” themselves (i.e. exclude all references to faith beliefs) as previously required. Bush’s executive orders created a pathway for religious organizations to access over 3 billion tax dollars via federal programs in the five-year period from 2002-2007.¹

Georgia A. Persons further updates the historical perspective of the administration succeeding President Bush. President Barack Obama issued an executive order in February 2009 establishing a new faith-based initiative, renewing and slightly revising the policy initiative originally established under President Bush. Bush’s Faith-Based and Community Initiative (FBCI) became the Faith-Based and Neighborhood Partnerships initiative (FBNP) under President Obama. The Obama executive order reaffirms that

Faith-based and neighborhood organizations are close to the people and trusted by them, and must be strengthened in their ability to deliver services effectively in partnership with government at all levels, and with other private organizations, while preserving fundamental constitutional commitments.²

¹ Jay Poole, “The Impact of the Faith-Based and Community Initiative on Rural Mental Health Care,” *Forum on Public Policy: A Journal of the Oxford Round Table*, 2007, accessed on October 11, 2015, <http://www.questia.com/read/1G1-192639888/the-impact-of-the-faith-based-and-community-initiative>.

² Georgia A. Persons, “How Firm a Foundation? Comparing the Bush and Obama Faith-Based Initiatives,” *Forum on Public Policy: A Journal of the Oxford Round Table*, 2011, accessed on October 12, 2015. <http://www.questia.com/read/1G1-317588317/how-firm-a-foundation-comparing-the-bush-and-obama>.

Bush's Faith-Based and Community Initiative provided an opportunity for religious organizations to become more established in the social service arena, as many people who need services for mental illness benefit from the religious component that may be offered in conjunction with professional services. Poole contends that "not all would benefit from the religious aspect" and further, "the faith-based and community initiative does not offer clear systems for measuring or enforcing regulations or accountability measures, a problem that puts those receiving such services in jeopardy."³ In other words, Poole expresses concern that faith communities may not conduct their social service programs with the same academic and scientific rigor as other governmental agencies. For instance, faith-based organizations may not utilize evidenced-based practices or comply with external accountability in order to ensure the safety and welfare of the general public (for example, state examination and licensure of programs and/or personnel).

Example of Success

Explorations of some state prison systems offer an example where faith-based initiatives have a proven track record of success. Due to the economic recession, which began in late 2008-2009, budget shortfalls in the two years following reduced the ability of most state prison systems to start new programs and provide much-needed services for inmates. Volunteer faith-based programs surfaced and served as a welcome addition in correctional systems, offering the option of inexpensive and promising intervention to increase successful reentry into communities and possibly decrease recidivism.

³ Poole.

According to Louis B. Cei, faith-based approaches are informed by spiritual values and help offenders by

introducing moral concepts found in the Bible, the Koran and other spiritual texts. While there is no commonly accepted definition of faith-based programs, the consensus is that they operate mainly on the theory that by conforming to such religious principles as honesty, truthfulness, nonviolence and service to the community, offenders will not commit further crimes.⁴

When individuals conform to these principles, a new sense of being beyond oneself emerges and serves to guide him or her into a greater sense of meaning and purpose in life.

Efficacy via Research

In order to demonstrate efficacy for faith-based initiatives, research needs to be conducted by the same rigorous standards established in the social sciences. Louis B. Cei indicates that the research on faith-based initiatives shows potential. Both meta-analyses (studies that combine other studies) and individual case studies indicate favorable outcomes concerning avoidance of future criminal behavior. For example, a 2002 meta-analysis by the University of Pennsylvania reviewed forty-six studies of religious programs and concluded that “research on religious practices ... indicates that higher levels of religious involvement are associated with ... lower rates of delinquency among youth and reduced criminal activity among adults.”⁵

⁴ Louis B. Cei, “Faith-Based Programs Are Low-Cost Ways to Reduce Recidivism,” *Corrections Today*, August 2010, Questia, accessed on October 12, 2015 <http://www.questia.com/read/1G1-236026981/faith-based-programs-are-low-cost-ways-to-reduce-recidivism>.

⁵ Ibid.

In a 1997 study of Prison Fellowship (PF) ministry programs in four New York prisons, researcher Byron Johnson concluded that “after controlling for levels of participation in PF-sponsored Bible studies, PF inmates in the high-participation category (ten or more Bible studies) were significantly less likely to be arrested during the follow-up period (14 percent versus 41 percent).”⁶

Research demonstrates that faith-based initiatives can and do make a difference. As political policy has provided increased opportunities for faith-based initiatives, which have, in turn, produced positive results, it has led to the formation of many faith-based organizations (FBOs).

Faith-based Organizations

Faith-based organizations (FBOs) formally provide services as part of their role as social service organizations. Most often, they represent professional or paraprofessional organizations that have a *primary* social service mission. Religious congregations may include social service as an important *secondary* mission. FBOs increasingly provide a wide range of services in communities, though generally have been slow to embrace evidence-based practices (EBPs)—those that have scientific evidence of being beneficial. John D. Terry et al. contend that incorporating EBPs into both new and existing FBOs’ service programs can enhance their effectiveness:

There are significant benefits when FBOs deliver social services, as acknowledged by ecological theory and federal policy initiatives ... including increased access to hard-to-reach populations, provision of services within naturally occurring settings, a more publically favorable and less stigmatizing

⁶ Cei.

view of emotional and behavioral health services, and the use of a culturally meaningful context to deliver services.⁷

In addition to utilizing EBPs in service provision, formal evaluation will help FBOs determine whether their services are meeting their intended goals. Issues such as null or iatrogenic effects—psychological and/or educational services that are ineffective and even some plausibly helpful interventions delivered with good intentions shown to be harmful—must be cautioned against and avoided.

One of the reasons that FBOs have struggled to utilize EBPs in comparison to secular organizations lies in the oft-perceived incompatibility of faith and science. Terry et al. describe the tension between faith and science often perceived by individuals in FBOs:

Tensions between faith and science are often due to conflicting philosophical ideas ... some individuals within FBOs may tend to value theology, spiritual guidance, and God's will, whereas EBPs are often based on the philosophical assumptions of determinism, human agency, empiricism, and objectivism. However, it is possible for these values to be in tension without being incompatible.⁸

An example of the tension between God's will and human agency plays out in organizations like Alcoholics Anonymous, which though technically secular, popularized the Serenity Prayer: "God, give me grace to accept with serenity the things that cannot be

⁷ John D. Terry et al., "Incorporating Evidence-Based Practices into Faith-Based Organization Service Programs," *Journal of Psychology and Theology* 43, no. 3 (2015), Questia, accessed on October 12, 2015, <http://www.questia.com/read/1G1-428751840/incorporating-evidence-based-practices-into-faith-based>.

⁸ Ibid.

changed, Courage to change the things which should be changed, and the Wisdom to distinguish the one from the other.”⁹

Theological Basis for Involvement

Even though the concept of faith-based initiatives as political policy has existed for nearly fifteen years, considerable hesitancy and questions exist regarding churches, para-church organizations, and people of faith involving themselves as social service providers. James T. Spivey posits a solid theological basis for such involvement:

All Christian values such as caring for others are rooted in social and ethical monotheism. While God is one—the only one and sovereign over all creation—God also exists in social relationship: Father, Son, and Holy Spirit. Every human is made in God’s image, with equal dignity, access, responsibilities, and rights in his sight. His ethical nature is love, mercy, and justice, and his two greatest commandments are to love him and to love one’s neighbor. He is most pleased when people are just, merciful, and humble. God shows special concern for the poor, widows, orphans, and aliens, and he expects this kind of social justice from his people.¹⁰

Further, he purports the unquestionable scriptural mandate for churches (and Christians, in general) to do social ministry in the secular community:

This is a logical extension of the biblical command for Christians to obey their civil rulers, who work for the good of the people. Church-based public social ministry supports three foundational purposes of American government as listed in the preamble of the United States Constitution: ‘establish justice, insure domestic tranquility, and promote the general welfare.’¹¹

⁹ Rienhold Niebuhr, *The Essential Rienhold Niebuhr: Selected Essays and Addresses* (New Haven, CT: Yale University, 1986), 251.

¹⁰ James T. Spivey, “Charitable by Choice: A Biblical View of Faith-Based Initiatives,” *Baptist History and Heritage* 48, no. 1 (2013), Questia, accessed on October 12, 2015, <http://www.questia.com/read/1G1-331079277/charitable-by-choice-a-biblical-view-of-faith-based>.

¹¹ *Ibid.*

It is, therefore, politically and theologically expedient that faith-based initiatives be offered in local communities in order to meet the needs of fellow-citizens in the broadest context possible.

Relationship to Attachment Theory

As referenced in the previous chapter, attachment theory from the field of psychology provides an explanation for the connection and importance of faith within the construct of faith-based initiatives. One's attachment to God is central to living a faith-based life. This focus sets faith-based initiatives apart from non-faith-based or secularized initiatives.

Addiction presents a spiritual sense or basis for the understanding of attachments.

Don Williams affirms this perspective:

If we do not worship the living God, we will worship someone or something else. Compulsivity is not simply biologically or psychologically driven; it is a spiritual issue. Stuffing chemicals or passions or people into it will never ultimately satisfy. The Bible says we become like what we worship (Jer. 2:5; Hos. 9:10).¹²

Human beings worship the focus of their attachments.

People often review their attachments as a result of a crisis in life. Danger and opportunity inherently arise in the midst of a crisis of faith. Danger offers the propensity to increase the sense of crisis and opportunity presents the possibility to abate the crisis.

Tim Clinton and Joshua Straub underscore this reality as it relates to the Chinese symbol for crisis—a sign of both danger and opportunity, which has the potential to lead to a process of change in one's life:

¹² Don Williams, *12 Steps with Jesus: How Filling the Spiritual Emptiness in Your Life Can Help You Break Free from Addiction* (Ventura, CA: Regal Books, 2004), 26.

Danger represents a time of threat—to our sense of being, shaking our already established belief system to the core; and a time of opportunity—a time when people are most open or susceptible for change. Many times we reach this place in our lives where we question our meaning and reason for living because of an unexpected relational, spiritual, or emotional crisis. And it's usually during a crisis that we are forced to develop a new way of perceiving, coping, and dealing with life to resolve it and move forward.¹³

Danger and opportunity present a pathway to either negative change or positive change—depending upon the choice made during the crisis of faith.

As noted by Clinton and Straub, when individuals question the meaning and reason for life, they access a deep and intrinsic longing: “Researchers are finding that we have a system built into the very fabric of our DNA that explains the longing every one of us has for meaning and purpose greater than ourselves—a longing that usually comes alive in times of crisis.”¹⁴ Viktor Frankl, a well-known Viennese psychiatrist who survived the Nazi death camp at Auschwitz, understood the search for meaning to be “the primary motivational force in man.”¹⁵ This search for meaning resembles a respirator for souls, as Dallas Willard declares: “Meaning is not a luxury for us. It is a kind of spiritual oxygen, we might say, that enables our souls to live.”¹⁶ Therefore, Clinton and Straub correctly assert that “this spiritual longing, this discontent or existential struggle, if you will, for purpose, meaning, and making sense of who God is in the disappointments of

¹³ Tim Clinton and Joshua Straub, *God Attachment: Why You Believe, Act, and Feel the Way You Do About God* (New York, NY: Howard Books, 2010), 31.

¹⁴ *Ibid.*, 33.

¹⁵ Victor E. Frankl, *Man's Search for Meaning* (Boston, MA: Beacon Press, 1992), 7.

¹⁶ Dallas Willard, *The Divine Conspiracy: Rediscovering Our Hidden Life in God* (San Francisco, CA: HarperCollins, 1988), 386.

life, is as intrinsic to our souls as the longing for air.”¹⁷ It appears, then, that Blaise Pascal rightly described this condition as “a God-shaped vacuum in the heart of every man.”¹⁸

Spiritual longing actually consumes one’s being (Ps. 84:2; 119:131).

Every human experiences a drive towards discovery of reason, purpose, and meaning for living, as delineated by Clinton and Straub:

New research described in the neurobiological and psychological literature is now suggesting that we have a ‘Seeking System’ experienced as restlessness, longing, or an unformed need state—a thirsting for God—that is both a conscious and an unconscious process that has roots in development, leading to an object-seeking relationship with a Transcendent One.”¹⁹

At some point in everyone’s life, whether amidst a crisis of faith or at some other juncture, each person will face the need for something beyond one’s self. This crisis is best described as a choice with far-reaching consequences:

At some point in your life you will face your need for something more—your need for a relationship with God. And whether you choose or don’t choose to believe, and what you decide or don’t decide to do with it, is up to you. But the bottom line is this: You will have to make a choice—a choice that will lead you in only one of two ways, either toward God or away from him.²⁰

Attachments, correctly understood, emerge from one’s perceptions of the world and, more specifically, one’s beliefs and the relationships at the core of one’s being. From a Judeo-Christian perspective, the Bible provides the best source for one’s beliefs about relationship or attachment to God or to other things.

¹⁷ Clinton and Straub, 42-43.

¹⁸ Blaise Pascal, *Pensees* (New York, NY: Penguin Classics, 1997), 45.

¹⁹ Clinton and Straub, 43.

²⁰ *Ibid.*, 45.

The establishment of God-centered attachments plays a crucial role in the spiritual growth of individuals. The connection between addiction and attachment lies in what one chooses to do with his or her desires. Gerald G. May offers an interesting perspective:

While repression stifles desire, addiction attaches desire, bonds and enslaves the energy of desire to certain specific behaviors, things, or people. The word attachment has long been used by spiritual traditions to describe this process. It comes from the old French *attaché*, meaning ‘nailed to.’ Attachment ‘nails’ our desire to specific objects and creates addiction.²¹

Addiction, as used by May, attaches desire to whatever human beings allow as the intrinsic locus of control for living. He continues to explain:

Addiction exists wherever persons are internally compelled to give energy to things that are not their true desires. To define it directly, addiction is a *state* of compulsion, obsession, or preoccupation that enslaves a person’s will and desire. Addiction sidetracks and eclipses the energy of our deepest, truest desire for love and goodness. We succumb because the energy of our desire becomes attached, nailed, to specific behaviors, objects, or people. *Attachment*, then, is the process that enslaves desire and creates the state of addiction.²²

Giving in to false desires—a substitute for our true deepest desires—can lead to an addictive process in one’s life.

Detachment uncovers a person’s basic desire for God and sets it free. In May’s estimation, “Detachment is the word used in spiritual traditions to describe freedom of desire. With freedom of desire comes the capacity to love, and love is the goal of the spiritual life.”²³ Detaching from false desires illuminates a pathway for fulfillment of one’s true desire for relationship with God. When a person encounters a crisis of faith,

²¹ Gerald G. May, *Addiction and Grace: Love and Spirituality in the Healing of Addictions* (New York, NY: Harper One, 2007), 3.

²² *Ibid.*, 14.

²³ *Ibid.*, 14-15.

detachment serves to launch him or her toward a spiritual quest. The addiction surfaces primarily as a spiritual issue—the collision of false and true attachments in one’s life.

Attachment theory provides a basis for understanding how individuals attach to God. This attachment to God, and the subsequent change rendered in an individual’s life, is one of the basic tenants in the Alcoholics Anonymous (AA) movement and, by extension, many of the mutual-help groups in existence today. Oliver J. Morgan and Merle Jordon state, “In Tiebout’s [Harry Tiebout, M.D.] view, the ‘change which A.A. induces’ is a spiritual process of conversion and surrender with clear psychoemotional, cognitive, and behavioral dynamics.”²⁴ Therefore, surrendering to God can be synonymous with attachment to God.

According to D. W. Griffin and K. Bartholomew, people espouse four primary styles of relating: secure, anxious, avoidant, and fearful:

- Secure attachment describes those who hold a positive view of their self and others.
- Anxious people hold on to a negative view of their self and an unrealistically positive view of others.
- Avoidant people are the opposite of anxious people, in that avoidants have an overly positive view of their self, but an excessively negative view of others.
- Fearful people have a negative view of both their self and others.²⁵

Understanding these relationship styles is furthered through Bartholomew’s research based on levels of attachment anxiety and attachment avoidance:

- Secure adults experience low levels of avoidance and anxiety.
- Anxious adults show increased levels of anxiety and decreased levels of avoidance.

²⁴ Oliver J. Morgan and Merle Jordon, eds., *Addiction and Spirituality: A Multidisciplinary Approach* (St. Louis, MO: Chalice Press, 1999), 12.

²⁵ D. W. Griffin and K. Bartholomew, “Models of Self and Other: Fundamental Dimensions Underlying Measures of adult Attachment,” *Journal of Personality and Social Psychology*, 67 (1994): 430-445.

- Avoidant adults report high levels of avoidance and lower levels of anxiety.
- Fearful adults experience high levels of avoidance and anxiety.²⁶

Adults who experience secure attachments view themselves and others positively and exhibit lower levels of anxiety, avoidance, and fear.

Another factor for exploration concerns the topic of connectedness as it relates to meaningful and healthy spiritual attachments. The University of Dartmouth Medical School researchers, in association with the Commission on Children at Risk, released an executive summary of their study reporting:

- In large measure, what's causing this crisis of American childhood is a lack of connectedness. We mean two kinds of connectedness—close connections to other people, and deep connections to moral and spiritual meaning.
- Much of the first half of this report is a presentation of scientific evidence—largely from the field of neuroscience, which concerns our basic biology and how our brains develop—showing that the human child is “hardwired to connect.” We are hardwired for other people and for moral meaning and openness to the transcendent. Meeting these basic needs for connection is essential to health and to human flourishing.
- For what may be the first time, a diverse group of scientists and other experts on children's health is publicly recommending that our society pay considerably more attention to young people's moral, spiritual, and religious needs.²⁷

What does all of this mean? “We are hardwired as human beings—truly created and programmed to: (1) long for deep, lasting, and satisfying relationships; and (2) seek, search, and live for a destiny that is greater than ourselves.”²⁸ In other words, human beings are created for deep connections fulfilled through nourishing relationships and for

²⁶ K. Bartholomew, “Avoidance of Intimacy: An Attachment Perspective,” *Journal of Social and Personal Relationships*, 7 (1990): 147-178.

²⁷ “Hardwired to Connect: The New Scientific Case for Authoritative Communities, Executive Summary,” *Institute for American Values*, September 9, 2003, accessed December 30, 2013, <https://docs.google.com/viewer?url=http://americanvalues.org/catalog/pdfs/hwexsumm.pdf>.

²⁸ Clinton and Straub, 53.

a purpose larger than simply living for one's self—one which embraces a meaningful spirituality.

Clinton and Straub further explain how humanity's "hardwired to connect" relates to their God attachment concept:

Another set of factors—this one rising out of attachment theory and research—is understanding what shapes the way we think, feel, and act, creating our basic perception of the world. ... At the heart of these factors are two essential questions that all of us instinctively ask: (1) Am I worthy of love? and (2) Are others capable of loving me? Your answers to these questions, both cognitively and emotionally, are the basis for the formation of your core relational beliefs, and they have a profound impact on how you see yourself and on the way you relate in the closest and most important relationships in your life, including your relationship with God. ... Your specific God attachment and the core beliefs and presuppositions you have about God directly affect the way you relate with him every day.²⁹

A secure adult attachment creates the ability to understand one's life as a comprehensible story that includes all of one's experiences and memories—both good and bad. It integrates them into an understanding of where one is at, why one does certain things, and, ultimately, impacts one's relationship with God, who provides a deeper sense of meaning and purpose to one's life. The "Discovering Your Attachment Style Questionnaire" can serve as a tool to help individuals discover their primary attachment or relationship style. The survey is included in the implementation phase of this project (refer to chapter four and Appendix D, pages 256-257; used by permission of the author).

Summary

In summary, faith-based initiatives, which have existed for nearly a decade-and-a-half, have established permanency in the social service delivery system. Research

²⁹ Clinton and Straub, 53-54, 62.

validates the efficacy of faith-based programs in some state prison systems. Faith-based organizations have often filled the gap where deficits existed. Continued growth in the utilization of evidenced-based practices among faith-based organization will strengthen existing efforts and launch new programs. Attachment theory provides a framework of understanding for the importance of assisting an individuals' transition from the false attachment of addiction, which produces bondage, to attachment to God, which produces freedom and increased reason, purpose, and meaning for living that exceeds living for one's self.

Early Intervention: Importance and Role in the Continuum of Care

Prevention

Prevention serves as the initial stage in the continuum of care. Prevention programs provide education in order to enhance protective factors and reverse or reduce risk factors. The majority of prevention programs in the United States target children and adolescents and are most often conducted in collaboration with schools and public agencies. Prevention programs targeting college students have emerged in the last five to ten years—primarily as a way to combat binge drinking on college campuses.

Mutual-Help Groups: Alcoholics Anonymous

On the continuum of care, the next stage includes various forms of mutual-help groups, also known as community based groups. The most well-known of these is Alcoholics Anonymous (AA). J. Keith Miller shares the story of the founding of AA:

The founders of AA who developed the Twelve Steps were experiencing the pain of an apparently incurable spiritual and emotional illness, alcohol addiction that was destroying their minds, their bodies, and their ability to make a contribution to society. Their “disease” had driven God out of their lives; they and their

compulsions had replaced him as the center of their motivations and relationships. Then, in the experience of their own powerlessness, admitting the bankruptcy of their self-centeredness and the insanity of their self-destructive addictive behavior, these spiritually crippled men and women turned to God and each other as their only hope. They developed a hunger for healing and a hunger for God. They discovered a more simple [sic] way to live; trying to find and do God's will amid the noise and shattering vibrations of contemporary life. The simple yet profoundly powerful spiritual model that is hidden within the Twelve Steps has caused these groups collectively to become perhaps the fastest-growing spiritual movement in America today.³⁰

AA emerged as one of the first attempts to help alcoholics in the United States. Writing about the theological roots of AA and the parachurch evangelical organization, the Oxford Group,³¹ Linda Mercadante makes the following observation:

For early AA, alcoholism was understood to be a spiritual illness and a psychological one, but also very much a physical one as well ... AA's description has distinctive theological roots, and is still fundamental. It is a prototype for addiction recovery, and it is still the main approach that seriously considers the spiritual issues in addiction.³²

From the very beginning of AA, alcoholism was observed as a spiritual, psychological, and physical illness.

AA's chief publication, known as the *Big Book*, and used by hundreds of thousands of people since its first publication in 1939, relates the multifaceted problem faced by alcoholics. Mercadante makes the following observation: "The Big Book makes

³⁰ J. Keith Miller, *A Hunger for Healing: The Twelve Steps as a Classic Model for Christian Spiritual Growth* (New York, NY: HarperCollins Publishers, 1991), xiv-xv.

³¹ The Oxford Group was founded by Frank Buchman. For more information, refer to the following resources: Philip Boobbyer, *The Spiritual Vision of Frank Buchman* (Pennsylvania State University Press: University Park, PA: 2013); Glenn Chesnut, *Changed by Grace: V. C. Kitchen, the Oxford Group, and A.A* (Lincoln, NE: iUniverse, 2006); Arthur J. Russell, *For Sinners Only: The Book of the Oxford Groups* (Tucson, AZ: Hats Off Books, 2003); Dick B., *The Oxford Group & Alcoholics Anonymous: A Design for Living that Works* (Kihei, HI: Paradise Research Publications, 1998).

³² Linda Mercadante, *Victims & Sinners: Spiritual Roots of Addiction and Recovery* (Louisville, KY: Westminster John Knox Press, 1996), 61, 97.

clear that the alcoholic's problem has at least three facets, the physical, the psychological, and the spiritual."³³ Since 1939, other views of alcoholism and drug abuse emerged, dotting the landscape with competing explanations, which often elicit more confusion than understanding on the topic.

Regarding the topic of spirituality, Christopher D. Ringwald relays that the word spirituality "derives from spirit, which in turn comes from the Latin words for breath or breathe. 'Spirit' is used in the Bible to speak of God's power and presence. Today, spirituality is understood as a quest for ultimate reality, meaning, truth."³⁴ Given this understanding, he elucidates further:

Today, simply put, AA and other Twelve-Step fellowships continue to view the lack or distortion of spirituality as the cause of addiction and an improved spiritual life as the solution. AA is a way of life, not a treatment. Only the first step mentions alcohol, the others concern spiritual processes. Abstinence merely allows a journey toward wholeness to begin.³⁵

A correct observation of AA's inclusion of spirituality provides both a deeper understanding for the cause of addiction (a false spirituality or none at all) as well as the answer for addiction (a healthy and positive spirituality). Prior to launching out on this journey to wholeness, additional clarity proves useful to sojourners.

In one of Duane F. Reinert's many interviews with alcoholics, one member of AA explains, "The approach of AA was really rather simple: 'Love God. Clean house. Help

³³ Mercadante, 84.

³⁴ Christopher D. Ringwald, *The Soul of Recovery: Uncovering the Spiritual Dimension in the Treatment of Addictions* (New York, NY: Oxford University Press, 2002), 6, Questia, accessed January 20, 2014, <http://www.questia.com/read/106429179>.

³⁵ *Ibid.*, 18.

others.”³⁶ Reinert developed the “Reinert S-Scale,” which focuses on one’s surrender toward God (refer to chapter four and Appendix D, pages 258-259; used by permission of the author). He saw the act of surrender to God as the entrance to a relationship with God, which creates the foundation for a transformed life. As Reinert states:

Those who make this religious act of surrender utterly commend their hearts, their lives, their decisions to God. When they do, this act forms a foundation on which the rest of their life is based. Jesuit theologian Bernard Lonergan stated that humanity’s highest achievement is falling in love with God. Why? Because once we fall in love with God, all is transformed.³⁷

He defines cleaning house as “sorting through our faults, our limitations, our weaknesses ... the reason for cleaning house is for growth and improvement, and for deepening our relationships with God and others.”³⁸ Helping others moves a person beyond self and into making a difference in the life of another individual:

When we transcend ourselves and get interested in someone else’s need, paradoxically we feel much better. There is nothing quite like the satisfaction and the joy one gets in making a difference in the life of another ... For our own self-giving to be transformative, the act cannot be self-serving. It must be in keeping with God’s will. The giving must truly be *for* the other.³⁹

Therefore, according to Reinert, establishing a love relationship with God, cleaning house by dealing with one’s own character defects, and reaching out to help others demonstrates true transformation of one’s life.

At the very core or center of recovery is the concept of personal transformation.

Ringwald reflects on the importance of personal transformation,

³⁶ Duane F. Reinert, *Love God ... Clean House ... Help Others* (Mahwah, NJ: Paulist Press, 1996), 3.

³⁷ *Ibid.*, 9-11.

³⁸ *Ibid.*, 23-24.

³⁹ *Ibid.*, 44, 54.

Without a personal transformation, usually spiritual in nature, little happens over the long term. Addicts and clinicians told me that a spiritual life, of almost any kind, was *critical* to recovery ... Some psychologists recognize the deep personal transformations that are basically conversion experiences. AA presents its spiritual approach as one that can change a personality dramatically and, often, quickly when other methods fail.⁴⁰

Personal transformation is inseparable from the concept of living a spiritual life—since a vibrant spiritual life produces personal transformation—without it, it is nearly impossible.

M. Scott Peck provides a similar clue, “In the end, all things point to God.”⁴¹ He describes individuals who embrace God rather than themselves as the center of the universe, “The person with a sacred consciousness, on the other hand, does not think of himself as the center of the universe. For him the center resides elsewhere, specifically in God—in the Sacred—and it is from this relationship that he derives his meaning and significance.”⁴² Peck’s observation provides an alternative to the narcissistic living rampant in many cultures today. An individual whose life is centered in God, enjoys depth of meaning and purpose in life.

Harold E. Doweiko supports the notion of substance use disorders as a symptom of a spiritual disease:

The process of recovery involves introducing the individual to a program of spiritual growth which will challenge his or her defense mechanisms, and through which the person can begin to move beyond the point where chemicals are needed to cope. The Twelve Step program has emerged as a way of recovery that offers

⁴⁰ Ringwald, 27, 265.

⁴¹ M. Scott Peck. *The Road Less Traveled and Beyond* (New York, NY: Touchstone, 1998), 241.

⁴² *Ibid.*, 244-245.

the individual a step-by-step program for spiritual growth, based on the experiences of the earliest members of this self-help movement.⁴³

Spiritual growth emerges as the antitheses of self-centeredness—living a God-centered life affords the opportunity to develop healthy coping skills thereby replacing one's dependence upon unhealthy defense mechanisms.

A perceived conflict often relates to whether AA is spiritual or religious, or neither. Mercadante reflects on this thought: "Members [of AA] explain that AA is spiritual but not religious."⁴⁴ One could assume that no place for religion exists in this enigma. However, in her article regarding helping addicts move beyond the spiritual wading pool, Mercadante expands the understanding:

Throughout human history, religion has existed to provide a framework of meaning for people, making sense of life and death. In fact, across time and culture religion has been the most constant source of meaning for humanity. To say that because religion can be used harmfully, it should be avoided—is like saying that we should not eat food because some of it is bad for us.⁴⁵

Matter of fact, she reports there is increasing evidence that Americans are both spiritual and religious. Data compiled by researchers from various surveys cited by Mercadante reveals:

- Belief in God is held by some 96 percent of the American public.
- Prayer is common with 9 out of 10 people asserting that they pray, most of them (67-75 percent) on a daily basis.
- Many respondents claim that faith is a central guiding force in their lives.

⁴³ Harold E. Doweiko, "Substance Use Disorders as a Symptom of a Spiritual Disease," in *Addiction and Spirituality: A Multidisciplinary Approach*, ed. Oliver J. Morgan and Merle Jordon (St. Louis, MO: Chalice Press, 1999), 51.

⁴⁴ Mercadante, *Victims & Sinners*, 67.

⁴⁵ Linda Mercadante, "Helping Addicts Move beyond the Spiritual Wading Pool: A New Approach to Religion and Spirituality in the Healing of Addictions," *International Journal of Existential Psychology and Psychotherapy* 3, no. 1 (January, 2010): 1-2; accessed January 20, 2014, <http://journal.existentialpsychology.org/index.php?journal=ExPsy&page=article&op=view&path%5B%5D=135&path%5B%5D=80>, 1-2.

- Interest in spirituality is high and growing. In 1994, 58 percent of respondents expressed interest in spirituality. By 1998 there was nearly a 25 percent increase, as 82 percent expressed interest.
- Religion is claimed as “very important” in the lives of 67 percent of people surveyed.
- Over two-thirds (69 percent) recently reported that they were members of a church or synagogue
- Forty-two percent attend services regularly.⁴⁶

The good news is there is a place for healthy spirituality in recovery—even once the physical addiction is under control. Mercadante’s model presents a “circle of spiritual guidance” intended to lay the groundwork for religious involvement:

The ultimate goal is to help move recovering persons to become engaged with a responsible, stable and compassionate community of faith. This would include active involvement in larger benevolent causes, ongoing mutual commitment, and a positive foundation for life-meaning that will last. The schema is designed to do four things:

1. Allow people to enter at any place they can
2. Take into account diversity of background and tradition
3. Not minimize or trivialize religion
4. Recognize that while not everyone has the expertise to be a religious and spiritual mentor, everyone can make a contribution to spiritual healing.⁴⁷

One’s initial participation in AA or a similar Twelve Step mutual-help group represents a beginning place or starting point in one’s spiritual awareness and journey. However, it is not the final destination. Becoming an active participant in a healthy community of faith affords opportunities to discover one’s calling and gifting, one’s reason for living, and a purpose for life that is greater and larger than one’s self. This is what is meant by “giving back” and “serving others,” key tenets of both healthy spirituality and holistic recovery.

Having meaning and purpose in one’s life and the values that promote this, represent the most important intangibles. Four active values can help individuals discover

⁴⁶ Mercadante, “Helping Addicts,” 3.

⁴⁷ Ibid., 4-5.

the meaning of life and help connect them with other people—hopefully leading them into a recognized, responsible, and stable religious community. The four active values presented are:

1. Risk for Good: Risking for good is ultimately counting on the fact that there is a good God, a benevolent foundation for all reality.
2. Hope Actively: Hoping actively is lending your hand to making good prevail; this is eschatological behavior.
3. Accept Accountability: Accepting your connection to others and living it out realizing that we are all community to one another, under God’s gaze and all loved by God.
4. Seek Higher Ground: If you search ever higher, you will arrive at God’s goals, an acceptance of them, a desire to help out, in ways you are best suited to help. So you are also accountable to yourself because you must know what you have and can contribute.⁴⁸

Mercadante concludes her article with the following statement: “We can no longer encourage people to say they are spiritual but not religious. That is a start, but it is not going to be enough. Instead of keeping people in the spiritual wading pool, we must help them learn to swim in the deep water of God’s grace.”⁴⁹ The transition from wading to swimming demonstrates growth in character and skills for effervescent living.

Mutual-Help Groups: Alternatives to Alcoholics Anonymous

Pursuing a positive and healthy sense of spirituality when utilizing traditional 12-step programs presents difficulties for some populations. Jan Parker and Diana L. Guest accurately state, “Sending all alcoholics to AA and all drug addicts to NA is too

⁴⁸ Mercadante, “Helping Addicts,” 5-6.

⁴⁹ Ibid., 6.

simplistic and may result in the client having a negative reaction to the 12-step program that could be avoided by a more in-depth assessment.”⁵⁰

According to Charlotte Kasl’s perspective, aspects of the AA approach seem counter to the needs of some women, especially those who had been abused or battered and need to build their ego strength and feel positive about themselves. There was no focus on appreciating one’s talents, strengths, and intellect. Kasl posits that AA offers a masculine approach to recovery, which can actually undermine women attempting to deal effectively with some of the underlying causes and contributing factors to their alcohol and/or drug use.⁵¹ Other women hold a different perspective than Kasl regarding AA’s benefit for female alcoholics. Amy Gutman, whose written work has appeared in an array of venues, writes, “AA’s official literature has traces of 1950s-era sexism, but the program can still be tremendously beneficial for female alcoholics.”⁵² This author concurs with Gutman—there are many women who have found hope and healing in Twelve Step programs—AA, as well as other programs, such as Celebrate Recovery. The old adage, “Don’t throw out the baby with the bath water” seems fitting in this regard.

Some faith communities may also seem reluctant to embrace the 12-steps at first glance. In 1980, the Jewish Alcoholics, Chemically dependent persons, and Significant

⁵⁰ Jan Parker and Diana L. Guest, *The Clinician’s Guide to 12-Step Programs: How, When, and Why to Refer a Client* (Westport, CT: Auburn House, 1999), 46, Questia, accessed June 15, 2014, <http://www.questia.com/read/9460780>.

⁵¹ Charlotte Kasl, “Many Roads, One Journey: One Woman’s Path to Truth,” in *Addiction and Spirituality: A Multidisciplinary Approach*, ed. Oliver J. Morgan and Merle Jordon (St. Louis, MO: Chalice Press, 1999), 112.

⁵² Amy Gutman, “No, Alcoholics Anonymous is Not “Ill-Suited to Women,”” *The Atlantic*, July 12, 2013, accessed February 1, 2016, <http://www.theatlantic.com/sexes/archive/2013/07/no-alcoholics-anonymous-is-not-ill-suited-to-women/277738>.

Others Foundation (JACS) launched their work as an organization dedicated to the needs of chemically dependent Jews and their loved ones. Carol Glass reflects on Judaism's understanding of alcoholism as a disease: "The American Medical Association, of course, has long defined alcoholism as a disease. Interestingly, Judaism recognizes sin as a disease, a disease of the spirit."⁵³ Additionally, Glass discusses the change process from a Jewish perspective:

The Jewish method for letting go of this unwanted behavior and returning to ethical living is a step-by-step process known as *Teshuvah*, or 'repentance.' Literally, *Teshuvah* means 'the process of return,' [and Jewish tradition teaches that] it involves a return to a complete relationship with God as well as a return to the whole self. It is accomplished by a return to centered, ethical living.⁵⁴

A comparison of "The Generic Steps for Change" with Bill Wilson and Dr. Bob's "The Twelve Steps of Alcoholics Anonymous," Maimonides' (a preeminent medieval Sephardic Jewish rabbi, physician, philosopher and astronomer) work entitled, "The Laws of Repentance," and Rabbenu Yonah of Gerona's (a Catalan rabbi and moralist, the leader of the opponents of Maimonides' philosophical works) composition entitled, "The Gates of Repentance" demonstrate "spiritual and tactical compatibility."⁵⁵ A parallel exists between viewing alcoholism (or addiction) as a disease and Judaism's recognition of sin as a disease of the spirit—and the benefit of a changed life that comes from adhering to a step-by-step process that includes re-connecting to God. Jonathan Diamond affirms the value of confession and repentance:

⁵³ Carol Glass, "Addiction and Recovery through Jewish Eyes," in *Addiction and Spirituality: A Multidisciplinary Approach*, ed. Oliver J. Morgan and Merle Jordon (St. Louis, MO: Chalice Press, 1999), 239, 242.

⁵⁴ *Ibid.*, 242.

⁵⁵ *Ibid.*, 244. See Appendix E, "Comparison of AA, Maimonides, and Rabbenu Yonah of Gerona."

Within both Christianity (the religious tradition that informed most of AA's early writings and work) and Judaism, confession and repentance atones only for transgressions between human beings and God. For transgressions between one individual and another, atonement is achieved by reconciling with the person who has been offended.⁵⁶

Inherent in both traditions is the concept that one needs to work on relationships both vertically and horizontally: one needs to be rightly related to God as well as rightly related to other people in order to experience healing from addiction and sin as diseases of the spirit.

Rick Warren affords a glance at the founding of Celebrate Recovery (C.R.):

C.R. is a biblical and balanced program that helps us overcome our hurts, hang-ups, and habits. It is based on the actual words of Jesus ... Most people are familiar with the classic 12-Step program of AA and other groups. While undoubtedly many lives have been helped ... I've always been uncomfortable with that program's vagueness about the nature of God, the saving power of Jesus Christ, and the ministry of the Holy Spirit. So I began an intense study of the Scriptures to discover what God had to say about 'recover.' To my amazement, I found the principles of recovery—in their logical order—given by Christ in His most famous message, the Sermon on the Mount.⁵⁷

Rather than focusing only on alcohol or drugs, Celebrate Recovery casts a broader net to include individuals exhibiting any type of hurt, hang-up, or habit that has controlled their life in any manner. The solution—a healthy spiritual life—lies in eight principles of recovery adapted from the Beatitudes (Matt. 5:3-12).

⁵⁶ Jonathan Diamond, *Narrative Means to Sober Ends: Treating Addiction and Its Aftermath* (New York, NY: Guilford Press, 2000), 114-115, Questia, accessed December 3, 2015, http://www.questia.com/read/1178_23339/narrative-means-to-sober-ends-treating-addiction.

⁵⁷ Rick Warren, "Introduction," in *Your First Step to Celebrate Recovery: How God Can Heal Your Life*, John Baker (Grand Rapids, MI: Zondervan, 2012), 7-8.

Since the origin of time, humanity has searched for happiness—usually in all the wrong places and with all the wrong things. John Baker, regarding the backdrop of launching C.R., reflects:

There's only one place where we can find tested-and-proven, absolutely-gonna-work principles that will lead to healing and happiness. These principles come in the form of eight statements from the truest of all books—the Bible—and from the most revered teacher of all time—Jesus Christ ... called 'the Beatitudes' or the Sermon on the Mount.⁵⁸

Regarding what generates the power to facilitate change in one's life, he observes, "The power to change comes only from God's grace. When we admit we are powerless [in and of ourselves], we go on to recognize that we need a power greater than ourselves to restore us. That power is the one and only true Higher Power, Jesus Christ."⁵⁹ Celebrate Recovery submits that Jesus Christ is the One and only true Higher Power that can produce the healing that is needed from the devastation caused from living a dysfunctional life.⁶⁰

Some individuals make their way to mutual-help groups via the invitation of a friend. Others participate due to a desire to quit using and abusing alcohol and other drugs and reach out for help from co-strugglers. However, for some people, early intervention is necessary.

⁵⁸ John Baker, *Your First Step to Celebrate Recovery: How God Can Heal Your Life* (Grand Rapids, MI: Zondervan, 2012), 27.

⁵⁹ *Ibid.*, 31-32.

⁶⁰ See Appendix F, "Celebrate Recovery: Twelve Steps and their Biblical Comparisons" and Appendix G, "Celebrate Recovery: The Eight Principles of Recovery."

Early Intervention

A gap in the delivery of services to those who struggle with alcohol and drug use and abuse issues, especially adults, exists. Good prevention programs for children and adolescents exist, even programs for college students. Good mutual-help groups are available, as well as outpatient, intensive outpatient, and inpatient treatment programs; long-term residential treatment options are also available for adults diagnosed with substance use disorders. However, research of current literature found no concrete examples of early intervention programs for adults. Although driver intervention programs exist in the State of Ohio, these are focused solely on individuals who have driving-related violations, identified by the acronyms DUI, DWI, OMVI and OVI—which all refer to the same thing—operating a vehicle under the influence of alcohol or drugs. It is important to note that these acronyms and description in Ohio law have changed:

However, Ohio law no longer uses the DUI and DWI acronyms because, in 1982, Ohio enacted a law that refers to driving under the influence of alcohol or drugs as “OMVI,” an acronym for Operating a Motor Vehicle Impaired. Because a more recent change in Ohio law removed the requirement that a vehicle must be “motorized,” the current acronym that refers to driving under the influence is “OVI” (Operating a Vehicle Impaired). It is now a crime in Ohio to operate almost any vehicle while impaired. This includes not only motorized “vehicles,” but also, bicycles, horse-drawn carriages and several other types of “vehicles.”⁶¹

Programs serving OVI clients, most often referred to as weekend intervention programs, neglect to serve individuals with other types of alcohol and/or drug offenses. In other words, these programs do not address issues such as drug possession, drug paraphernalia

⁶¹ *Jon J. Saia and Jessica G. Fallon*, “DUI, DWI, OMVI and OVI: What Do They Mean?” in *Law You Can Use*, January 17, 2014, Ohio State Bar Association, accessed October 14, 2015, <https://www.ohioabar.org/ForPublic/Resources/LawYouCanUse/Pages/LawYouCanUse-368.aspx>.

possession, larceny-thefts, simple assaults, liquor law violations, disorderly conduct and drunkenness, public intoxication; domestic, family or intimate partner violence offences; and child endangerment. Statistically, many of these crimes present in very large numbers nationally.

According to the FBI's Uniform Crime Reports (UCR) in 2012, law enforcement agencies nationwide made an estimated 12.1 million arrests for all criminal infractions, except traffic violations. The highest arrest counts were:

- Over 1.5 million for drug abuse violations;
- Over 1.2 million for driving under the influence;
- Over 1.2 million for larceny-thefts;
- Over 1.1 million for simple assaults;
- Nearly .5 million for liquor law violations; and
- Over .5 million each for disorderly conduct and drunkenness. (*Arrest totals are based on all reporting agencies and estimates for unreported areas. Source: FBI, Uniform Crime Reports, *Crime in the United States*, annually.)
- Drug and alcohol use by family violence offenders occurs in 30-47.8% of incidents; and
- Four out of 10 (41.4%) offenders involved in violence with a boyfriend or girlfriend were under the influence of drugs or alcohol, compared to 26.3% of offenders involved in violence against a friend or acquaintance and 29.3% of stranger violence.⁶²

The aforementioned gap represents a barrier in the continuum of care. As Edith M. Freeman states, “The current division between prevention, intervention, and treatment in preservice education, practice, and program administration is a barrier to a comprehensive analysis of the continuum (of care).”⁶³ Most often the term intervention

⁶² Matthew R. Durose, et al., “Family Violence Statistics Including Statistics on Strangers and Acquaintances,” June 2005, U.S. Department of Justice: Bureau of Justice Statistics, accessed November 2, 2015, <http://www.bjs.gov/content/pub/pdf/fvs02.pdf>.

⁶³ Edith M. Freeman, *Substance Abuse Intervention, Prevention, Rehabilitation, and Systems Change Strategies: Helping Individuals, Families, and Groups to Empower Themselves* (New York, NY: Columbia University Press, 2001), 139, Questia, accessed September 15, 2014, <http://www.questia.com/read/99814002/substance-abuse-intervention-prevention-rehabilitation>.

refers to a process for persuading an individual struggling with alcohol or drug abuse and/or use toward receptivity to and entry into some type of rehabilitation or treatment program. Freeman indicates that this understanding of intervention is

generally viewed as static, and its success is evaluated informally, according to one standard: whether the substance abuser enters rehab following the event. But this view does not focus on what happens from the different perspectives of interveners and substance abusers, and it ignores the possibility that intervention may be a continuous process or transition. . . . Intervention is best conceptualized as a continuous process rather than a static event. Such a view is consistent with an ecological perspective and systems theory. When intervention is viewed as a continuous *preservice* process it sets the stage for both better treatment outcomes as well as improved prevention outcomes.⁶⁴

In other words, intervention is best viewed as a precursor to rehabilitation and treatment efforts, and done successfully, contributes to improved outcomes for those who go on to rehabilitation and treatment programs.

Arnold R. Fleagle and Donald A. Lichi discuss a sociological concept known as “the broken windows theory”—developed by Stanford University psychologist Philip Zimbardo—which suggests that “to reduce or prevent crime and maintain social order, ‘small’ problems must be fixed immediately ... a little disorder that goes unattended invites even more disorder”⁶⁵ Applied to the concept of early intervention, working to bring assistance to individuals with AoD issues early in their using process has the potential to avoid larger catastrophic issues later, keeping damage at a minimum and improving long-term outcomes.

⁶⁴ Freeman, 140.

⁶⁵ Arnold R. Fleagle and Donald A. Lichi. *Broken Windows of the Soul*, (Camp Hill, PA: Wing Spread Publishers, 2011), 16-17.

Paulo Freire's model of intervention as an empowerment-based preservice foundation for prevention and treatment, "offers one way of reconceptualizing and explaining aspects of the intervention process, using continuous cycles of consciousness raising, education, investigatory research, and political action."⁶⁶ Consciousness raising assists the individual to work through denial and admit difficulties caused by the abuse/use of alcohol and/or drugs in his or her life. Education provides facts about the various resources for recovery, including types of services available, location of service centers, and referral information. Freeman notes that education plays a role in acquiring the unique services an individual needs: "Special needs related to gender, sexual orientation, ethnicity and race, age, or the severity of the problem(s) (e.g., a need for culture-specific, residential, or dual diagnosis services) can be acknowledged and the availability of specialized services pointed out."⁶⁷ Investigative research, with a particular view towards utilization of evidenced-based practices and outcomes, affords opportunities for continuous program and service improvement. Political action focused on changing public policy and increasing private and public funding for intervention services will help ensure the efficacious elimination of the gap between prevention and treatment.

⁶⁶ Paulo Freire's model of "Intervention as the Foundation for Prevention and Treatment," in *Substance Abuse Intervention, Prevention, Rehabilitation, and Systems Change Strategies: Helping Individuals, Families and Groups to Empower Themselves*, Edith M. Freeman (New York, NY: Columbia University Press, 2001), 141-142, Questia, accessed September 15, 2014, <http://www.questia.com/read/99814005/substance-abuse-intervention-prevention-rehabilitation>. See Appendix H, "Paulo Freire's Model."

⁶⁷ Freeman, 147.

Elizabeth C. Pomeroy and Lori Holleran Steiker reflect that prevention efforts in the late 1990s and early 2000s focused almost exclusively on “information provision in an attempt to change behaviors and norms for youths and adults.”⁶⁸ They cite three examples:

The early version of the DARE program that youths received had police passing around a bag of marijuana for students to see and smell, being told that “this is what you shouldn’t use.” Other dramatic prevention attempts such as Scared Straight (a program that attempted to instill fear about drug use as a technique) and Shattered Dreams (a psychodramatic recreation of a fatal driving while intoxicated accident and its aftermath for high school students) made adults feel good about their efforts to prevent dangerous, high-risk behaviors and outcomes. However, subsequent research has continually found these programs to be ineffective at best and injurious at worst.⁶⁹

In the twenty-first century, with prominence placed on evidence-based research and best practices, intervention is often prioritized over prevention efforts. This paradigm shift may engender further support of intervention efforts in the continuum of care.

Treatment

Treatment serves as the logical end of the continuum of care. Generally, treatment settings include outpatient, intensive outpatient, inpatient, and residential care, often with a duration of three to eighteen months. Each of these treatment settings usually provide some type of aftercare services, which can extend for two years post-treatment.

Founded in 1954, the American Society of Addiction Medicine (ASAM) is a professional society representing over 3,600 physicians, clinicians, and associated

⁶⁸ Elizabeth C. Pomeroy and Lori Holleran Steiker, “Prevention and Intervention on the Care Continuum,” *Social Work* 57, no. 2 (2012), Questia, accessed October 15, 2015, <http://www.questia.com/read/1G1-302403778/prevention-and-intervention-on-the-care-continuum>.

⁶⁹ Ibid.

professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment by educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction. ASAM began its work in the 1980s to define one set of criteria—on a national level—for providing outcome-oriented and results-based care in the treatment of addictions. The ASAM criteria, also known as the ASAM patient placement criteria (ASAM-PC) is the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with addiction and co-occurring conditions.⁷⁰

Motivation serves as one of the most important factors for successful treatment. Length of stay in a treatment program is one way to measure motivation for treatment. Jayadeep Patra et al. note the importance of combining intrinsic and extrinsic motivation: “Although several studies have shown that in order for treatment participants to therapeutically improve intrinsic motivation is important, some forms of extrinsic motivation represent powerful and active states and help in internalization and integration of values and behavioral regulations.”⁷¹ Therefore, an effective change process involves integrating one’s values and behaviors. Longer stays in treatment provide the opportunity for individuals to re-examine and clarify their values and determine how to apply values

⁷⁰ American Society of Addiction Medicine, “How to Use the ASAM Criteria,” American Society of Addiction Medicine, accessed October 14, 2014, <http://www.asam.org/publications/the-asam-criteria/how-to-use-the-asam-criteria>.

⁷¹ Jayadeep Patra et al., “Factors Associated with Treatment Compliance and Its Effects on Retention among Participants in a Court-Mandated Treatment Program,” *Contemporary Drug Problems* 37, no. 2 (2010), Questia, accessed on October 14, 2015, <http://www.questia.com/read/1P3-2209404521/factors-associated-with-treatment-compliance-and-its>.

clarification to behaviors and, by extension, to one's lifestyle, thereby increasing the likelihood of transformation.

Further, research supports that a combination of intrinsic and extrinsic motivation serves as a powerful deterrent for relapse (i.e. a return to abusing/using alcohol or other drugs). Patra et al. reports

A number of scholars and theoretical perspectives have maintained that the effects of extrinsic and intrinsic rewards are generally additive in nature. In the case of this specific examination on the basis of a DTC [Drug Treatment Court] population, the combined motivation for therapeutic improvement (i.e., intrinsic motivation in conjunction with extrinsic forms of motivation—i.e., the desire to stay out of jail) may act as determinants for nonrelapse.⁷²

The old adage, “You can lead a horse to water, but can't make him drink,” in light of this discussion, seems only partially true. One can certainly put salt in the horse's oats and make him thirsty. In other words, creative utilization of combined intrinsic and extrinsic motivation helps combat relapse and provides the opportunity for a better outcome post-treatment.

Court mandated treatment has been on the rise over the last five to ten years, as the judiciary has sought to provide opportunities for treatment rather than defaulting to incarceration for alcohol and drug offenses. Compliance or noncompliance with court mandated treatment is directly related to treatment engagement. Individuals effectively engaged in the treatment process with high compliance progress toward recovery result in a reduction of recidivism and an increase in public safety.⁷³

⁷² Patra.

⁷³ Ibid.

Recidivism is one of the most essential concepts in criminal justice. It denotes a person's relapse into criminal behavior after receiving sanctions or intervention for a previous crime. Recidivism is measured by criminal acts that resulted in rearrest, reconviction, or return to prison with or without a new sentence during a three-year period following the prisoner's release.

Studies by the Bureau of Justice Statistics (BJS) indicate high rates of recidivism among released prisoners. One study tracked 404,638 prisoners in thirty states after their release from prison in 2005. The researchers identified the following data:

- Within three years of release, about two-thirds (67.8 percent) of released prisoners were rearrested.
- Within five years of release, about three-quarters (76.6 percent) of released prisoners were rearrested.
- Of those prisoners who were rearrested, more than half (56.7 percent) were arrested by the end of the first year.
- Property offenders were the most likely to be rearrested, with 82.1 percent of released property offenders arrested for a new crime compared with 76.9 percent of drug offenders, 73.6 percent of public order offenders and 71.3 percent of violent offenders.⁷⁴

Reducing recidivism rates is connected to successful treatment outcomes and is at the forefront of concern throughout the United States.

One program that has demonstrated reduced recidivism rates is Celebrate Recovery Inside (CR-I), which brings the Christ-centered, life-changing recovery ministry of Celebrate Recovery to people who are incarcerated and want to overcome their hurts, hang-ups, and habits. In 1998, Crossings, a faith-based prison program in New Mexico, began to use Celebrate Recovery materials at the Southern New Mexico

⁷⁴ Matthew R. Durose, Alexia D. Cooper, and Howard N. Snyder, *Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010*, Bureau of Justice Statistics Special Report, April 2014, NCJ 244205, accessed October 16, 2015, <http://www.bjs.gov/content/pub/pdf/rprts05p0510.pdf>.

Correctional Facility in Las Cruces and quickly grew to five prisons.⁷⁵ Jan Thomas, a retired prison warden from New Mexico and the national director of CR-I until February 2009, saw a need to reach men and women in prison with the good news of hope. CR-I was formally launched in New Mexico to meet that need. The ministry has since expanded throughout the United States and internationally. The success of the program is reported in a study conducted on a group of 124 male prisoners in which the recidivism rate dropped from 80 percent to 26 percent.⁷⁶ There are currently over 370 CR-I Ministries active in prisons and jails in forty-two states in the U.S., and eleven active in two other countries.⁷⁷

Summary

The continuum of care begins with prevention programs, most often targeting children and adolescents—and college students by extension—with a dual foci of decreasing risk factors for substance use/abuse and increasing protective factors. Mutual-help groups, inaugurated by Alcoholics Anonymous and followed later by Celebrate Recovery, emphasize addiction as primarily a spiritual illness for which the remedy is surrender to God, which results in personal transformation. Research demonstrates subsequent recidivism for some incarcerated individuals who have experienced such a spiritual transformation.

⁷⁵ “About CR Inside,” accessed October 16, 2015, <http://www.cr-inside.org/about.aspx>.

⁷⁶ “History of CRI,” Celebrate Recovery of Greater Jacksonville, accessed October 16, 2015, <http://www.crjacksonville.com/crinside.htm>.

⁷⁷ “About CR Inside.”

The literature research did not reveal any early intervention programs for adults who struggle with alcohol and other drug issues, with the exception of the Ohio driver intervention programs, which traditionally serve a very limited population. One reason for this gap lies in the narrow definition and application of intervention. Historically, intervention has been viewed as an event with the goal of getting an individual into a treatment program that embraces total abstinence. A holistic approach would see intervention as a process of working with an individual to establish personal goals that lead towards transformation. Intervention needs increased prioritization in public policy, funding, and professional practice.

Treatment programs follow intervention services on the continuum of care. Court mandated treatment can be effective. One program, in particular, Celebrate Recovery-Inside has demonstrated its efficacy. Treatment outcomes can be improved with a combination of intrinsic and extrinsic motivation, as well as integration of values and behaviors, which also serve as powerful relapse deterrents.

Understanding Alcohol and Drug Use and Abuse

The problem of alcohol and other drug (AoD) use and abuse in the U.S. is enormous. Jerry Dunn reports that William C. Menninger of the famed Menninger Clinic wrote, "If any other disease (other than alcoholism) affected our citizens so much, a national emergency would be declared."⁷⁸ This section will provide a broad understanding of alcohol and drug use and abuse by defining addiction and its prevalence, identifying the characteristics of AoD use and abuse, noting its diagnostic

⁷⁸ Jerry Dunn, *God is for the Alcoholic*, rev. and exp. (Chicago, IL: Moody Publishers, 1986), 237.

criteria, identifying contributing factors, listing harmful effects, and enumerating the negative consequences of substance use disorders.

Definition and Prevalence of Alcohol and Drug Use

There are many definitions of addiction, each with a slightly different slant depending upon the focus of the individual or group utilizing a particular definition.

ASAM provides a comprehensive working definition of addiction, embracing addiction in a bio-psycho-social-spiritual framework of understanding:

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.⁷⁹

The prevalence of the problem of addiction is staggering. ASAM reports that 40 million Americans ages 12 or older—or more than 1 in 7 people—have addiction involving nicotine, alcohol, or other drugs. This is more than the number of Americans with heart conditions (27 million), diabetes (26 million), or cancer (19 million). Addiction exacts more than \$700 billion annually in costs related to crime, lost work productivity, and health care. Studies have documented the effectiveness of treatment with total savings related to health care, reduced drug-related crimes, and criminal justice exceeding costs by

⁷⁹ American Society of Addiction Medicine.

a ratio of 12 to 1. Too often, however, addiction goes untreated—only 10 percent of people who need treatment receive it.⁸⁰

Characteristics

In addition to ASAM's comprehensive working definition of addiction, Gerald G.

May identifies five essential characteristics that mark true addiction:

1. Tolerance: the phenomenon of always wanting or needing more of the addicted behavior or the object of attachment in order to feel satisfied.
2. Withdrawal symptoms: two types are stress reaction, when the body is deprived of something it has become accustomed to; and the second type is a rebound or backlash reaction, symptoms that are exact opposite of those caused by the addictive behavior itself.
3. Self-deception: the exquisite inattentiveness that the mind can demonstrate in order to perpetuate addictive behaviors.
4. Loss of willpower: as soon as one tries to control any truly addictive behavior by making autonomous resolutions, one begins to defeat oneself. For the most part, defeat is due to mixed motivations.
5. Distortion of attention: addiction and its associated mind tricks inevitably kidnap and distort our attention, profoundly hindering our capacity for love.⁸¹

May offers these items as characteristics, not diagnostic criteria from the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5). Further, he comments on the interplay between concepts of attachment theory noted earlier in this chapter and addiction, "The destructiveness of addiction lies in our slavery to these things, turning desire into compulsion, with ugly and loveless consequences for ourselves and our world ... The process of attachment moves from Stage 1: Learning, to Stage 2: Habit

⁸⁰ Ibid.

⁸¹ May, 25-29.

Formation, to Stage 3: Struggle.”⁸² He connects these stages to what lies at the center or core of human beings, the heart:

As nearly as I can tell, our core is what Hebrew and Christian spiritualities have called heart. It is the aspect of oneself that is not only one’s own center but also where one can be in closest, most directly feeling contact with the presence of God. And it is meant to be the center of our will, the nucleus of all choice and action.⁸³

The heart, in May’s estimation, is the locus of one’s volition, choices, and behavior.

Based on the DSM-5, Johanna Medina makes the following observation:

A substance use disorder describes a problematic pattern of using alcohol or another substance that results in impairment in daily life or noticeable distress. As with most addiction problems, despite any consequences [suffered] ... they will generally continue to use their drug of choice. They may make half-hearted attempts to stop or cut back their use, usually to no avail.⁸⁴

In other words, an individual suffering with a substance use disorder not only exhibits impairment in daily functioning, and regardless of ensuing harmful consequences, continues to use even though attempts to control use to some extent are attempted. The DSM-5 criteria provides greater detail of how a substance use disorder unfolds in one’s life.

Diagnostic Criteria

The DSM-5 outlines that in order for an individual to be diagnosed with a disorder due to a substance, he or she must display two of the following eleven symptoms within twelve months:

⁸² May 41, 57.

⁸³ *Ibid.*, 102.

⁸⁴ Johanna Medina, “Symptoms of Substance Use Disorders (Revised for DSM-5),” *Psych Central*, accessed October 12, 2015, <http://psychcentral.com/disorders/revised-alcoholsubstance-use-disorder>.

- Consuming more alcohol or other substance than originally planned.
- Worrying about stopping or consistently failed efforts to control one's use.
- Spending a large amount of time using drugs/alcohol, or doing whatever is needed to obtain them.
- Use of the substance results in failure to fulfill major role obligations at home, work, or school.
- Craving, or a strong desire or urge to use the substance (alcohol or drug).
- Continuing the use of a substance despite health problems caused or worsened by it. This can be in the domain of mental health (psychological problems may include depressed mood, sleep disturbance, anxiety, or "blackouts") or physical health.
- Continuing the use of a substance despite its having negative effects in relationships with others (for example, using even though it leads to fights or despite people's objecting to it).
- Repeated use of the substance in a dangerous situation (for example, when having to operate heavy machinery, when driving a car).
- Giving up or reducing activities in a person's life because of the drug/alcohol use.
- Building up a tolerance to the alcohol or drug. Tolerance as used by the DSM-5 means either needing to use noticeably larger amounts over time to get the desired effect or noticing less of an effect over time after repeated use of the same amount.
- Experiencing withdrawal symptoms after stopping use. Withdrawal symptoms typically include such things as anxiety, irritability, fatigue, nausea/vomiting, hand tremor or seizure in the case of alcohol.⁸⁵

Additionally, the severity of a substance use disorder is defined as mild (the presence of two-three symptoms); moderate (the presence of four-five symptoms); and severe (the presence of six or more symptoms).⁸⁶

Contributing Factors, Harmful Effects, and Negative Consequences of Substance Use Disorders

A contributing factor is something partially responsible for a development or phenomenon as compared to a causal factor, which is best understood as *a condition that*

⁸⁵ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Arlington, VA: American Psychiatric Publishing, 2013), 481-485.

⁸⁶ "Alcohol Use Disorder: A Comparison Between DSM-IV and DSM-5," National Institute on Alcohol Abuse and Alcoholism, NIH Publication No. 13-7999, July 2015, accessed October 17, 2015, <http://pubs.niaaa.nih.gov/publications/dsmfactsheet/DSMfact.pdf>.

produces an effect. Harmful effects cause damage or injury, especially to a person's health or to the environment. A negative consequence is something that happens as a result of a particular action or set of conditions.

Katherine Van Wormer and Diane Rae Davis introduce addiction as a “bio-psycho-social-spiritual phenomenon” offered as an atheoretical model that can be used with any philosophical approach.⁸⁷ With this in mind, an overview of the most common components of alcohol and drug use and abuse follow.

Behavioral Components

Some of the identified risk factors include early aggressive behavior, most often due to poor impulse control; lack of parental supervision; substance abuse by caregivers, family members, or friends; drug availability, including prescription drugs and illicit drugs; and poverty. Drug use can negatively affect academic performance and motivation to excel in school. A personality prone to taking risks presents one of the top contributing factors for alcohol and drug abuse. These people engage in risky behaviors such as operating machinery or a motorized vehicle while under the influence of alcohol or other drugs. They are prone to accidental injury, such as drowning, and have an increased likelihood of committing crimes or being the victim of a crime. They may also choose to engage in risky, unprotected sex, or become the victim of sexual abuse or date rape.⁸⁸

⁸⁷ Katherine Van Wormer and Diane Rae Davis, *Instructor's Manual to Accompany Addiction Treatment: A Strengths Perspective*, 3rd ed. (Belmont, CA: Brooks/Cole/Cengage Publishers, 2013), 7.

⁸⁸ Elizabeth B. Robertson, Susan L. David, and Suman A. Rao, *Preventing Drug Use among Children and Adolescents (In Brief)*, National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services, 2003, accessed September 1, 2015, <https://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents>.

Cultural/Familial Components

Positive family history of addiction serves as one of the top contributing factors for alcohol and drug abuse. Specifically, a blood relative, such as a parent, grandparent, sibling, or other close relative, who has problems with alcohol or drugs is likely influenced by genetic predisposition. Furthermore, men are more likely to exhibit problems with drugs than women, although progression of addictive disorders is accelerated in females. Familial accessibility and religious and social customs around drinking/drug use also encourage drug and alcohol use or abuse. Environmental factors, including one's family's beliefs and attitudes regarding alcohol and other drug use play a role in initial use. Family and/or relational problems due to behavioral changes can cause marital or family strife or loss of relationship, such as divorce or custody issues.⁸⁹

Financial and Legal Components

Employment related issues such as poor job performance, absenteeism, work related injuries, loss of wages, and loss of employment constitute some of the financial consequences of alcohol and/or drug use and abuse. Additionally, inappropriate use of finances for acquiring/purchasing alcohol or drugs creates further financial hardship. Legal components can include charges for possessing illegal drugs or stealing to support one's addiction as well as a host of other offenses. Most legal issues also carry direct financial obligations—court costs, fines, higher vehicle and health insurance rates, cost of reinstatement of a driver's license, attorney fees, and costs for counseling/rehabilitation/treatment. Individuals can also incur costs for medical appointments and treatment as

⁸⁹ "Drug Addiction," Mayo Clinic Staff, December 5, 2014, accessed October 10, 2015, <http://www.mayoclinic.org/diseases-conditions/drug-addiction/basics/definition/con-20020970>.

well as costs for medications. Drug and alcohol use imposes a cost to society through lost productivity, increased health care costs, and criminal violations, including property damage, theft, and incarceration.

Medical/Physical Components

According to the National Institute of Health, National Institute on Drug Abuse, the following are medical consequences of drug abuse:

- Cancer has been directly related to prolonged tobacco use and is the most preventable cause of cancer in the U.S. Smoking cigarettes has been linked to cancer of the mouth, esophagus, pharynx, larynx, liver, breast, neck, stomach, lung, among others.
- Researchers have found a connection between the abuse of most drugs and adverse cardiovascular effects, ranging from abnormal heart rate to heart attacks. Injection drug use can also lead to cardiovascular problems such as collapsed veins and bacterial infections of the blood vessels and heart valves. Other notable conditions include cardiomyopathy, arrhythmias, stroke and high blood pressure.
- Gastrointestinal effects, in particular nausea and vomiting, have been known to occur soon after use. Specifically, cocaine can cause severe abdominal pain in some individuals.
- Hormonal effects occur with steroid abuse as it disrupts the normal production of hormones in the body, causing both reversible and irreversible changes. These changes include infertility and testicle shrinkage in men and as well as masculinization in women.
- Drug abuse not only weakens the immune system but it is also linked to risky behaviors like needle sharing and unsafe sex. The combination greatly increases the likelihood of acquiring HIV-AIDS, hepatitis and many other infectious diseases.
- Some drugs may cause kidney damage or failure, either directly or indirectly from dangerous increases in body temperature and muscle breakdown. Chronic use of some drugs, such as alcohol, heroin, inhalants and steroids, may lead to significant damage to the liver, including jaundice, steatosis or fatty liver, alcoholic hepatitis, fibrosis, and cirrhosis.
- Musculoskeletal effects have been demonstrated with steroid use during childhood or adolescence, resulting in artificially high sex hormone levels, can signal the bones to stop growing prematurely, leading to short stature in adulthood. Other drugs can cause severe muscle cramping and overall muscle weakness.
- All drugs of abuse act in the brain to produce their euphoric effects; however some of them also have severe negative consequences producing neurological effects in the brain such as seizures, stroke, and widespread brain damage that can

impact all aspects of daily life. Drug use can also cause brain changes that lead to problems with memory, attention and decision-making. Chronic use of some drugs of abuse can cause long-lasting changes in the brain, producing mental health effects which may lead to paranoia, depression, aggression, and hallucinations.

- Acute or chronic pancreatitis, severe inflammation of the pancreas due to heavy or excessive alcohol use, is a risk factor for the development of pancreatic cancer.
- Prenatal effects in women, in terms of the full extent of the effects of prenatal drug exposure on a child, is not fully known. However, studies show that various drugs of abuse may result in premature birth, miscarriage, low birth weight, and a variety of behavioral and cognitive problems. Fetal alcohol spectrum disorders—Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE)—are the leading preventable birth defects associated with mental and behavioral impairment in the US today.
- Drug abuse can lead to a variety of respiratory problems. Smoking cigarettes has been shown to cause bronchitis, emphysema and lung cancer. Marijuana smoke may also cause respiratory problems. The use of some drugs may also cause breathing to slow, block air from entering the lungs or exacerbate asthma symptoms.
- In addition to the effects noted above as well as the effects that various drugs of abuse may have on specific organs of the body, many drugs produce global body changes such as dramatic changes in appetite and increases in body temperature, which may impact a variety of health conditions. Withdrawal from drug use may also lead to numerous adverse health effects, including restlessness, mood swings, fatigue, changes in appetite, muscle and bone pain, insomnia, cold flashes, diarrhea, and vomiting.
- In terms of mortality, drug-related deaths have more than doubled since the early 1980s. There are more deaths, illness, and disabilities from substance abuse than from any other preventable health condition. Today, one in four deaths is attributable to alcohol, tobacco, and illicit drug use.⁹⁰

This is a representative, not a comprehensive, description of medical consequences of drug abuse effecting some of the major organs and systems of the physical body.

Mental Components

The lack of healthy coping mechanisms and life skills serves as a contributing cause for alcohol and drug abuse. Alcohol use shrinks and disturbs brain tissue. Brain

⁹⁰ “Medical Consequences of Drug Abuse,” National Institute of Health, National Institute on Drug Abuse, accessed October 11, 2015, <http://drugabuse.gov/publications/medical-consequences-drug-abuse>

mass shrinks and the brain's inner cavity grows bigger, affecting motor coordination, temperature regulation, sleep, mood, and various cognitive functions, including learning and memory. Blacks outs, a loss of memory caused by excessive alcohol intake or drug use, cause disruption to the ability of the brain to form long-term memories.⁹¹

Psychological/Emotional Components

The presence of psychological problems or mental illness contributes to alcohol and drug abuse. People with a mental health disorder such as anxiety, depression, schizophrenia, bipolar disorder, post-traumatic stress disorder, or attention-deficit/hyperactivity disorder are at greater risk for having problems with alcohol or other substances. The risk of attempted or completed suicide also increases.⁹²

Sociological/Relational Components

Social risk or peer pressure creates another contributing factor for alcohol and drug abuse. Peers and role models play an influential role in whether or not a person develops a substance use disorder. Having close friends or a spouse who drinks regularly could increase one's risk. The glamorous way drinking and drug use is portrayed in the media may also send the message that drinking or excessive drinking is permissible. College students who consume alcohol in a binge fashion face a higher risk for alcohol poisoning and development of an alcohol use disorder in their 20s or 30s.⁹³

⁹¹ "Beyond Hangovers: Understanding Alcohol's Impact on Your Health," National Institute of Health, National Institute on Alcohol Abuse and Alcoholism, NIH Publication No. 13-7604, 2010, accessed October 11, 2015, <http://pubs.niaaa.nih.gov/publications/Hangovers/beyondHangovers.htm>.

⁹² Mayo Clinic Staff, "Drug Addiction."

⁹³ Mayo Clinic Staff, "Alcohol Use Disorder," Mayo Clinic, July 25, 2015, accessed October 10, 2015, <http://www.mayoclinic.org/diseases-conditions/alcohol-use-disorder/basics/definition/con-20020866>.

Spiritual/Theological Components

A crisis of faith can yield a loss of identity, meaning of life, and reason for living. One's purpose for existence outside of one's self can get lost amid the chaos that emerges from such a crisis, often creating increased anger at oneself, others, and God. Doubt, unbelief, and loss of one's spiritual center are other common residual effects co-occurring with a crisis of faith.

This section presented the ASAM definition of addiction, provided a brief description of the prevalence of the problem, outlined the DSM-5 criteria for substance use disorder, and delineated the contributing factors, harmful effects and negative consequences of substance use disorders.

Conclusion

This chapter reviewed key contemporary literature works regarding the care components in the field of addiction treatment, commencing with faith-based initiatives, a well-established element in the social service delivery system. Research validates the efficacy of faith-based programs in some state prison systems. Faith-based organizations have emerged and often filled the gap where deficits exist. Continued growth in the utilization of evidenced-based practices is needed to strengthen existing efforts and launch new programs. Attachment theory provides a framework for understanding the importance of helping individuals transition from the false attachment of addiction, which produces bondage, to attachment to God, which produces freedom and increased reason, purpose, and meaning for living that is greater than living for one's self.

In the field of addiction, the continuum of care begins with prevention programs, most often targeting children, adolescents, and college students with a dual foci of

decreasing risk factors for substance use/abuse and increasing protective factors. Mutual-help groups, inaugurated by Alcoholics Anonymous and followed later by Celebrate Recovery, emphasize addiction as primarily a spiritual illness. Therefore, the remedy is surrender to God, which results in personal transformation. Research demonstrates subsequent recidivism for some incarcerated individuals who have experienced such a spiritual transformation.

Research did not reveal any early intervention programs for adults who struggle with alcohol and other drug issues, with the exception of the driver intervention programs in Ohio, which traditionally serve a very limited population. One reason for this gap lies in the narrow definition and application of intervention. Increased prioritization in public policy, funding, and professional practice would have beneficial results in this area.

Treatment programs continue to demonstrate a wide range of results. Court mandated treatment can be effective. One program in particular, Celebrate Recovery-Inside, has demonstrated its efficacy. It is noted that treatment outcomes can be improved with a combination of intrinsic and extrinsic motivation, as well as integration of values and behaviors. This also serves as a powerful relapse deterrent. The final section of this chapter provides some basic descriptions to help a person understand the prevalence, criteria, contributing factors, harmful effects and negative consequences of alcohol and drug use and abuse.

CHAPTER 4: DESCRIPTION OF FIELD PROJECT

Introduction

Chapter 4 describes the four procedural phases of the project: (1) preparation of the project, (2) execution of the project, (3) presentation of the results of the project, and (4) reflection on the project's contribution to ministry. The following discussion will highlight the tasks in each of these phases.

Preparation of the Project

This section provides an overview of the steps taken in preparation of the project, including compliance with state and federal government requirements, personal certification and licensure, advertising and marketing, program materials, and personnel.

State Government Requirements

In 1997, Three Oaks Center, Inc. was founded as a non-profit organization in the state of Minnesota. It remained active until 2002 when the founder and author of this project moved to the state of Ohio. Due to a change in primary occupation, the organization sat dormant for ten years. In order to meet legal requirements for the State of Ohio, the non-profit organization had to be registered with the Secretary of State and the Attorney General's Office in Ohio. Research and writing of the prospectus for the project occurred simultaneously.

Due to the nature of the project—operating an early intervention program for adults with alcohol and drug issues—Ohio requires such programs, known as driver intervention programs, to be licensed by the Office of Mental Health and Addiction

Services (OMHAS). Therefore, the project offered a forty-eight hour (Friday-Sunday) and seventy-two hour (Thursday-Sunday) residential program (meaning clients must sleep overnight at the site location). The first 90-Day Certificate issued in March 2015 expired in June 2015; coincidentally, the original launch of the project had to be postponed due to a number of issues. The second 90-Day Certificate issued in September 2015 covered the launch of the project and expired in November 2015. OMHAS conducts a survey approximately forty-five days into the period; this survey was conducted on October 10, 2015. A letter detailing the need for a Plan of Corrective Action was received on November 3, 2015 regarding issues that needed remediation prior to the end of the second 90-Day Certificate.

In order to comply with OMHAS requirements, a board of directors was recruited from members of the community, comprised of eight individuals representing specific areas—legal, financial, human resources, law enforcement, judicial, chemical dependency treatment, and the medical community. I served as president and treasurer and my wife served as vice president and secretary, which satisfied the requirement for board officers. The inaugural board meeting was held in December 2014. The board established the following meeting schedule: April, August, and December.¹

Further compliance requirements included the creation of various forms, as well as developing policies and procedures.² Securing a program site location that met all Americans with Disabilities Act (ADA) guidelines proved challenging. Initially faith-

¹ See Appendix A, “Board of Directors’ Manual.”

² See Appendix D, “Personnel, Policy, Procedures and Program Manual.”

based retreat centers were considered, as they provide an environment conducive to quietness and personal reflection. As the program director, I explored seven sites and visited three potential locations. However, either non-compliance with ADA guidelines (some sites were grandfathered prior to the enactment of ADA) or lack of scheduling availability eliminated retreat centers from further consideration. Next, I explored and visited twelve hotels. As a result of these visits, I decided to host the early interventions at the DoubleTree Suites Hotel in Miamisburg, Ohio. This location met requirements for availability, compliance with ADA guidelines, meeting space, pricing, and sleeping rooms per OMHAS specifications. In order to purchase supplies needed for the project, without paying sales tax, a Sales and Use Tax Blanket Exemption Certificate was secured through the Ohio Department of Taxation.³ Additionally, this tax exemption status required meeting various federal regulations.

Federal Government Requirements

Since Three Oaks Center, Inc. is registered as a non-profit organization, application was made to the Internal Revenue Service (IRS) for recognition of exemption per IRS 501(c)(3) guidelines. The process commenced in April 2014. A correction letter, filed in August 2014, sought to correct a misspelling in the organization's name. The final acceptance letter, issued in October 2014, actually provided approval retroactive to January 2013 when the organization was granted legal status in the state of Ohio.

³ Certificate information is available in Appendix B, "Organizational Information."

Personal Certification and Licensure

Another requirement in the state of Ohio relates to certification and licensure of professionals working in the chemical dependency field. The Ohio Chemical Dependency Professionals Board (OCDP) oversees this function. I made initial application to the OCDP, which resulted in certification as a Licensed Chemical Dependency Counselor II (LCDC-II) for the two year period of July 2013-July 2015. Licensure renewal occurred in July 2015 and expires in July 2017. In conjunction with the state certification process, I made application to International Certification and Reciprocity Consortium (IC&RC) organization, which provides certification as an Internationally Certified Alcohol and Drug Counselor (ICADC) for the same time periods.

In order to maximize credibility with local churches and clergy and to facilitate their confidence in making referrals to the project's program, application for certification as a Certified Pastoral Counselor and Fellow with the American Association of Pastoral Counselors (AAPC) began in December 2013. The process traversed seventeen months and included supervision of pastoral counseling sessions utilizing a case presentation format, submission of a video tape and written verbatim of fifteen minutes from a pastoral counseling session, and submission of written documentation demonstrating integration of personal spirituality with professional psychotherapeutic theoretical applications in pastoral counseling. The process culminated in a four-member panel interview to provide critique of submitted materials, the application process, and affirm acceptance into the AAPC organization as a professional member. Final certification occurred in April 2015. During the AAPC process, research and writing commenced on chapter two, the biblical and theological basis for the project.

Advertising and Marketing

Good advertising and marketing are essential to the success of any business, and held true for this project as well. As the program director, I hired a graphic designer to create a new company logo for use on brochures, business cards, and letterhead. In addition, I contracted a web designer to create and design a website that reflected the information and style of the brochure. It also provided potential clients with access to registration forms completed online or downloadable applications they could print and submit via email or traditional U.S. mail service.

A marketing plan, crucial for any business, included the formation of a target audience and geographical area. Initially, common pleas court judges were identified in Montgomery and Greene counties. Municipal court judges in the cities of Dayton, Xenia, Oakwood, Fairborn, Kettering, and Miamisburg were placed on a list in order to schedule face-to-face meetings. In addition to meetings with judiciary, I conducted meetings with chief probation officers and applicable court administrators. Attorneys, Certified Employee Assistance Professionals (CEAPs), pastors, professionals in the counseling field, and alcohol and drug treatment programs were emailed or mailed marketing materials or met with face-to-face in order to facilitate referrals to the project's program. Advertising and marketing efforts generated over 500 contacts over a five-month period.

Program Materials

I conducted a review of applicable and appropriate audiovisual program materials (i.e. DVDs) and selected and ordered several items. Questionnaires were written to

coincide with the use of audiovisual materials. Other program materials, such as outlines for presentation of psychoeducational topics, were also created.⁴

Personnel

The process of recruiting staff personnel took several months. Three Oaks Center, Inc. sought to fill several positions: (1) chemical dependency counselors and chemical dependency counselor assistants to facilitate large group psychoeducational sessions, as well as individual and small group processing; (2) a registered nurse to provide access to medications as needed; (3) hallway monitors for overnight monitoring of hallways outside of client's sleeping rooms; (4) a vendor certified to provide the eight-hour driver remediation training; and (5) a program director, a role fulfilled by this author. Recruitment of these five staffing positions met the requirement for initial staffing.

A staff orientation occurred in May 2015. Besides reviewing all of the necessary forms and process for hiring staff as independent contractors, the staff examined the program schedule for both the forty-eight-hour and seventy-two-hour programs. All potential contracted staff members received specific training on how to conduct small groups in order for them to see how the entire weekend program flowed together. Final decisions regarding hiring staff were completed in August 2015. Individuals received job offers via letter along with the necessary hiring forms and independent contractor agreement forms. Individuals signed and returned these forms to the organization's

⁴ See Appendix D, "Personnel, Policy, Procedures and Program Manual."

office. Concurrently, the author completed research for and wrote chapter three, a general literature review.⁵

Execution of the Project

In order to launch the program weekend successfully, tasks were divided into three phases: pre-weekend, weekend, and post-weekend. Each phase contained specific tasks, which are delineated below.

Pre-weekend Phase

Participants for the Early Intervention Program (EIP) weekend came from referrals from a pastor, an attorney, and from a driver's license bureau. All three clients registered online through the parent organization's website, www.ThreeOaksCenter.com. Once registered, the website generated an email to the program director. The program director confirmed each registration by phone and invited them to attend an orientation the week prior to the EIP weekend.

Prior to the launch of the project's weekend program, staff scheduling was completed and hours confirmed with all contracted staff members. A chemical dependency counselor was available to conduct individual screening sessions and small group sessions with clients. The registered nurse was on duty to provide access to medications for one client, and a hallway monitor was in place for security. As the program director, I prepared to conduct the large group psychoeducational sessions. Arrangements were finalized for a private vendor to provide the eight-hour driver remedial training program.

⁵ See Appendix D, "Personnel, Policy, Procedures and Program Manual."

Organization of program materials included placing audiovisuals (i.e. DVDs) in the respective order for use throughout the weekend, along with making photocopies of the particular questionnaires for each session. Availability of audiovisual equipment at the hotel was confirmed. A trial run with the audiovisual equipment was conducted in order to ensure it functioned properly.

Food and beverage requirements comprised another important component for the weekend. As program director, I planned a menu for breakfast, lunch, dinner, and snacks and made arrangements for food purchase, preparation, serving, and clean-up.

The last task in the pre-weekend phase incorporated organizing and conducting an orientation for clients. After clients registered online via the organization's website, each registrant completed the Drug Use Screening Inventory-Revised (DUSI-R) online. The client received an email with a link and a login code for this assessment tool. After all clients completed the DUSI-R, the program director downloaded, printed, and placed a copy in each client's file. Clients were notified via telephone of the date, time, and place for the orientation, which was scheduled one week prior to the program weekend. Each client received a folder that included various forms, including an overview of the weekend program. Clients signed the forms and submitted them to the program director. Prior to concluding the orientation, clients had an opportunity to ask questions regarding the program.

Weekend Phase

The primary focus of the weekend phase was to conduct the EIP weekend, commencing Thursday at 5:00 p.m. and concluding Sunday at 3:00 p.m. A two-hour individual session, conducted with each client, continued the screening process with the

completion of the Triage Assessment for Addictive Disorders-5 (TAAD-5). The screening process concluded with a review of each instrument with clients in an individual session. Per OMHAS requirements, clients received written information on Hepatitis B, Hepatitis C, HIV Testing, STD Facts, and Tuberculosis, as provided by the Dayton-Montgomery County Public Health Department.

Table 1 identifies the psychoeducational topic sessions presented over the four-day weekend program.

Table 1. Psychoeducational Topics for EIP

Thursday	Title/Topic	Movies
	Alcohol/Substance Abuse Education Movies (with discussion and life application)	<ul style="list-style-type: none"> • “Impaired Driving: Awareness” • “The Secret to a Satisfied Life” • “Chalk Talk on Alcohol”
Friday	Eight (8) hour remedial driving intervention program	
	Alcohol/Substance Abuse Education: Traffic Safety Education Movies (with discussion and life application)	<ul style="list-style-type: none"> • “Secret World of Recovery” • “20/20” Drunk Driving”
	Alcohol/Substance Abuse Education: Relational/Social/Familial Movie (with discussion and life application)	<ul style="list-style-type: none"> • “Home Run”
Saturday	Alcohol/Substance Abuse Education: Lecture and Discussion: Mental/Emotional Aspects (presented by Program Director; topics include psychological aspects of using AoD, signs/symptoms of abuse/dependence on AoDs, dysfunctional behavior resulting from the use of AoDs, progressive nature of AoD abuse/dependence)	
	Alcohol/Substance Abuse Education: Lecture and Discussion: Physical/Medical Aspects (presented by Program Director; topics include: physical aspects of using AoD, combining use of alcohol with other drugs)	
	Alcohol/Substance Abuse Education: (Movie with discussion and life application)	<ul style="list-style-type: none"> • “28 Days”
	Introduction to Celebrate Recovery: 8 Principles & 12 Steps (presented by Southwest Ohio State Representative for	

	Celebrate Recovery; topics include: abstinence as a lifestyle/mutual-help programs/treatment alternatives/local resources)	
Sunday	Alcohol/Substance Abuse Education: Lecture and Discussion: “Faith and Spirituality” (Includes completion of the “Discovering Your Attachment Style Questionnaire” and the “Reinert S-Scale” inventory)	
	Alcohol/Substance Abuse Education (Movie with discussion and life application)	<ul style="list-style-type: none"> • “The Art of Living with Change”

Including the driver remediation component, the four-day EIP weekend provided a total of 19.5 hours of psychoeducation.

Six and a half hours of small groups provided a forum for processing psychoeducational information and making life application as follows:

- Small Group Discussion, Saturday morning 2 hours [Topics: Introductions, Legal & Financial Aspects of AoD Abuse]
- Small Group Discussion, Saturday afternoon 1.5 hours [Topics: Physical, Medical, Vocational, Educational Aspects of AoD Abuse]
- Small Group Discussion, Saturday evening 1.5 hours [Topics: Family, Recreational, Relational, Social, Mental, Spiritual Aspects of AoD Abuse]
- Small Group Discussion, Sunday morning 1.5 hours [Topic: Plan for Change]

Completion of client evaluation and staff evaluation forms followed the final large group session. Each client received a final individual session where they could review their progress and receive personalized recommendations for post-weekend follow-up. In addition, they received properly executed release forms and a Certificate of Completion.

Post-weekend Phase

Two tasks comprise the post-weekend phase. The first task involved sending the 72-Hour Residential EIP Completion Report and the properly executed release form to each client’s referral sources (attorneys, courts, pastors, state motor vehicle departments,

etc.) via fax and/or U.S. mail within one week. The second task involved sending copies of the same report to each client via regular U.S. mail. As a courtesy, an email was also sent to each client to inform them of the completion of each of these tasks.

Results of the Project

Measuring the results of the project utilized four elements: a review of the client evaluation forms, a review of staff evaluation forms, completion of the OMHAS 90-Day Survey, and results of the DUSI-R 3-month follow-up.

Client Evaluation Forms

Each client who participated in the first weekend program submitted an evaluation form at the end of the weekend. Two men and one woman participated in the program—ages 20, 42 and 44. All three participants described themselves as Caucasian. Each individual acknowledged this as the first time to complete a weekend intervention program. Participants made the following comments:

“It helped me dig up some repressed memories and helped me refresh my mind.”

“During breaks, it was nice to be able to get out of the room. Getting outside was nice. If I would recommend this program to someone I would tell them how much it opened my mind, heart, and feelings. Very helpful and job well done.”

“I would suggest to recommend this program. I really appreciate the love and hard work that has been put into creating this program.”

See Table 2 for how the clients rated the various components of the program

Table 2. Client Rating of the Program Components

Program Item	Very Helpful	Helpful	Somewhat Helpful	Not at all Helpful
Small Groups	3			
Movies	1	2		
Lectures	1	2		
Celebrate Recovery	1	2		
Individual Sessions	1	2		

Staff Evaluation Forms

Due to limited contact with clients and no involvement in programming, neither the registered nurse nor the overnight hallway monitor completed staff evaluation forms. Since an outside vendor provided the eight-hour driver remediation component, that person did not submit a staff evaluation form. Both the chemical dependency counselor and the program director submitted forms at the end of the weekend. Comments included:

“It will be beneficial for all the clients to have more outdoors break time; brief 5 minute breaks.”

“Add outside breaks. Improve handouts for Saturday lectures.”

See Table 3 for how the staff rated the components of the program.

Table 3. Staff Rating of the Program Components

Program Item	Very Helpful	Helpful	Somewhat Helpful	Not at all Helpful
Small Groups	2			
Movies		2		
Lectures	1	1		
Celebrate Recovery	2			
Individual Sessions	1	1		

Analysis of Evaluation Forms

The evaluation forms consisted of five demographic items and nineteen items assessing aspects of the program.⁶ Items were presented as questions with four response choices based on ratings of competence, helpfulness, and satisfaction. Four items were questions with responses ranging from “A lot” to “Nothing.” The last three items addressed overall satisfaction with the program and possible responses. These items are:

- a. All things considered, do you think the program was worthwhile?

⁶ See Evaluation Form in Appendix D, “Personnel, Policy, Procedures and Program Manual.”

- b. Would you recommend the program to someone who might have a problem?
- c. Do you think that you will be in touch with any agency or program in the future about getting some more assistance/support?

A final item asked open-ended questions and allowed the participants to offer a suggestion for improvement or provide other feedback.

Clients expressed a positive response to the program. On all items, participants selected the most positive or second most positive response for each item. Maximum point values were typically four points. Participants gave the maximum to ten items. On seven items, mean responses were above 3.0 but failed to achieve the maximum. The lowest level of endorsement were for the movies and lectures that were a part of the program. On the last item, which asked the clients about their likelihood of contacting an agency or program for help in the future, two of the three clients indicated they would do so. Table 4 presents each of the assessment items with the minimum and maximum scores as well as the mean score for the aforementioned five individuals.

Table 4. Minimum, Maximum, and Mean Responses Assessment Items on Evaluation Forms

Item	Minimum	Maximum	Mean
Accessibility of program	4	4	4.00
Counselor respect and understanding	4	4	4.00
Counselor interest in participant as a person	3	4	3.80
Appropriateness and helpfulness of activities in helping examine alcohol consumption or use of other mood altering substances			
Group Sessions	4	4	4.00
Movies	3	4	3.20
Lectures	3	4	3.40
Celebrate Recovery	3	4	3.60
Individual Sessions	3	4	3.60
Satisfaction with meals	4	4	4.00
Satisfaction with room accommodations	3	4	3.80
Safe at program (yes, somewhat, or no)	1	1	1.00
EIP personnel courteousness	4	4	4.00
Helpful in learning about self	4	4	4.00
Education on alcohol/drug abuse	4	4	4.00
Thinking about drinking/using and driving	4	4	4.00
Effect of whether participant will drink/use and drive in the future	4	4	4.00
Value of program	4	4	4.00
In touch with agency or program for help in future	3	4	3.40

OMHAS 90-Day Survey

The State of Ohio provided two individuals to complete the OMHAS 90-Day Survey. The Survey, conducted forty-five days into the period, lasted approximately four hours. A Program Certification Report detailing a Corrective Action Plan was received on November 3, 2015 regarding issues needing remediation prior to the end of the second 90-Day Certificate. The report did not note any general deficiencies. Site-Specific Deficiencies identified one deficiency in client records, seven deficiencies in personnel

records, and one technical assistance issue. All deficiencies were corrected and submitted by November 16, 2015.

DUSI-R Initial and Three-month Follow-up

Each client completed the DUSI-R prior to the program weekend. The target population, for purposes of the project, was adults. Administratively, the instrument contains 159 items, with eleven subscales. It is computer self-administered and requires approximately twenty minutes and a fifth grade reading level. Psychometrically, reliability measures include test-retest (interrater only), split half, and internal consistency. Validity measures include content, criterion (predictive, concurrent, postdictive), and construct. Clinical utility includes case identification, diagnosis in ten areas, treatment monitoring for change, and follow-up assessment at three months and six months as utilized for this project.

During the program weekend, the results were reviewed with each client. The DUSI-R evaluates adjustment in ten domains, measuring severity of disturbances that precede and co-occur with alcohol and drug use (See Figure 1): (1) substance use—frequency of use of twenty substances, degree of involvement, and severity of consequences (See Figure 2); (2) psychiatric disorder—anxiety, depression, antisocial behavior, psychotic symptoms; (3) behavior patterns—social isolation, anger, acting out, self-control; (4) school performance—academic performance, school adjustment; (5) health status—accidents, injuries, illnesses; (6) work adjustment—work competence, motivation; (7) peer relationships—social network, gang involvement, quality of friendships; (8) social competence—social interactions, social skills, refusal skills; (9) family system—dysfunction, conflict, parental supervision,

marital agility; and (10) leisure/recreation—quality of activities during leisure. In addition, it contains a deception or lie scale that gauges honesty. The DUSI-R also provides screening and prediction of six mental health disorders (see Figure 3: attention deficit/hyperactivity disorder, conduct disorder up to age 16, antisocial personality disorder, depression disorder, anxiety disorder, substance use disorder); as well as nine adverse outcomes (see Figure 4: head injury, treatment for injury after a fight, sexually transmitted disease, giving someone drugs for sex, driving under the influence, car accident while alcohol or drugs in system, sell or deal drugs, illicit drug use, violence proneness). The output is in the form of two profiles: (1) a profile indexing absolute severity of disorder (0 to 100 percent); and (2) a relative problem index ranking the order of severity in the ten domains. An overall problem density score, ranging from 0 to 100 percent, documents severity of maladjustment. The DUSI-R is used for measuring current status, identifying areas in need of prevention, and evaluating the magnitude of change after a treatment intervention—the EIP weekend.

The initial group report focused on four key areas:

PART A: Absolute Problem Density (See Figure 1):

This section of the report describes the type and severity of problems that require intervention. DUSI-R scores reflect severity of problems ranging from 0-100%. In addition, an overall problem density score is captured automatically ranging from 0-100%. In general, scores greater than 15% are significant. A Lie Scale score of 5 or higher should alert the examiner to possible invalidity of results due to deliberate deception by the client.⁷

⁷ DUSI Adult Intake Assessment EOC1 (Jackson's Point, ON Canada: eCenter Research, Inc., 2013), 1.

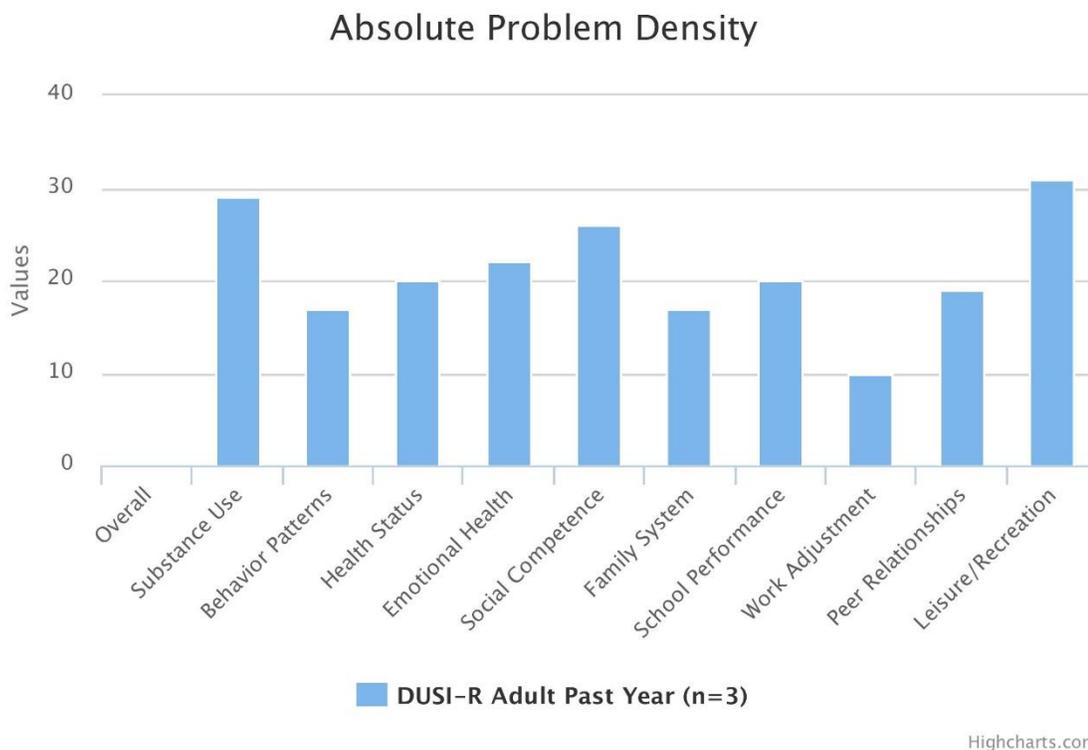


Figure 1. Absolute Problem Density (Initial)

PART B: Substance Use Frequency (See Figure 2)

This section of the report describes the frequency of use of twenty substances, degree of involvement, and severity of consequences. In general, scores greater than 15 percent are significant. Figure 2 is an aggregate report of all three clients who participated in the program.

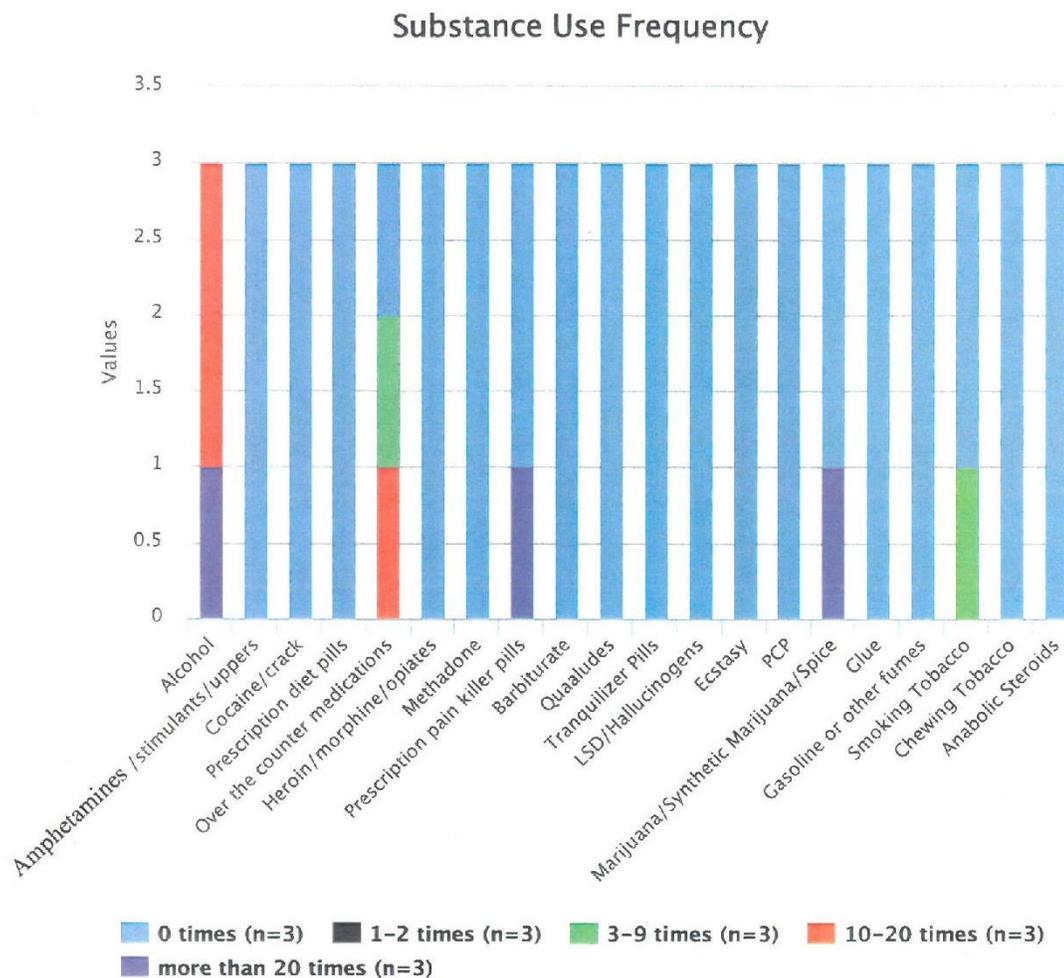


Figure 2. Frequency of Substance Use Each Month (Initial)

3) PART D: Screening and Prediction of Mental Health Disorders (See Figure 3)

This section identifies disturbances that point to the need for diagnostic evaluation of mental disorders. Asterisks * in the following table indicates the likelihood of a current diagnosis as well as prediction of diagnosis by ages 19 and 22. Predictions are based on administration of the DUSI-R to youth (male) 12 to 16 years of age.⁸

⁸ DUSI, 2.

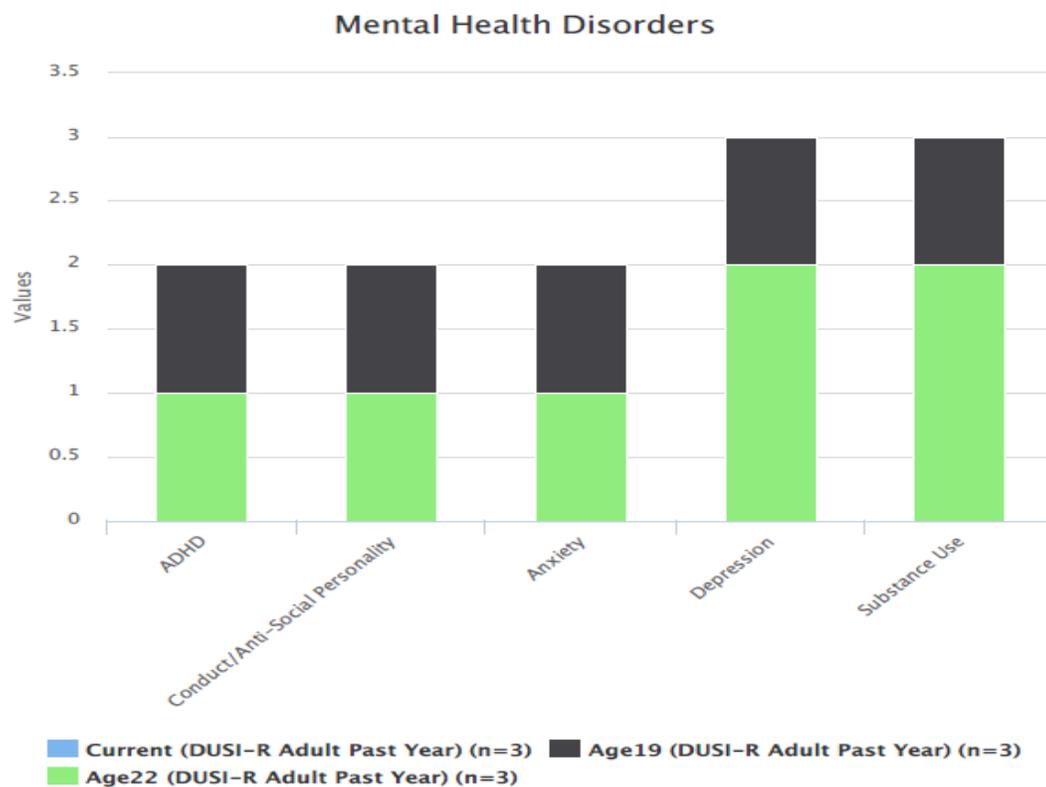


Figure 3. Mental Health Disorders (Initial)

PART E: Prediction of Adverse Outcomes (See Figure 4)

This section provides information regarding the individuals risk for adverse health and legal outcomes. Overall Problem Density (OPD) score has been studied in research to determine whether it predicts disease, injury, and proneness to violence. Asterisks * in the following table point to areas of risk for adverse outcomes. These outcomes are based on administration of the DUSI-R to youth (male) 16 years and events that occur by age 19.⁹

As Figure 4 demonstrates, no adverse outcomes were noted on the initial group report.

⁹ DUSI, 3.

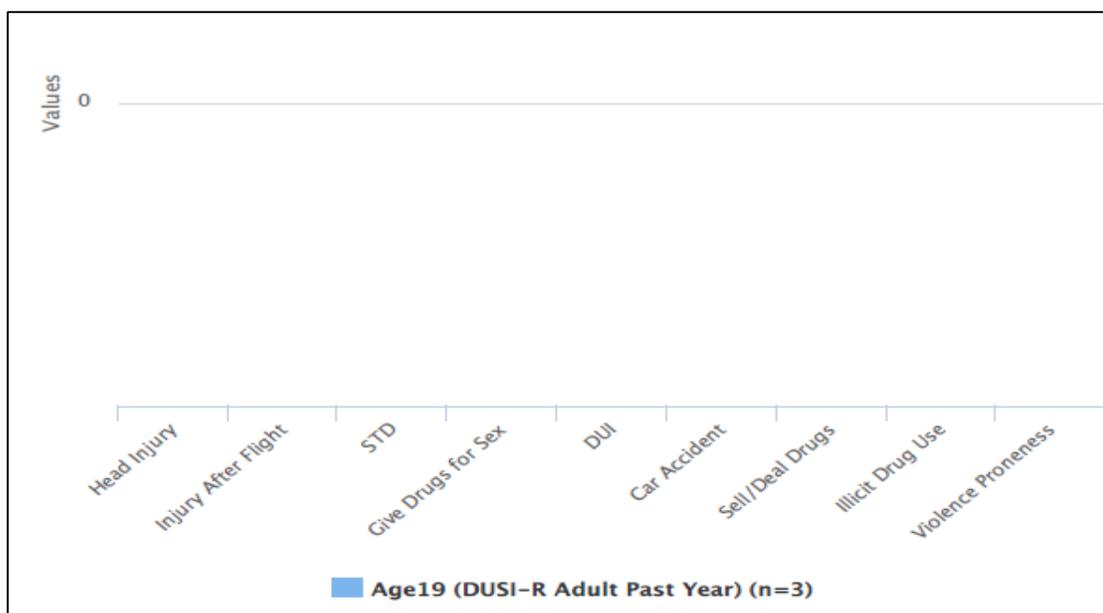


Figure 4. Adverse Outcomes(Initial)

Three months after the initial assessment, each client received an email with a link and login code to complete the DUSI-R a second time. The aggregate group report also focused on four key areas:

PART A, Absolute Problem Density (See Figure 5): In general, scores greater than 15 percent are significant. A Lie Scale score of 5 or higher indicates possible invalidity of results due to deliberate deception by the client. In general, there were no scales above 11 percent and, as in the initial assessment, there was no indication of any deception by any client. Specific results on the ten sub-scales are as follows: (1) substance use—decreased significantly from 29 percent to 0 percent ; (2) psychiatric disorder—lessened by nearly four-fifths from 22 percent to only 5 percent; (3) behavior patterns—shrunk from 17 percent to only 3 percent ; (4) school performance—decreased markedly from 20 percent to 0 percent ; (5) health status—20 percent to 7 percent ; (6) work adjustment—10 percent to 3 percent ; (7) peer relationships--reduced

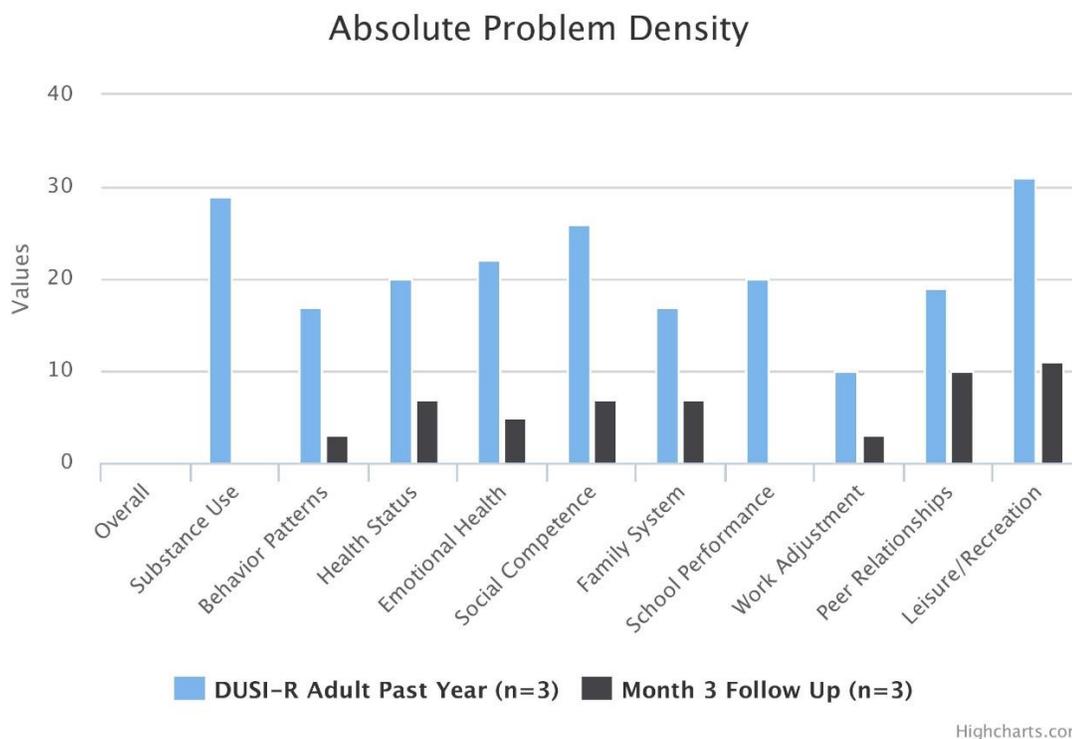


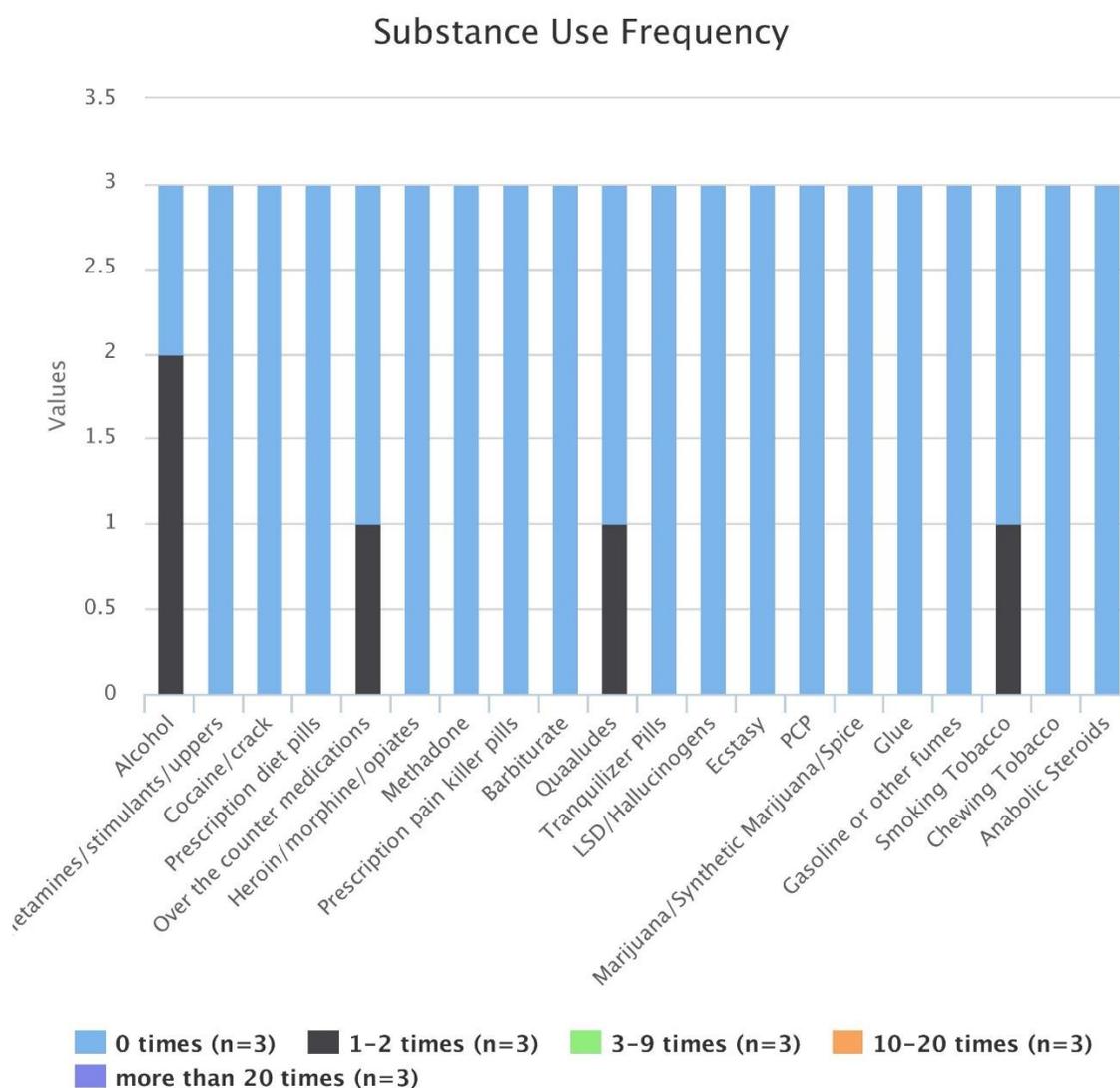
Figure 5. Absolute Problem Density (3-Month Follow-Up)

nearly by half from 19 percent to 10 percent ; (8) social competence—substantially diminished from 26 percent to 7 percent ; (9) family system—fell by nearly two-thirds from 17 percent to 7 percent ; and (10) leisure/recreation—dropped off by nearly two-thirds from 31 percent to 11 percent .

PART B, Substance Use Frequency (See Figure 6): This section of the report describes the frequency of use of twenty substances, degree of involvement, and severity of consequences. In general, scores greater than 15 percent are significant.

Comparatively, between the initial assessment and the 6-month follow-up assessment, alcohol use significantly reduced from 10-20 times to 1-2 times by two clients in each report; use of over-the-counter medications dropped from 3-9 times by one client and 10-20 times by one client to only 1-2 times by only one client and 0 times by the other two

clients; prescription pain killer usage was eradicated from more than 20 times by one client to 0 times; a client did report use of quaaludes 1-2 times in the follow-up assessment, although it is unclear whether this was a prescription or otherwise. Marijuana use was completely eliminated from more than 20 times to 0 times by one client; and smoking tobacco declined from 3-9 times to 1-2 times by one client. None of the participants reported use of any other substances, either in the initial assessment or the follow-up assessment.



Highcharts.com

Figure 6. Substance Use Frequency (3-Month Follow-Up)

PART D, Screening and Prediction of Mental Health Disorders (See Figure

7): This section identifies disturbances that point to the need for diagnostic evaluation of mental disorders or the likelihood of a current diagnosis as well as prediction of diagnosis in the future. In the initial and follow-up assessments, two clients were identified for the possibility of ADHD, Conduct/Anti-Social Personality, and Anxiety Disorders; all three clients were identified in the initial assessment for the possibility of depression and only two were so identified in the follow-up assessment. The initial assessment identified all three clients for the possibility of a substance use disorder but the follow-up assessment did not identify any of the clients for this issue.

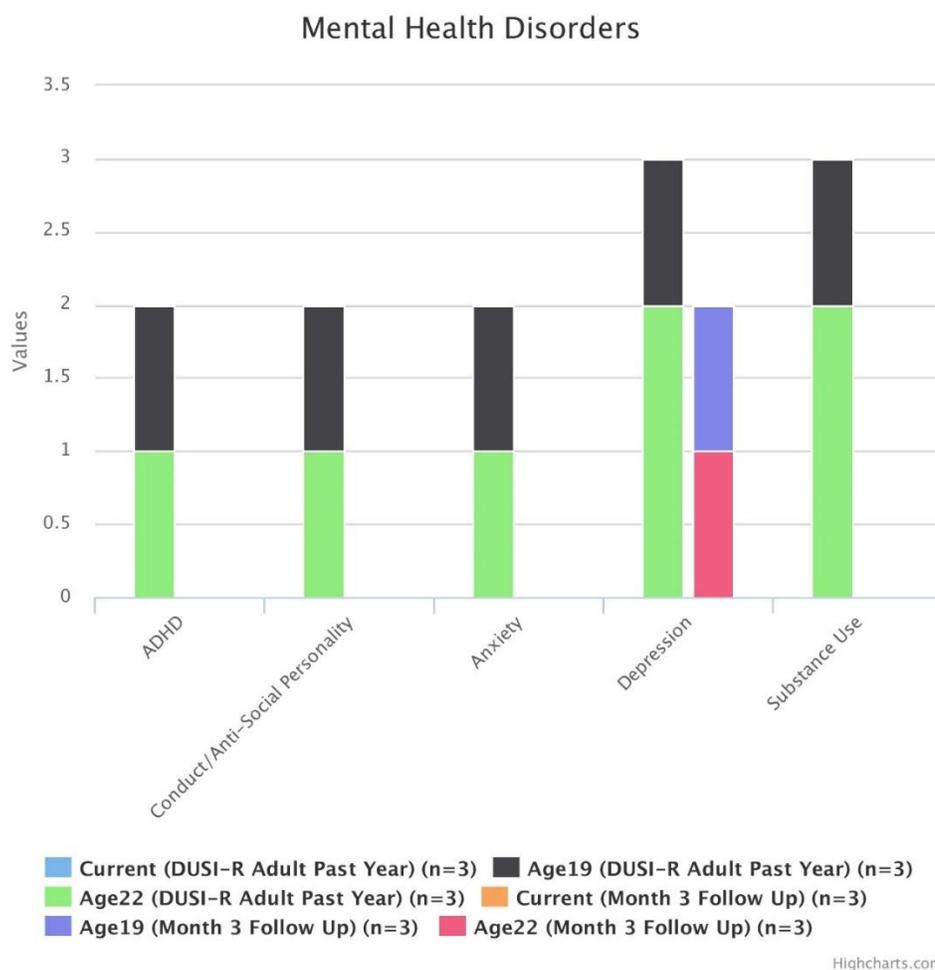


Figure 7. Screening and Prediction of Mental Health Disorders (3-Month Follow-Up)

PART E, Prediction of Adverse Outcomes (See Figure 8): This section provides information regarding the individuals' risk for adverse health and legal outcomes. As Figure 8 demonstrates, no adverse outcomes were noted on the follow-up assessment group report.

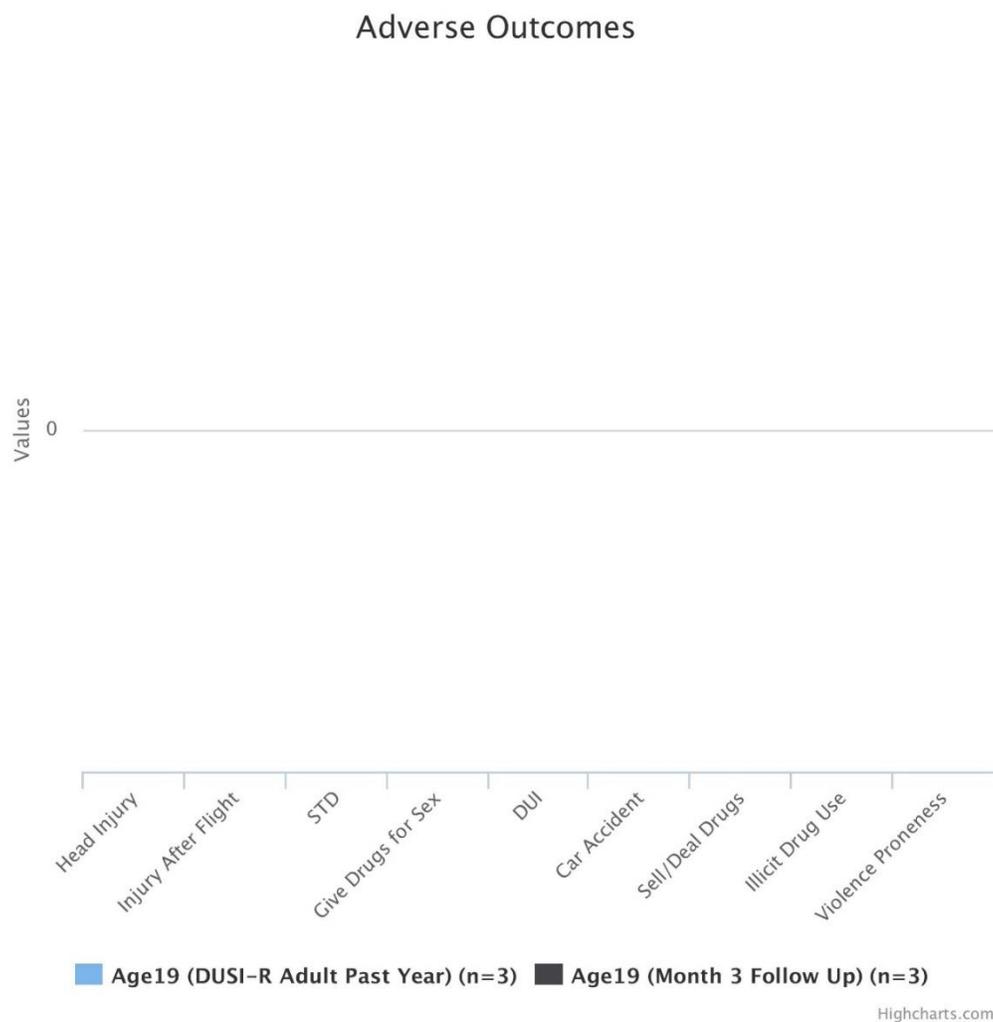


Figure 8. Prediction of Adverse Outcomes (3-Month Follow-Up)

The Project's Contribution to Ministry

The project's greatest contribution to ministry is the successful development of a faith-based early intervention program with a complete complimentary curriculum and

state recognition (licensure). Another contribution to ministry is best described as a Kingdom dynamic—the ability to connect other churches and partner with them via connections throughout the community in various events. One such activity, called Hope Over Heroin (HOH)—targeted the opiate epidemic in the greater Dayton area. The HOH occasion, a two-night weekend Christian evangelistic experience held on September 19-20, 2014 in Dayton, had the following outcomes: “20 churches involved in the project, 10,000 people in attendance, 600 people come to faith in Christ, 103 people baptized in water, 1,000 requests for treatment [including assistance or help], and 60 immediate treatment requests.”¹⁰ August 2015 data reports the following information: “*Four thousand plus* in attendance over the two night outreach with *over five hundred salvations* and *ninety-eight baptisms*.”¹¹ In conjunction with Three Oaks Center, Inc., the non-profit organization responsible for conducting this dissertation project, a comprehensive professional resource directory was compiled to meet OMHAS requirements for referrals to community resources and to serve the HOH events by providing assistance in making appropriate referrals during those events.

The project also established connections with a United States District Court Judge, several Common Pleas Court Judges in Montgomery and Greene Counties, as well as Municipal Court Judges in the cities of Dayton, Xenia, Oakwood, Fairborn, Kettering, and Miamisburg. Important contacts were also made with each court’s respective administrators, probation offices, and/or parole offices. Additionally, exchanges occurred

¹⁰ Holly Hendrichs, e-mail message to author, November 12, 2015.

¹¹ Ibid.

with Certified Employee Assistance Professionals (CEAPs), several pastors, and numerous attorneys.

Another contribution to ministry included an invitation to become part of the State Attorney General's Office through its "Saving Our Communities: Drug Education Conference for Pastors" initial conference (March 2015) and subsequent initiative, "Taking Back Our Communities: Combatting the Opiate Epidemic" throughout the state. The Champion's Network (CN) was formed as a follow-up to the initial conference. This network of church leaders champion the cause of eradicating opiate addiction in local communities. A resource for training church leaders is in its nascent stages. Three Oaks Center serves as a collaborative partner in the network, offering its Early Intervention Program (EIP) as a model for communities to consider in the melee against the growing problem of alcohol and drug abuse in the state of Ohio.

One additional contribution to ministry included an invitation to become a part of the Ohio Department of Rehabilitation and Correction's (ODRC) Southeast and Southwest Regions Faith-based Summit entitled, "Building Bridges to Better Lives" (April 2015). The summit addressed reducing recidivism by helping offenders build bridges through faith, which would result in changed lives, with the assistance of the faith community. The summit afforded opportunities to expand networks and establish relationships with colleagues from both the ODRC and faith communities. Three Oaks Center is now a collaborative partner in the network, offering its Early Intervention Program (EIP) as a model for communities to consider making referrals to or possibly replicating in the future.

The EIP addresses a real felt need in Ohio's culture and society—the growing heroin epidemic as well as the battle over the legalization of marijuana for medicinal and recreational uses—by providing a faith-based resource for individuals to carefully consider the underlying issues and contributing factors to their substance use and/or abuse. Through the utilization of a faith-based approach, individuals can assess their own spirituality and determine how to incorporate positive spirituality into their lives as an alternative to further substance use and/or abuse. Through Celebrate Recovery, individuals can also work on resolving their hurts, hang-ups, and habits, which too often serve as the underlying issues and contributing factors to their substance use and/or abuse.

Since Celebrate Recovery (CR) has proven to offer an effective way to work on one's hurts, hang-ups, and habits, and since these mutual-help groups are most often conducted in churches, collaborative relationships were developed with several churches offering CR groups throughout the greater Dayton area. The ensuing network of churches offering CR groups furthered the work of the aforementioned Hope Over Heroin event as well as inclusion in the aforementioned Champions Network. The combined results of these strategic partnerships demonstrated the ability to maximize Kingdom effectiveness through working together verses remaining separate.

Conclusion

This chapter described the four procedural phases of the project: (1) preparation of the project, (2) execution of the project, (3) presentation of the results of the project, and (4) reflection on the project's contribution to ministry. The project provided an effective EIP experience for three individuals. While this does not provide statistical data

to substantiate the effectiveness of the EIP, it resulted in the creation of an EIP model that can be replicated in other churches and faith-based organizations. The project implementation process opened the door for networking with several statewide organizations that will have fruitful outcomes for years to come.

CHAPTER 5: PROJECT SUMMARY

Introduction

This chapter provides a summary of the project by evaluating the keys to the project's effectiveness and identifying the areas that need improvement. Furthermore, it will clarify the implications of the project, make recommendations for the church regarding future implementation of the Early Intervention Program (EIP), and highlight areas for further research.

Evaluation of the Project

Keys to Project Effectiveness

The EIP weekend proved to be a successful ministry for three reasons. First, in one client, it assisted with examination and exploration of memories, which served as underlying issues and contributing factors to substance use and abuse. This client said, "It helped me dig up some repressed memories and helped me refresh my mind." The subsequent empowerment provided the impetus to formulate a new direction and create new goals to pursue in the next year.

Second, in another client, the weekend served to provide greater openness to review thinking processes and emotional states. This client said, "If I would recommend this program to someone I would tell them how much it opened my mind, heart, and feelings." Defense mechanisms, in particular, denial and emotional constriction, prohibit healthy recovery; dismantling unhealthy defense mechanisms and opening one's heart to experience emotions and choosing to deal with them in a healthy manner is a hallmark of holistic recovery.

Third, unconditional positive regard¹—or in Judeo-Christian terms, unconditional love—as well as the exemplary work ethic displayed by EIP program staff, provided a healthy environment conducive to pursuit of recovery from AoD issues. One client said, “I would suggest to recommend this program. I really appreciate the love and hard work that has been put into creating this program.” Motivational interviewing² serves as a positive methodology for supporting clients where they are, yet encouraging them to consider entering a healthy change process to facilitate an improved future.

The EIP’s effectiveness came as a result of four key elements: (1) it addressed a felt need; (2) it implemented a faith-based approach; (3) it used comprehensive and high quality intervention tools; and (4) it incorporated a dedicated and flexible program site and contracted staff.

Substance use and abuse, especially the current heroin epidemic in Ohio identified by government officials, healthcare personnel, and law enforcement, demonstrates a felt need in Ohio’s communities. The EIP weekend addressed this felt need by providing individuals with an opportunity to examine their substance use, review its consequences, and explore desired future outcomes. Utilization of an interactive journal during the weekend provided clients the opportunity to create actionable steps and goals for the ensuing year to support their recovery.

¹ Unconditional positive regard (UPR) is a term credited by humanistic psychologist Carl Rogers and is used in client-centered therapy. Practicing unconditional positive regard means accepting and respecting others as they are without judgment or evaluation.

² Motivational Interviewing (MI) is a method that works on facilitating and engaging intrinsic motivation within the client in order to change behavior. MI is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

A faith-based approach presented a positive spirituality found in relationship with God through faith in Jesus Christ and provided a solid foundation for the clients' lives. Further, the aforementioned faith-based orientation to life yielded a secure attachment, which set the stage for the potential eradication of anxious, avoidant, and fearful approaches to relationships. Finally, the faith-based approach embraced the concept of personal responsibility for all of one's choices as an adult, including the choice to pursue recovery from AoD issues.

Comprehensive and high quality intervention tools, specifically the Drug Use Screening Inventory-Revised (DUSI-R) and the Triage Assessment of Addictive Disorders-5 (TAAD-5) provided a thorough screening for problem areas. Furthermore, since both instruments are mapped to the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5), as well as the six dimensions of multidimensional assessment of the American Society of Addiction Medicine (formerly known as the ASAM patient placement criteria), they also assist in understanding a client's potential need for additional treatment, allowing for more accurate referrals for assistance post-EIP weekend. The DUSI-R provides unique opportunities for a follow-up at three and six months, which enables careful monitoring of the change process and allows supplementary interventions, as needed, to support the client's identified changes.

Dedicated and flexible program site and contracted staff compose the fourth key element for project effectiveness. Initially, we contracted nine program weekends in 2015 but seven were cancelled: two canceled due to delays in receiving the appropriate certificate of licensure from the state of Ohio, and five canceled due to not enough clients to conduct the program weekend. The program site chose not to charge for these cancellations, which saved the organization over \$5,000. The contracted staff also demonstrated flexibility and grace

with the cancellations. The core of the original contracted staff group chose to flow with the changes in scheduling due to their belief in and support of the organization's faith-based approach.

Keys to Project Improvement

Even though the EIP was successful in various ways, the project could benefit from several adjustments. Four key changes would have dramatically improved the outcome of the EIP and would contribute to its improvement in future implementations: (1) broader focus and target audience, (2) longer period of time to prepare for the completion of state program licensing, (3) earlier commencement of advertising and marketing endeavors, and (4) proactive anticipation of resistance from the judiciary and probation departments and creation of potential solutions.

First, the EIP needed a broader focus and target audience for the project than just AoD first-time offenders. Early on in the project implementation process, we expanded our target audience by including all adults with alcohol and drug issues. Feedback from the community suggested that the word "offenders" carried a negative connotation and intimidated the idea that the program only served individuals who had more than one legal offense—repeat offenders. Furthermore, people could interpret the language as exclusive, thereby not including individuals who had no legal offenses, such as individuals who surfaced for the first time with an AoD issue in other settings, such as a pastor or other faith leader's office due to marital or family issues, a Certified Employee Assistance Professional's (CEAP) office due to work related issues, or a primary care physician's office due to medical/physical issues. The concept of early intervention remains intact; the aforementioned change represents a broader target audience, yet still includes all

individuals who surface for the first time with an AoD issue in a variety of settings per above.

Second, the project would have experienced greater success by allowing a longer period of time to prepare for the completion of state program licensing. This could have avoided the cancellation of at least two EIP weekends. The elongated six-plus months in the initial certificate licensure application process proved to be extremely time-consuming and either significantly slowed or interfered with other implementation tasks. Further, inadequate or incomplete wording in some of the policies, procedures, or forms, as deemed by the state license surveyor, forced us to focus on licensing issues rather than other tasks. State officials could reduce this dynamic by providing more in-depth coaching during the initial licensure process. Applicable feedback was provided to the appropriate state office.

Third, the effectiveness of the project could have been enhanced by commencing with advertising and marketing endeavors at an earlier date. This could have avoided the cancellation of the other five EIP weekends. It took over five months to secure appointments with key personnel in the judiciary and probation departments. These individuals are key to potential referrals to the EIP weekend, as they control the information clients in the court system receive regarding weekend intervention programs they can attend to fulfill the court's requirements. The project's EIP weekend provides the only program in the greater Dayton, Ohio area to offer scientifically validated screening tools, a partial scholarship, if needed, and both a three- and six month follow-up on every client post-EIP weekend. Although these are compelling reasons to select the

EIP weekend, getting traction with those who are extremely influential in the referral process proved to be more difficult than anticipated.

Finally, proactive anticipation of resistance from the judiciary and probation departments and creation of potential solutions would have dramatically improved the outcome of the EIP and contributed to its improvement in future implementations. The attorney representative on the board of directors proved beneficial in gaining access to several members of the judiciary for face-to-face meetings between the attorney, the program director, and the respective judge. Although these individuals offered verbal affirmations in support of the EIP weekend concept, this did not translate to either direct referrals or the availability of EIP information that would have created parity with other organizations offering driver weekend intervention programs. Even though the EIP weekend accepts clients with not only AoD driving related offenses, but also all AoD legal offenses, including fourth and fifth degree felonies, which other weekend driver-intervention programs do not accept, this did not evoke referrals to the EIP weekends, nor greater availability of EIP literature for clients. Further progress requires the exploration of this resistance in order to acquire greater quantities of referrals in the future.

Implications of the Project

The project provided a pathway for Kingdom connections between the church and the larger public sector, as mentioned in chapter four. The EIP endeavor provided a way for partnering churches to link with other entities throughout the community in a variety of faith-based initiatives. Together, these faith-based initiatives facilitated a greater awareness of both the growing problem of AoD use and abuse and the need for collaboration between organizations in order to assist people in finding freedom from

substance use disorders, learn how to remain free, and become productive members of society.

Hope Over Heroin (HOH)—a two-night weekend Christian evangelistic experience—targeted individuals snared by the opiate epidemic. HOH sponsors their events in several communities in Ohio, as well as in other states and on other continents. It takes many churches and other community organizations working together to successfully conduct the event, as well as the follow-up post-event, which is necessary to attach people to faith communities and mutual-help groups, like Celebrate Recovery, for ongoing healing, growth, and support.

Another pathway of connection was made with the State Attorney General's Office through its "Saving Our Communities: Drug Education Conference for Pastors" initial conference (March 2015) and subsequent periodic conferences, "Taking Back Our Communities: Combatting the Opiate Epidemic" throughout the state. The Champion's Network (CN) was formed as a follow-up to the initial conference. This network of church leaders champions the cause of eradicating opiate addiction in local communities, as well as provides connections to applicable resources for assistance, training, and treatment. Further, an additional connection was made with the Ohio Department of Rehabilitation and Correction's (ODRC) Southeast and Southwest Regions in their faith-based summit. Their summits afford opportunities to expand networks and establish relationships with colleagues from both the ORDC and faith communities.

Three Oaks Center serves as a collaborative partner in each of these faith-based initiatives, offering its Early Intervention Program (EIP) as a model for communities to consider in the melee against the growing problem of AoD use and abuse. In the state of

Ohio, the driver intervention programs provide the only brief intervention resource and are limited in their approach and scope, as outlined in chapter four. Therefore, the EIP weekend supplies a unique faith-based approach that previously did not exist. The EIP weekend presents itself as a viable extension of Judeo-Christian ministry outside the four walls of faith community buildings, creating the potential to reach individuals that faith communities might not otherwise reach.

Recommendations for the Church

Even though a few churches utilize the EIP weekend as a unique outreach ministry, I would make several recommendations. First, in general, the church (also identified in this project as faith communities) need to become more accepting of the presence and reality of AoD issues. Too often a prohibitive dynamic exists—such as denial (that does not happen to our people), minimization (if it does happen, it is not that severe or widespread), deflecting (dealing with that problem belongs to the professionals), or blaming (it is their own fault due to their bad choices, due to their sin)—which represses the church’s ability to be viewed as a positive, helpful resource to individuals or families struggling with AoD issues. The church may begin by embracing their role as a change agent, a Kingdom force to make a difference in the lives of individuals, families, and communities.

Second, more churches can utilize the EIP weekend as a unique outreach ministry or even as a domestic missions’ endeavor. The EIP weekend is a fee-for-service program; in other words, individuals pay for the program out-of-pocket. Since insurance companies as well as government agencies do not provide funding for the EIP weekend, churches have a unique opportunity to assist parishioners with funding via either a partial or full scholarship, depending on the need. Another avenue is simply to donate finances to the EIP weekend’s scholarship fund and allow the program to administrate the funds.

Third, churches can partner with other community based groups and organizations that offer assistance to individuals struggling with AoD issues. For example, the Champions Network (CN) stated purpose is “connecting addicted people to Christ and to resources.”³ CN is currently looking for individuals to serve as champions in their local church in order to build a network to achieve their aforementioned purpose.

Fourth, churches can explore participation in reentry⁴ initiatives. According to the National Institute of Justice,

In 2011, 688,384 men and women—approximately 1,885 individuals a day—were released from state or federal custody. According to the Bureau of Justice Statistics, 4.8 million offenders were under community supervision by the end of 2011 ... Upon reentering society, former offenders are likely to struggle with substance abuse, lack of adequate education and job skills, limited housing options, and mental health issues.⁵

It is estimated that even more are released from local jails. Churches can engage in such ministry by connecting with the Federal Bureau of Prisons, a state department of corrections office, local probation and parole departments, chaplaincy offices in jails and prisons, or Christian organizations such as Prison Fellowship (PF). One of PFs ministries is reentry support, preparing prisoners for reentry into communities. To accomplish this, PF “offers mentorships, life-skills training, marriage and parenting classes, and programs that teach biblical ways to live, so that when men and women walk out the gate, they’re

³ “What is Champions Network?” Champions Network, accessed November 20, 2015, <http://ohiochampionsnetwork.org>.

⁴ *Reentry* refers to the transition of offenders from prisons or jails back into the community.

⁵ “Overview of Offender Reentry,” National Institute of Justice, accessed November 20, 2015, <http://www.nij.gov/topics/corrections/reentry/pages/welcome.aspx>.

prepared to thrive in their communities.”⁶ The church is uniquely positioned to offer these types of assistance. To this end, the EIP’s parent organization, Three Oaks Center, Inc., is partnering with the Adult Parole Authority-Dayton Region to encourage participation in the EIP weekend. It recently participated in the “Restoration, Recovery and Re-Entry” conference October 17, 2015 at United Theological Seminary in Dayton, Ohio. The annual conference was sponsored by the Montgomery County Volunteer Jail Chaplaincy Ministry. The conference is

designed to attract returning citizens coming home from incarceration, individuals with misdemeanor/felony conviction(s), the faith community, and community service agencies. The conference will educate returning citizens overcoming barriers to successfully re-enter, network the faith community with service agencies who need volunteers and provide all participants with information that will help make Montgomery County a better community.⁷

Such participation in reentry initiatives allows the church to make a difference in tangible ways.

Fifth, the church can offer a mutual-help group ministry, such as Celebrate Recovery,⁸ which is a Christ-centered recovery process with curriculum for adults, teens and children—a great opportunity to minister to the entire family affected by AoD issues. Celebrate Recovery provides training across the United States in its one-day seminars held throughout the year and its annual conferences held on the East and West Coasts. Some training may be available through its regional and state representatives, as well as

⁶ “Preparing Prisoners for Reentry,” Prison Fellowship, accessed November 20, 2015, <https://www.prisonfellowship.org/about/reentry-support>

⁷ Hope Williams, e-mail to author, October 1, 2015.

⁸ Celebrate Recovery, accessed November 20, 2015, www.celebraterecover.com

through their website. The church is uniquely positioned to care, love, and serve individuals and families and assist them in their desire for wholeness and wellness.

Recommendations for Future Study

The narrow focus of this project limited the topics for research. However, various areas for further research could provide unique and positive contributions to future EIP weekend programs. First, additional research is needed regarding early intervention as it relates to AoD issues. The traditional understanding of early intervention comes from the field of medicine—usually meaning appropriate action taken to reduce susceptibility or exposure to health problems and to detect and treat disease in early stages. However, often the lines of demarcation between prevention and early intervention in the field of substance abuse are blurred or used interchangeably. Conceptually, early intervention in medicine is often considered a predictor of improved outcomes; research may demonstrate that this is also true for AoD issues.

Second, a larger sample pool is needed in order to demonstrate the efficacy of the EIP weekend. Since only three clients have completed the program to date, no conclusions can be drawn from this small sample size. Once more than 100 samples are available in the study, strong indicators will emerge to demonstrate efficacy.

Third, additional research is needed to determine what contributes to the best outcomes for individuals participating in the EIP weekend. Once this information is available, program content can be evaluated, thereby informing changes in program content, structure, delivery, and so forth in order to increase the EIP weekend's outcomes.

Conclusion

The success of the EIP clearly achieved its goal of meeting a felt need for people in the community while also affirming the utilization of a faith-based approach as an important construct in recovery from AoD issues. The solid biblical foundation served the project well by undergirding the EIP weekend with a sound theological perspective. This aspect supported the faith-based focus of the project. Further, the research regarding faith-based initiatives and early intervention provided a guideline for topics for inclusion in the weekend EIP. The two-pronged approach created a solid knowledge and evidence-based program that churches can replicate. The success provides cause for celebration; however, the project could be improved through the implementation of several new strategies and additional research. Future development of the EIP weekend offers outstanding potential for reaching the local community with the importance of the role of faith in helping people address AoD issues through the lens of holistic salvation.

APPENDIX A. BOARD OF DIRECTORS' MANUAL

Note: The following materials are a *representative* although *not comprehensive* reflection of the Board of Directors' Policy & Procedures, Personnel, and Program manuals.

THREE OAKS CENTER, INC. Board of Directors Organizational Meeting Agenda

Date: Tuesday, December, 23, 2014

Facilitated by: Kevin R. Hoffman, President

Location and Time: Racquet Club, Dayton, OH; 11:30am-12:30pm

Agenda:

Call to Order
Welcome

New Business: Adoption of the following for 2015 ~

Board Officers, Board Members, Personnel Rosters
Organization Information; State of OH Certificate; IRS 501 (c) (3) Certificate;
D.Min. Project Prospectus
Budget, EIP Projected Annual Operation Costs, Fundraising
Policies and Procedures
Program Materials

Adjourn

THREE OAKS CENTER, INC. Board of Directors Organizational Meeting Minutes

Date: Tuesday, December, 23, 2014

Facilitated by: Kevin R. Hoffman, President/Treasurer

Location and Time: Racquet Club, Dayton, OH; 11:30am-1:00pm

Minutes: After ordering lunch, the meeting was called to order at 11:45am by Kevin Hoffman, President/Treasurer, who opened the meeting in prayer, welcomed the board members, and thanked them for their willingness to serve on the Board. A brief history of Three Oaks Center, Inc. was provided by President Hoffman; who also explained that the Early Intervention Program (EIP) is in process of State licensure through the Ohio Department of Mental Health and Addiction Services (OMHAS) office (a program brochure was provided in the Board Manual). At present, the EIP will be conducted every four to six weeks in 2015, based upon availability at the program site location. Bergamo Retreat Center in Beavercreek, OH is being considered as the primary choice; and area hotels are being explored as a secondary choice.

Present at the meeting were the following board officers and board members who took turns introducing themselves: Kevin Hoffman, President/Treasurer; Michelle Hoffman, Vice President/Secretary; Matthew D. DiCicco, Attorney Representative; Eva Walker, Financial Representative; Sherri Herrick, Human Resource Representative; and Benjamin Walker, Law Enforcement Representative.

Absent from the meeting were the Judiciary Representative and the Treatment Representative whose positions remain vacant at the time of this meeting. President Hoffman and board members Matt DiCicco and Sherri Herrick are working together to fill those positions prior to the next board meeting.

Old Business: Since this is the first board meeting, there was no old business to conduct.

New Business: President Hoffman presented the following for the board's approval and adoption for 2015 ~

1. Matt moved that the Board Officers, Board Members, and Personnel Rosters (tab 1) as written be adopted by the board. Sherri provided the second. Unanimously approved and adopted.
2. Eva moved that the Organization Information; State of OH Certificate; and IRS 501 (c) (3) Certificate; and the D.Min. Project Prospectus (tab 2) as written be adopted by the board. Sherri provided the second. Unanimously approved and adopted.
3. Matt moved that the Organizational Budget detailing EIP Projected Annual Operation Costs; Fundraising efforts with AmazonSmile, DLM Good Neighbor Program, Kroger Community Rewards, and Meijer Community Rewards programs (tab 3) as written be adopted by the board. Ben provided the second. Unanimously approved and adopted.

President Hoffman also reported:

- a. that the organization had just received a \$1,000 grant from a donor through the Dayton Foundation;
- b. that a PayPal account will be set-up on the organization's website for donor contributions;
- c. an application will be made to the Montgomery County ADAMHS Board (Alcohol/Drug Addiction and Mental Health Services) for funding through the Indigent Driver Alcohol Treatment (IDAT) fund.;
- d. and that the organization is seeking a grant writer to work with for additional funding, especially for a scholarship fund for those who demonstrate an inability to pay for services.

Matt indicated that he will reach out to a contact of his, J. Thomas Maultsby, President and CEO at the United Way of the Greater Dayton Area regarding getting our organization on the list of charities that United Way donors may designate to.

4. Eva moved that the Policies and Procedures (tab 4) as written be adopted by the board, and that the Board review the policies and procedures on a two-year cycle, by conducting a review of several at each board meeting. Sherri provided the second. Unanimously approved and adopted.
5. Sherri moved that the Program Materials (tab 5) as written be adopted by the board. Matt provided the second. Unanimously approved and adopted.

Next Meeting: Board meetings will be conducted in April, August and December of each year. Matt agreed to host our next meeting in April at the Racquet Club. Ben indicated that in April he will work a split shift; in August a day shift, and in December a late afternoon shift; and that he will make an effort to attend as many meetings possible in light of his rotating shifts.

Discussion of preferences resulted in Friday as the best day to meet over breakfast.

Adjournment: Matt moved to adjourn at 1:00pm, Ben provided the second. Voting resulted in unanimous agreement. President Hoffman thanked board members for their attendance and support.

Respectfully submitted,

Michelle Hoffman
Vice President/Secretary

THREE OAKS CENTER, INC.
Board of Directors Spring Meeting
Agenda

Date: Monday, April, 20, 2015

Facilitated by: Kevin R. Hoffman, President

Location and Time: Racquet Club, Dayton, OH; 12:30pm

Agenda:

Call to Order
 Welcome

Old Business: Approval of minutes from organizational meeting, December 23, 2014

New Business: Adoption of the following for 2015 ~

Tab 1: Board Officers, Board Members, and Personnel Rosters as amended
 Tab 2: Insurance binder review; State of OH Certificates review

Tab 3: Budget, EIP Projected Annual Operation Costs, Fundraising as amended
 Tab 4: Policies and Procedures as amended
 Tab 5: Program Materials as amended

Adjourn

THREE OAKS CENTER, INC.
Board of Directors Minutes ~ Spring Meeting

Date: Monday, April 20, 2015

Facilitated by: Kevin R. Hoffman, President/Treasurer

Location and Time: Racquet Club, Dayton, OH; 12:30pm-2:00pm

Minutes: After ordering lunch, the meeting was called to order at 12:45am by Kevin Hoffman, President/Treasurer, who opened the meeting in prayer, welcomed the board members, and thanked them for their willingness to serve on the Board.

Present at the meeting were the following board officers and board members who took turns introducing themselves: Kevin Hoffman, President/Treasurer; Michelle Hoffman, Vice President/Secretary; Matthew D. DiCicco, Attorney Representative; Sherri Herrick, Human Resource Representative; Benjamin Walker, Law Enforcement Representative; Honorable Robert (Bob) L. Deddens (retired), Judiciary Representative; Karen Nelson, Treatment Representative, Dr. Charles (Chuck) Russell, MD, Medical/Treatment Representative; and Eva Walker, Financial Representative who joined the meeting via speaker phone.

Old Business: Matt moved that the minutes of the previous board meeting as written be adopted by the board. Sherri provided the second. Unanimously approved and adopted.

New Business: President Hoffman presented the following for the board's approval and adoption for 2015 ~

1. Sherri moved that the Board Officers, Board Members, and Personnel Rosters (tab 1) be adopted subject to amendment by the board. Chuck provided the second. Unanimously approved and adopted. Corrected contact information was provided by each board member for adoption at the next board meeting.
2. Matt moved that the Certificate of Liability Insurance and State of OH Certificate (tab 2) be adopted subject to amendment by the board. Sherri provided the second. Unanimously approved and adopted. Kevin will

contact the insurance agent regarding increasing the Abuse and Molestation limit from the current \$100,000/\$300,000 to \$1,000,000; and provide verification of coverage for Directors and Officers.

3. Matt moved that the Organizational Budget (tab 3) be adopted subject to amendment by the board. Chuck provided the second. Unanimously approved and adopted. Bob suggested that today's date be inserted as a footer to the document. Kevin will add the footer to the document for distribution at the next board meeting.

President Hoffman also reported:

- a. Fundraising efforts with AmazonSmile, DLM Good Neighbor Program, Kroger Community Rewards, and Meijer Community Rewards programs and a PayPal account are set-up and fully operational on the organization's website for donor contributions;
 - b. Maximum number of clients that can be served in the 72-Hour program is 25 and in the 48-Hour program is 40;
 - c. and the organization is seeking a grant writer to work with for additional funding, especially for a scholarship fund for those who demonstrate an inability to pay for services.
4. It is noted that Matt and Sherri signed an Affidavit, witnessed by President Hoffman, stating board review of all policies and procedures to the Ohio Department of Mental Health and Addiction Services (OMHAS) as part of the program licensure process. Chuck moved that the Policies and Procedures (tab 4) be adopted subject to amendment by the board. Matt provided the second. Unanimously approved and adopted. Additional discussion regarding the Conflict of Interest policy yielded Eva suggesting annual review of this policy and that annually each board member write a letter regarding Conflict of Interest disclosure and mail it to Kevin. The document will be amended for final approval at the next board meeting. Karen affirmed the practice of providing three referrals to clients who need additional services post-intervention weekend, thereby avoiding any conflict of interest.
 5. Matt moved that the Program Materials (tab 5) be adopted subject to amendment by the board. Chuck provided the second. Unanimously approved and adopted. Bob suggested that additional clarification be provided in the Consent to Participate document, noting that the faith-based program presents a Christian perspective; Chuck suggested amending the language in the third paragraph to read: "I also understand that the Early Intervention Program being offered by Three Oaks Center, Inc. is a faith-based Christian program in which passages of Scripture may be utilized as part of the treatment program and I voluntarily consent to participate in this weekend program." Kevin will amend the document for approval at the next board meeting.

Next Meeting: Board meetings will be conducted in April, August and December of each year. Discussion of preferences affirmed that either a Friday or Monday as the best days to meet over breakfast.

Adjournment: Bob moved to adjourn at 2:00pm, Karen provided the second. Voting resulted in unanimous agreement. President Hoffman thanked board members for their attendance and support.

Respectfully submitted,

Michelle Hoffman
Vice President/Secretary

THREE OAKS CENTER, INC.
Board of Directors Summer Meeting
Agenda

Date: Monday, August 31, 2015

Facilitated by: Kevin R. Hoffman, President

Location and Time: Saxby's Coffee, Centerville, OH; 8:00am

Agenda:

Call to Order
 Welcome

Old Business: Approval of minutes from previous meeting, April 20, 2015

New Business: Adoption of the following for 2015 ~

Tab 1: Board Officers, Board Members, and Personnel Rosters as amended.
 Tab 2: Certificate of Liability Insurance review; State of OH Certificate review.
 Tab 3: Budget, Fundraising as amended.
 Tab 4: Conflict of Interest policy as amended.
 Tab 5: Consent to Participate form as amended.

Adjourn

THREE OAKS CENTER, INC.
Board of Directors Minutes ~ Summer Meeting

Date: Monday, August 31, 2015

Facilitated by: Kevin R. Hoffman, President/Treasurer

Location and Time: Saxby's Coffee, Centerville, OH; 8:00am-8:40am

Minutes: The meeting was called to order at 8:11am by Kevin Hoffman, President/Treasurer, who opened the meeting in prayer and welcomed the board members.

Present at the meeting were the following board officers and board members: Kevin Hoffman, President/Treasurer; Michelle Hoffman, Vice President/Secretary; Matthew D. DiCicco, Attorney Representative; Sherri Herrick, Human Resource Representative; Honorable Robert (Bob) L. Deddens (retired), Judiciary Representative; Karen Nelson, Treatment Representative, Dr. Charles (Chuck) Russell, MD, Medical/Treatment Representative; Eva Walker, Financial Representative and Benjamin Walker, Law Enforcement Representative joined the meeting via speaker phone.

Old Business: Matt moved that the minutes of the previous board meeting be adopted as written by the board. Karen provided the second. Unanimously approved and adopted.

New Business: President Hoffman presented the following for the board's approval and adoption for 2015 ~

1. Chuck moved that the Board Officers, Board Members, and Personnel Rosters (tab 1) be adopted as amended by the board. Bob provided the second. Unanimously approved and adopted.
2. Eva moved that the new Certificate of Liability Insurance with increased Abuse and Molestation limit from \$100,000/\$300,000 to \$1,000,000 and coverage for Directors and Officers with a limit of \$1,000,000; and new State OMHAS Certificate for the 90-Day period of September 1-November 29, 2015 (tab 2) be adopted by the board. Sherri provided the second. Unanimously approved and adopted. Kevin reported that 45-Days into the Certificate period an OMHAS license Surveyor will conduct a Survey reviewing client and personnel

records, Board of Directors' Manual, Policy and Procedure Manual, and Program Manual. Upon successful completion of the Survey, a licensure shall be granted for a three-year period.

3. Matt moved that the Organizational Budget (tab 3) be adopted as amended by the board. Karen provided the second. Unanimously approved and adopted.

President Hoffman also reported:

- a. Fundraising efforts with AmazonSmile, DLM Good Neighbor Program, Kroger Community Rewards, and Meijer Community Rewards programs ("Give As You Live!") and a PayPal account remain operational on the organization's website by clicking on the "Donate Now" tab (board members and their families are encouraged to participate in "Give As You Live!")—a check for \$11.14 was received from the Kroger Community Rewards program;
 - b. Grants for \$1,000 and \$500 were received via The Dayton Foundation as well as a \$1,000 gift from a donor towards operational expenses; a \$400 gift was received from a donor to start a scholarship fund—the first scholarship recipient is scheduled to attend the September 10-13, 2015 weekend program;
 - c. Contact will be made (by Kevin) with the United Way after September 1, 2015 to make application to be listed for possible donor designations as it appears Three Oaks Center meets their eligibility requirements per their Donor Designation Policy;
 - d. The organization continues seeking a grant writer to work with for additional funding, especially for the scholarship fund for those who demonstrate an inability to pay for services; grant foundations desire new innovative programs as well as a proven one year track record—however, there seems to be some openness to consider Three Oaks once we have conducted several weekend programs and can provide evidence-based results;
 - e. Both IRS 990N and 990T forms have been submitted for the tax years 2013 & 2014, pro bono by Ladd & Carter Tax Service in Dayton—it is probable that a full IRS 990 tax form as well as an audit may be required for tax year 2015. Eva suggested that John Harvey be contacted regarding an audit as he has experience with non-profits and is approved by the ADAMHS Board of Montgomery County. Eva will provide introduction and contact information.
4. Karen moved that the Conflict of Interest policy (tab 4) be adopted as amended by the board. Ben provided the second. Unanimously approved and adopted. Per this policy, Kevin requested that each board member write and submit a letter regarding Conflict of Interest disclosure as soon as possible.
 5. Sherri moved that the Consent to Participate document (tab 5) be adopted as amended by the board. Chuck provided the second. Unanimously approved and adopted. Matt suggested that additional clarification be provided in a document for judges regarding court referrals to our weekend programs—Bob will assist with the preparation of a document for utilization as soon as possible.

Additional Items Discussed:

1. Karen suggested that Kevin explore placing an online ad or listing with Psychology Today in order to boost Three Oaks' online presence.
2. Matt suggested a Google Ad to boost Three Oaks to the top of the list for Google searches—he will provide a contact person to Kevin and will secure funding via a donor to cover the cost. Kevin reported that a Search Engine Visibility plan has been purchased from Go Daddy (our website domain host) for \$83 per year for the next two years that will provide greater visibility as a first step towards this goal.
3. Kevin asked how to best connect with DUI attorneys in the Dayton area—Karen indicated to try Google; Matt will provide an introduction to Charles Rowland and Larry Denny.
4. Karen offered to create a brochure of all of the driver intervention programs offered in the Dayton area (with Three Oaks at the top) for use by area courts to distribute to their clients.

5. Matt suggested that information on our programs be provided to various professional licensure organizations to distribute to impaired professionals, i.e. attorneys/lawyers, physicians, counselors, nurses, etc. Kevin requested that each board member forward contact information for their respective organization(s) as soon as possible.

Next Meeting: Board meetings will be conducted in April, August and December of each year. The next meeting is scheduled for Friday, December 11 at 7:30am over breakfast at the House of Hoffman.

Adjournment: Charles moved to adjourn at 8:40am, Bob provided the second. Voting resulted in unanimous agreement. President Hoffman thanked board members for their attendance and support.

Respectfully submitted,
Michelle Hoffman
Vice President/Secretary

Board Officers Roster

President / Treasurer	Kevin R. Hoffman, D.Min. cand., LICSW (retired), LCDC-II, ICADC, Certified Pastoral Counselor & Fellow (American Association of Pastoral Counselors)
Vice President / Secretary	Michelle Hoffman, LMT Owner, Three Oaks Therapy, LLC Wellness Coordinator, JuicePlus+
Mailing Address	Three Oaks Center, Inc. 6077 Far Hills Ave., #157 Centerville, OH 45459
Phone	937-520-8496
Email	Kevin@ThreeOaksCenter.com
Web	www.ThreeOaksCenter.com

DEPARTMENTS AFFECTED:	All TOCI Departments
DATE OF ORIGIN:	11/17/14
APPROVED BY:	Board of Directors (Dec. 2014)
EFFECTIVE DATE:	01/01/15
REVIEWED:	Board of Directors (April 2015)
RENEWAL DATE:	04/01/15

Board Members Roster

Matthew D. DiCicco (Attorney Representative)
 Attorney/Shareholder
 Freund Freeze & Arnold
 1 South Main Street, Suite 1800
 Dayton, Ohio 45402
 Phone: 937-222-2424
 Cell: 937-287-7365
 Email: mdicicco@ffalaw.com

Eva Walker, CTFA (Financial Representative)
 Vice President, Senior Trust Officer
 Fifth Third Private Bank
 50 Central Avenue, BSFP8B
 Sarasota, FL 34236
 Phone: 941-329-4686
 Cell: 937-361-8026
 Email: eva.walker@53.com

Sherri Herrick, MSM, SPHR (Human Resources Representative)
 Director, Human Resources
 Kettering Physician Network
 10050 Innovation Drive
 Dayton, Ohio 45342
 Phone: 937-558-3205
 Fax: 937-522-7752
 Cell: 937-371-0188
 Email: sherri.herrick@khnetwork.org

Benjamin R. Walker (Law Enforcement Representative)
 Badge #150
 Sergeant - Operations Division

Vandalia Police Department
 245 James Bohanan Memorial Drive
 Vandalia, Ohio 45377
 Desk: 937-415-2295
 Cell: 937-689-0691
 Email: bwalker@vandaliaohio.org

Honorable Robert L. Deddens, Retired
 (Judiciary Representative)
 Robert L. Deddens Law Offices
 55 Park Avenue
 Oakwood, OH 45419
 Phone: 937-293-9696
 Cell: 937-572-0285
 Email: rldeddens@gmail.com

Karen Nelson, LPCC-S, CEAP, LICDC-CS
 (Treatment Representative)
 3095 Dayton-Xenia Road
 Beavercreek, OH 45434
 Cell: 937-903-6606
 Email: ImagoKaren@gmail.com

Dr. Charles Russell, MD (Medical/Treatment Representative)
 Addiction Medicine
 415 South Main Street
 Waynesville, Ohio 45068
 Cell: 937-718-7677
 Email: 2edgedswordrecovery@gmail.com

DEPARTMENTS AFFECTED: All TOCI Departments
DATE OF ORIGIN: 11/17/14
APPROVED BY: Board of Directors (Dec. 2014)
EFFECTIVE DATE: 01/01/15
REVIEWED: Board of Directors (April 2015)
RENEWAL DATE: 04/01/15

APPENDIX B. ORGANIZATIONAL INFORMATION

BIBLICAL FOUNDATION AND ORGANIZATIONAL INFORMATION

- I. In order for healing/wholeness to occur, people need to be rightly related to God (vertical relationship) and rightly related to others (horizontal relationship); his right relatedness with the addition of proper order/structure creates, “accord of three strands not quickly torn apart.”
Eccl. 4:9-12: Two are better than one because they have a good return for their labor.
For if either of them falls, the one will lift up his companion. But woe to the one who falls when there is not another to lift him up. Furthermore, if two lie down together they keep warm, but how can one be warm alone? And if one can overpower him who is alone, two can resist him. A cord of three strands is not quickly torn apart (NAS).
- II. The process of characterological change and growth is slow, and God calls us to assist people in the process of healing/becoming whole and strong (mature) in faith (i.e., change the tree that produces fruit), “so they will be called oaks of righteousness, the planting of the Lord, that He may be glorified.”
Isa. 61:1-3: The Spirit of the Lord GOD is upon me, because the LORD has anointed me to bring good news to the afflicted; He has sent me to bind up the brokenhearted, to proclaim liberty to captives and freedom to prisoners; To proclaim the favorable year of the LORD, and the day of vengeance of our God; to comfort all who mourn, To grant those who mourn in Zion, giving them a garland instead of ashes, the oil of gladness instead of mourning, the mantle of praise instead of a spirit of fainting. So they will be called oaks of righteousness, the planting of the LORD, that He may be glorified (NAS).
- [cp. Ps. 1:1-6]: How blessed is the man who does not walk in the counsel of the wicked, nor stand in the path of sinners, nor sit in the seat of scoffers! But his delight is in the law of the Lord, and in His law he meditates day and night. He will be like a tree firmly planted by streams of water, which yields its fruit in its season and its leaf does not wither; and in whatever he does, he prospers. The wicked are not so, but they are like chaff which the wind drives away. Therefore the wicked will not stand in the judgment, nor sinners in the assembly of the righteous. For the Lord knows the way of the righteous, but the way of the wicked will perish.
- III. The intrinsic motivation for our service to all people must always be the centrality of the cross and the Lordship of Jesus Christ, “for the Lamb in the center of the throne shall be their shepherd...”
Rev. 7:17: for the Lamb in the center of the throne will be their shepherd, and will guide them to springs of the water of life; and God will wipe every tear from their eyes” (NAS).
- [cp. Luke 5:17-26]: One day He was teaching; and there were some Pharisees and teachers of the law sitting there, who had come from every village of Galilee and Judea and from Jerusalem; and the power of the Lord was present for Him to perform healing. And some men were carrying on a bed a man who was paralyzed; and they were trying to bring him in and to set him down in front of Him. But not finding any way to bring him in because of the crowd, they went up on the roof and let him down through the tiles with his stretcher, right in the center, in front of Jesus. Seeing their faith, He said, “Friend, your sins are forgiven you.” The scribes and the Pharisees began to reason, saying, “Who is this man who speaks blasphemies? Who can forgive sins, but God alone?” But Jesus, aware of their reasonings, answered and said to them, “Why are you reasoning in your hearts? Which is easier, to say, ‘Your sins have been forgiven you,’ or to say, ‘Get up and walk’? But, so that you may know that the Son of Man has authority on earth to forgive sins,”—He said to the paralytic—“I say to you, get up, and pick up your stretcher and go home.” Immediately he got up before them, and picked up what he had been lying on, and went home glorifying God. They were all struck with astonishment and began glorifying God; and they were filled with fear, saying, “We have seen remarkable things today.”

DESCRIPTION:

Three Oaks Center, Inc. is a community-based center providing lay care-giving, clinical-pastoral care, counseling, educational and training services to individuals, couples, families, and organizations.

MISSION STATEMENT:

To provide opportunities for people to improve the quality of their emotional, mental, physical, relational and spiritual health.

NARRATIVE DESCRIPTION OF ACTIVITIES:

Description of past, present, and planned activities.

Past Activities:

Lay care giving ~ Two programs were developed. A series of Pre-Marriage Seminars were developed in collaboration with other churches in the community and offered to participants from January 1997 through December 2002. Various letters, brochures, schedules, hosting guidelines, biographical information on the presenters, menu for snacks & meals, certification of completion, and a sample invoice are included with this application. A support group program for children and parents was also designed and implemented called Confident Kids in collaboration with Confident Kids International. Various documents describing program goals, group rules, certificate of completion, a review of program years 1997-1999, staff meeting notes, and a schedule for 2000-2001 are included with this application.

Clinical-pastoral care & counseling ~ As a licensed social worker in MN, clinical-pastoral care and counseling services were offered to church attendees and those referred from the community. A sample release of information form, discharge summary template, physician referral checklist, proposal for counseling & guidance services, letters related to consultation services, letters related to credentialing privileges, sample instructions for relationship inventory completion, brochures for marriage preparation and marriage care are all included with this application.

Educational & training services ~ Several delivery modes were developed; letters describing retreats, seminars, support groups, and training events are provided as are other documents offering descriptions of other services offered to individuals, couples, families, businesses, churches, and other organizations are all included with this application.

Present Activities:

Authorship, research and design of a "Faith-based Early Intervention Model to be Used with First-time Alcohol and Drug Offenders" dissertation project is being conducted by Kevin R. Hoffman, President/Treasurer as part of the process of being a Doctor of Ministry candidate in the Pastoral Care and Counseling cohort of the Doctor of Ministry degree program at the Assembly of God Theological Seminary in Springfield, MO.

Planned Activities:

Implementation of a "Faith-based Early Intervention Model to be Used with First-time Alcohol and Drug Offenders" is planned for 2015.



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
8/18/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Reichley Insurance Agency Inc 2440 Dayton Xenia Rd Suite A Beavercreek OH 45434		CONTACT NAME: Liz Myers PHONE (A/C No. Ext): (937) 306-8003 FAX (A/C No.): (537) 426-4642 E-MAIL ADDRESS: Liz@Reichleyins.com	
INSURED Three Oaks Center Inc 6077 Far Hills Avenue #157 Centerville OH 45459		INSURER(S) AFFORDING COVERAGE INSURER A: Great American INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADOL SUBR INSR LTR	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY					EACH OCCURRENCE \$ 1,000,000
	<input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Abuse & Molestation <input checked="" type="checkbox"/> Professional Liability		CLP4616064	4/1/2015	4/1/2016	DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ 3,000,000
	<input type="checkbox"/> GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC					
	AUTOMOBILE LIABILITY					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	<input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS	<input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NOW OWNED AUTOS				
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB	<input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE				EACH OCCURRENCE \$ AGGREGATE \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	<input type="checkbox"/> Y/N N/A				WC STATU-TORY LIMITS E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	Directors & Officers/ Employment Practices		EPP4916529	7/20/2015	7/20/2016	\$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER 	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE Liz Myers/LIZ <i>Liz Myers</i>
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Promoting wellness and recovery

John R. Kasich, Governor • Tracy J. Plouck, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

April 14, 2015

Three Oaks Center, Inc.
6077 Far Hills Ave., #157
Centerville, Ohio 45459

Subject: Provider # 347

Dear Director:

Enclosed is the Certificate to operate an Alcohol and Drug Addiction Program.

If you close a program at the site listed on the certificate or move the program to another site, the certificate is void and is to be returned to the Bureau of Licensure & Certification.

Questions concerning program certification should be directed to Rosland Hawkins (614) 644-8317.

Sincerely,

Janel M. Pequignot, Chief
Licensure & Certification

Enc.: Certificate

cc: Executive Director, Montgomery County ADAMHS Board
File

JMP:rh

John Kasich,
Governor

Tracy Plouck,
Director

Ohio Department of Mental Health and Addiction Services



CERTIFICATE TO OPERATE A DRIVER INTERVENTION PROGRAM ISSUED TO :

Provider - 347

Three Oaks Center, Inc.
Double Tree Suites
300 Prestige Place
Miamisburg, OH 45342
Montgomery County

Owner

Three Oaks Center, Inc.
6077 Far Hills Ave., #157
Centerville, OH 45459
Montgomery County

PROGRAM	HOURS	Effective Date	Expiration Date
DIP	48 Hours 72 hours	3/31/2015	6/28/2015

Tracy Plouck
Tracy Plouck, Director

In accordance with section 3763.06 & 3763.11 of the Ohio Revised Code and section 3759.23-01 of the Ohio Administrative Code, this certificate is not assignable or transferable to any Owner or Provider other than those listed herein.



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August 31, 2015

Three Oaks Center, Inc.
6077 Far Hills Ave., #157
Centerville, Ohio 45459

Subject: Provider # 347

Dear Director:

Enclosed is the Certificate to operate an Alcohol and Drug Addiction Program.

If you close a program at the site listed on the certificate or move the program to another site, the certificate is void and is to be returned to the Bureau of Licensure & Certification.

Questions concerning program certification should be directed to Rosland Hawkins (614) 644-8317.

Sincerely,

Janel M. Pequignot, Chief
Licensure & Certification

Enc.: Certificate

cc: Executive Director, Montgomery County ADAMHS Board
File

JMP:rh

John Kasich,
Governor

Tracy Plouck,
Director

Ohio Department of Mental Health and Addiction Services



CERTIFICATE TO OPERATE A DRIVER INTERVENTION PROGRAM ISSUED TO :

Provider - 347

Three Oaks Center, Inc.
Double Tree Suites
300 Prestige Place
Miamisburg, OH 45342
Montgomery County

Owner

Three Oaks Center, Inc.
6077 Far Hills Ave., #157
Centerville, OH 45459
Montgomery County

PROGRAM	HOURS	Effective Date	Expiration Date
DIP	48 Hours 72 hours	9/1/2015	11/29/2015

Tracy Plouck, Director

In accordance with section 3763.06 & 3763.11 of the Ohio Revised Code and section 3793.2-3-01 of the Ohio Administrative Code, this certificate is not assignable or transferable to any Owner or Provider other than those listed herein.



Promoting wellness and recovery

John R. Kasich, Governor • Tracy J. Plouck, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

November 30, 2015

Three Oaks Center, Inc.
6077 Far Hills Ave., #157
Centerville, Ohio 45459

Subject: Provider # 347

Dear Director:

Enclosed is the Certificate to operate an Alcohol and Drug Addiction Program.

If you close a program at the site listed on the certificate or move the program to another site, the certificate is void and is to be returned to the Bureau of Licensure & Certification.

Questions concerning program certification should be directed to Rosland Hawkins (614) 644-8317.

Sincerely,

Janel M. Pequignot, Chief
Licensure & Certification

Enc.: Certificate

cc: Executive Director, Montgomery County ADAMHS Board
File

JMP:rh

John Kasich,
Governor

Tracy Plouck,
Director

**Ohio Department of
Mental Health and Addiction Services**



CERTIFICATE TO OPERATE A DRIVER INTERVENTION PROGRAM ISSUED TO :

Provider - 347

Three Oaks Center, Inc.
Double Tree Suites
300 Prestige Place
Miamisburg, OH 45342
Montgomery County

Owner

Three Oaks Center, Inc.
6077 Far Hills Ave., #157
Centerville, OH 45459
Montgomery County

PROGRAM	HOURS	Effective Date	Expiration Date
DIP	48 Hours 72 hours	11/30/2015	5/31/2017

Tracy Plouck, Director

In accordance with section 3793.06 & 3793.11 of the Ohio Revised Code and section 3793.2-3-01 of the Ohio Administrative Code, this certificate is not assignable or transferable to any Owner or Provider other than those listed herein



Promoting wellness and recovery

John R. Kasich, Governor • Tracy J. Plouck, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

Bureau of Licensure and Certification/Division of Legal and Regulatory Services

PROGRAM CERTIFICATION REPORT

Date of Review: October 15, 2015

Name of Reviewers: Edna Powell and Irina Yakhnitskly

PROGRAM OWNER:

Three Oaks Center, Inc.
6077 Far Hills Avenue, #157
Centerville, Ohio 45459

PROGRAM SITE:

Doubletree Suites
300 Prestige Place
Miamisburg, Ohio 45342

Provider # 347

6077 Far Hills Avenue, #157
Centerville, Ohio 45459
County: Montgomery
Telephone Number: (937) 520-8496

Type of Program: DIP Program

On October 15, 2015, we reviewed your agency's client records and personnel files to assess your agency's compliance with the Ohio Administrative Code for your Driver Intervention program (DIP).

Based on the following deficiencies, your agency needs to submit a **Corrective Action Plan** to the Department of Ohio Mental Health & Addiction Services no later than **November 9, 2015**. Failure to

submit the corrective action plan by the date above may result in a non-certified status for your program(s).

General Deficiencies

No general deficiencies noted.

Site-Specific Deficiencies

Provider # 347

Client Records:

The program's client records did not include documentation that Fire evacuation training for program site occurred, as required pursuant of OAC 3793:4-1-02(BB)(8).

Personnel Records:

1. The program's personnel records did not include documentation of: Copy of notification of hiring, to include starting date, position and starting salary or wage for those employees hired after April 20, 2004, as required pursuant of OAC 3793:4-1-02(W)(2)
2. The program's personnel records did not include documentation of: education, training and experience to demonstrate competency in providing and/or supervising alcohol and drug addiction services, as required pursuant of OAC 3793:4-1-02(W)(4).
3. The program's personnel records did not include documentation of: Position description, as required pursuant of OAC 3793:4-1-02(W)(5).
4. The program's personnel records did not contain evidence of: Program Director having a Bachelor's degree and two years experience in AoD services or allied profession to include one year as supervisor, as required pursuant of OAC 3793:4-1-02 (N)(1)(a),
OR
3 years' experience in AoD services or allied profession to include one year as supervisor, or as required pursuant of OAC 3793:4-1-02 (N)(1)(b).
OR
3 years' experience in business administration to include a minimum of one year as a supervisor, as required pursuant of OAC 3793:4-1-02 (N)(1)(c).
5. The program's personnel records did not contain evidence of: DIP program director position description must include the following responsibilities, as required pursuant of OAC 3793:4-1-02 (N)(2).
 - a. DIP program director Overseeing the day-to-day operations of the DIP, as required pursuant of OAC 3793:4-1-02 (N)(2)(a).

- b. DIP program director Developing/implementing the policies/procedures of DIP, as required pursuant of OAC 3793:4-1-02 (N)(2)(b).
 - c. DIP program director Developing/revising as necessary, DIP education curriculum, as required pursuant of OAC 3793:4-1-02 (N)(2)(c).
 - d. DIP program director Preparing annual plan for operation of DIP, as required pursuant of OAC 3793:4-1-02 (N)(2)(d).
 - e. DIP program director Implementing DIP's quality assurance/improvement activities/findings, as required pursuant of OAC 3793:4-1-02 (N)(2)(e).
 - f. DIP program director Hiring/terminating DIP staff, as required pursuant of OAC 3793:4-1-02 (N)(2)(f).
 - g. DIP program director Ensuring DIP is operating in accordance with ODADAS' DIP certification standards, as required pursuant of OAC 3793:4-1-02 (N)(2)(g).
6. Staff development, as required pursuant of OAC 3793:4-1-02 (V)(8).
7. The program's personnel records did not contain evidence of: Fire evacuation procedures for program site, as required pursuant of OAC 3793:4-1-02 (BB)(8).

Technical Assistance:

Technical Assistance was provide for disclosures not providing the date, event or condition upon which the consent will expire, unless revoked before that specified time, as required pursuant of OAC 3793:4-1-02(E)(3)(i).

Report prepared October 19, 2015 by:

Edna Powell

Edna Powell

Behavioral Health Standards Surveyor, Bureau of Licensing and Certification

cc: Executive Director, ADAMHS Board for Montgomery County

Corrective Action Plan



6077 Far Hills Ave., #157 Centerville, OH 45459
937-520-8496
Kevin@ThreeOaksCenter.com
ThreeOaksCenter.com

CORRECTIVE ACTION PLAN

Date: November 16, 2015

Program Owner: Three Oaks Center, Inc.
6077 Far Hills Avenue, #157
Centerville, OH 45459

Program Site: DoubleTree Suites Hotel
300 Prestige Place
Miamisburg, OH 45342

Provider # 347

6077 Far Hills Avenue, #157
Centerville, OH 45459
County: Montgomery
Telephone Number: (937) 520-8496

Type of Program: DIP Program

Site-Specific Deficiencies

Client records:

Deficiency: The program's client records did not include documentation that Fire evacuation training for program site occurred, as required pursuant of OAC 3793:4-1-02 (BB) (8).

Plan to Correct: As discussed on October 15, 2015 during the Survey, this is included on the "Consent to Participate" form as follows: "I further acknowledge that the fire and evacuation procedures for the DoubleTree Suites have been explained to me and that I have received the following:"

Documentation: Refer to attached "Consent to Participate" form (statement highlighted in yellow)

Check & Balance for Monitoring: Board of Directors to review all forms annually; recommend changes if needed; any recommended changes will be made by the Program Director and submitted to the Board for final approval; final approval will be recorded in the Board meeting minutes.



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 937-520-8496
 Kevin@ThreeOaksCenter.com
 ThreeOaksCenter.com

Personnel records:

1. Deficiency: The program's personnel records did not include documentation of: Copy of notification of hiring, to include starting date, position and starting salary or wage for those employees hired after April 20, 2004, as required pursuant of OAC 3793:4-1-02 (W) (2).
- Plan to Correct: Changed wording to reflect change on the "Letter of Hire Independent Contractor" and the "Independent Contractor Agreement" form.
- Documentation: Refer to attached "Letter of Hire Independent Contractor Template" and the "Independent Contractor Agreement" form. (statements highlighted in yellow)
- Check & Balance for Monitoring: Board of Directors to review all letters of hire and forms annually; recommend changes if needed; any recommended changes will be made by the Program Director and submitted to the Board for final approval; final approval will be recorded in the Board meeting minutes.

2. Deficiency: The program's personnel records did not include documentation of: Education, training and experience to demonstrate competency in providing and/or supervising alcohol and drug addiction services, as required pursuant of OAC 3793:4-1-02 (W) (4).
- Plan to Correct: Obtained documentation from independent contractors providing and/or supervising alcohol and drug addiction services of their ongoing continuing education for licensure renewal as discussed on October 15, 2015 during the Survey.
- Documentation: Refer to attached certificates of continuing education.
- Check & Balance for Monitoring: Board of Directors to review all certificates of continuing education annually; recommend changes if needed; any recommended changes will be made by the Program Director and submitted to the Board for final approval; final approval will be recorded in the Board meeting minutes.



THREE OAKS CENTER, INC.

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3. Deficiency: The program's personnel records did not include documentation of: Position Description(s), as required pursuant of OAC 3793:4-1-02 (W) (5).
- Plan to Correct: Position descriptions written.
- Documentation: Refer to attached position description descriptions.1
- Check & Balance for Monitoring: Board of Directors to review all position descriptions annually; recommend changes if needed; any recommended changes will be made by the Program Director and submitted to the Board for final approval; final approval will be recorded in the Board meeting minutes.
4. Deficiency: The program's personnel records did not contain evidence of: Program Director having a Bachelor's degree and two years experience in AoD services or allied profession to include one year as supervisor, as required pursuant of OAC 3793:4-1-02 (N) (1) (a),
OR
3 years' experience in AoD services or allied profession to include one year as supervisor, as required pursuant of OAC 3793:4-1-02 (N) (1) (b),
OR
3 years' experience in business administration to include a minimum of one year as a supervisor, as required pursuant of OAC 3793:4-1-02 (N) (1) (c),
- Plan to Correct: Program Director's Curriculum Vitae detailing training and experience provided as discussed on October 15, 2015 during the Survey.
- Documentation: Refer to attached Program Director's Curriculum Vitae.
- Check & Balance for Monitoring: Board of Directors to review Program Director's resume and/or curriculum vitae prior to employment to ensure compliance; any recommended changes will be made by the Program Director and submitted to the Board for final approval; final approval will be recorded in the Board meeting minutes.



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5. Deficiency: The program's personnel records did not contain evidence of: DIP program director position description must include the following responsibilities, as required pursuant of OAC 3793:4-1-02 (N) (2).
- a. DIP Program Director Overseeing the day-to-day operations of the DIP, as required pursuant of OAC 3793:4-1-02 (N) (2) (a).
 - b. DIP Program Director Developing/implementing the policies/procedures of the DIP, as required pursuant of OAC 3793:4-1-02 (N) (2) (b).
 - c. DIP Program Director Developing/revising as necessary, DIP education curriculum, as required pursuant of OAC 3793:4-1-02 (N) (2) (c).
 - d. DIP Program Director Preparing an annual plan for operation of DIP, as required pursuant of OAC 3793:4-1-02 (N) (2) (d).
 - e. DIP Program Director Implementing the DIP's quality assurance/improvement activities/findings, as required pursuant of OAC 3793:4-1-02 (N) (2) (e).
 - f. DIP Program Director Hiring/terminating DIP staff, as required pursuant of OAC 3793:4-1-02 (N) (2) (f).
 - g. DIP Program Director Ensuring that the DIP is operating in accordance with the OMHAS' DIP certification standards, as required pursuant of OAC 3793:4-1-02 (N) (2) (g).
- Plan to Correct: Program Director position description written.
- Documentation: Refer to attached Program Director position description.
- Check & Balance for Monitoring: Board of Directors to review all position descriptions annually; recommend changes if needed; any recommended changes will be made by the Program Director and submitted to the Board for final approval; final approval will be recorded in the Board meeting minutes.
6. Deficiency: Staff Development, as required pursuant of OAC 3793:4-1-02 (V) (8)
- Plan to Correct: Refer to attached Three Oaks Center, Inc. policy and procedure entitled, "MANDATORY STAFF EDUCATION/DEVELOPMENT."
- Documentation: Refer to the aforementioned policy and procedure as well as copies of certificates of training.



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Check & Balance for Monitoring: Board of Directors to review all policies and procedures And training certificates to ensure compliance with same; any recommended changes will be made by the Program Director and submitted to the Board for final approval; final approval will be recorded in the Board meeting minutes.

7. **Deficiency:** The program's personnel records did not include documentation that Fire evacuation procedures for program site occurred, as required pursuant of OAC 3793:4-1-02 (BB) (8).

Plan to Correct: As discussed on October 15, 2015 during the Survey, this is now included on the "Early Intervention Program (EIP): Personnel Acknowledgement" form as follows: " Yes No I have received and agree to abide by the EIP's instructions on fire evacuation procedures for the program site."

Documentation: Refer to attached "Early Intervention Program (EIP): Personnel Acknowledgement" form (statement highlighted in yellow)

Check & Balance for Monitoring: Board of Directors to review all forms annually; recommend changes if needed; any recommended changes will be made by the Program Director and submitted to the Board for final approval; final approval will be recorded in the Board meeting minutes.

Technical Assistance:

Deficiency: Technical Assistance was provided for disclosures not providing the date, event or condition upon which the consent will expire, unless revoked before that specified time, as required pursuant of OAC 3793:4-1-02 (EE) (3) (i).

Plan to Correct: As discussed on October 15, 2015 during the Survey, the attached "Criminal Justice Release of Confidential Information: Criminal Justice System Referral" and the "Authorization to Disclose Client Information" forms have been corrected with the required language.



THREE OAKS CENTER, INC.

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Documentation: Refer to the attached "Criminal Justice Release of Confidential Information: Criminal Justice System Referral" and the "Authorization to Disclose Client Information" forms (statements highlighted in yellow)

Check & Balance for Monitoring: Board of Directors to review all forms annually; recommend changes if needed; any recommended changes will be made by the Program Director and submitted to the Board for final approval; final approval will be recorded in the Board meeting minutes.

Respectfully Submitted,

Kevin R. Hoffman, D.Min. cand., LICSW (retired), LCDC-II, ICADC
 Certified Pastoral Counselor & Fellow (AAPC)
 President

Three Oaks Center, Inc.
 6077 Far Hills Ave., #157
 Centerville, OH 45459

Phone: 937-520-8496
 Email: Kevin@ThreeOaksCenter.com
 Web: www.ThreeOaksCenter.com



Reset Form

STEC B
Rev. 3/04

Sales and Use Tax Blanket Exemption Certificate

The purchaser hereby claims exception or exemption on all purchases of tangible personal property and selected services made under this certificate from:

Three Oaks Center, Inc.

(Vendor's name)

and certifies that the claim is based upon the purchaser's proposed use of the items or services, the activity of the purchase, or both, as shown hereon:

Three Oaks Center, Inc. is a non-profit organization according to the 501 (c) (3) Internal Revenue Code. Contributions are deductible under section 170 of the Code. Three Oaks Center, Inc. is also qualified to receive tax deductible bequests, devices, transfers or gifts under section 2055, 2106 or 2522 of the Code. All items purchased with this Blanket Exemption Certificate are for use by this non-profit organization and cannot be transferred and are not for resale. Thank you for your generosity in supporting our mission!

Purchaser must state a valid reason for claiming exception or exemption.

Three Oaks Center, Inc.; Kevin R. Hoffman, President

Purchaser's name

7413 Bunker Court

Street address

Centerville, Ohio 45459

City, state, ZIP code

Signature

February 9, 2015

Title

Date signed

EIN 41-1880446

Vendor's license number, if any

Vendors of motor vehicles, titled watercraft and titled outboard motors may use this certificate to purchase these items under the "resale" exception. Otherwise, purchaser must comply with either rule 5703-9-10 or 5703-9-25 of the Administrative Code. This certificate cannot be used by construction contractors to purchase material for incorporation into real property under an exempt construction contract. Construction contractors must comply with rule 5703-9-14 of the Administrative Code.



DATE	DOCUMENT ID	DESCRIPTION	FILING	EXPED	PENALTY	CERT	COPY
3/2013	201300700976	FOREIGN NONPROFIT CORPORATION - LICENSE (FLN)	125.00	.00	.00	.00	.00

Receipt

This is not a bill. Please do not remit payment.

THREE OAKS CENTER, INC
 KEVIN R. HOFFMAN
 7413 BUNKER COURT
 CENTERVILLE, OH 45459-4201

STATE OF OHIO CERTIFICATE

Ohio Secretary of State, Jon Husted

2163187

It is hereby certified that the Secretary of State of Ohio has custody of the business records for

THREE OAKS CENTER, INC.

and, that said business records show the filing and recording of:

Document(s):	Document No(s):
FOREIGN NONPROFIT CORPORATION - LICENSE	201300700976
Authorization to transact business in Ohio is hereby given, until surrender, expiration or cancellation of this license.	



United States of America
 State of Ohio
 Office of the Secretary of State

Witness my hand and the seal of the
 Secretary of State at Columbus, Ohio
 this 4th day of January, A.D. 2013.

Jon Husted

Ohio Secretary of State

INTERNAL REVENUE SERVICE
P. O. BOX 2508
CINCINNATI, OH 45201

DEPARTMENT OF THE TREASURY

Date: NOV 03 2014

THREE OAKS CENTER, INC
7413 BUNKER COURT
CENTERVILLE, OH 45459-4201

Employer Identification Number:
41-1880446
DLN:
17053113335024
Contact Person:
HERLEAN C YOUNCE ID# 31473
Contact Telephone Number:
(877) 829-5500
Accounting Period Ending:
December 31
Public Charity Status:
170(b)(1)(A)(vi)
Form 990 Required:
Yes
Effective Date of Exemption:
January 4, 2013
Contribution Deductibility:
Yes
Addendum Applies:
Yes

Dear Applicant:

We are pleased to inform you that upon review of your application for tax exempt status we have determined that you are exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code. Contributions to you are deductible under section 170 of the Code. You are also qualified to receive tax deductible bequests, devises, transfers or gifts under section 2055, 2106 or 2522 of the Code. Because this letter could help resolve any questions regarding your exempt status, you should keep it in your permanent records.

Organizations exempt under section 501(c)(3) of the Code are further classified as either public charities or private foundations. We determined that you are a public charity under the Code section(s) listed in the heading of this letter.

For important information about your responsibilities as a tax-exempt organization, go to www.irs.gov/charities. Enter "4221-PC" in the search bar to view Publication 4221-PC, Compliance Guide for 501(c)(3) Public Charities, which describes your recordkeeping, reporting, and disclosure requirements.

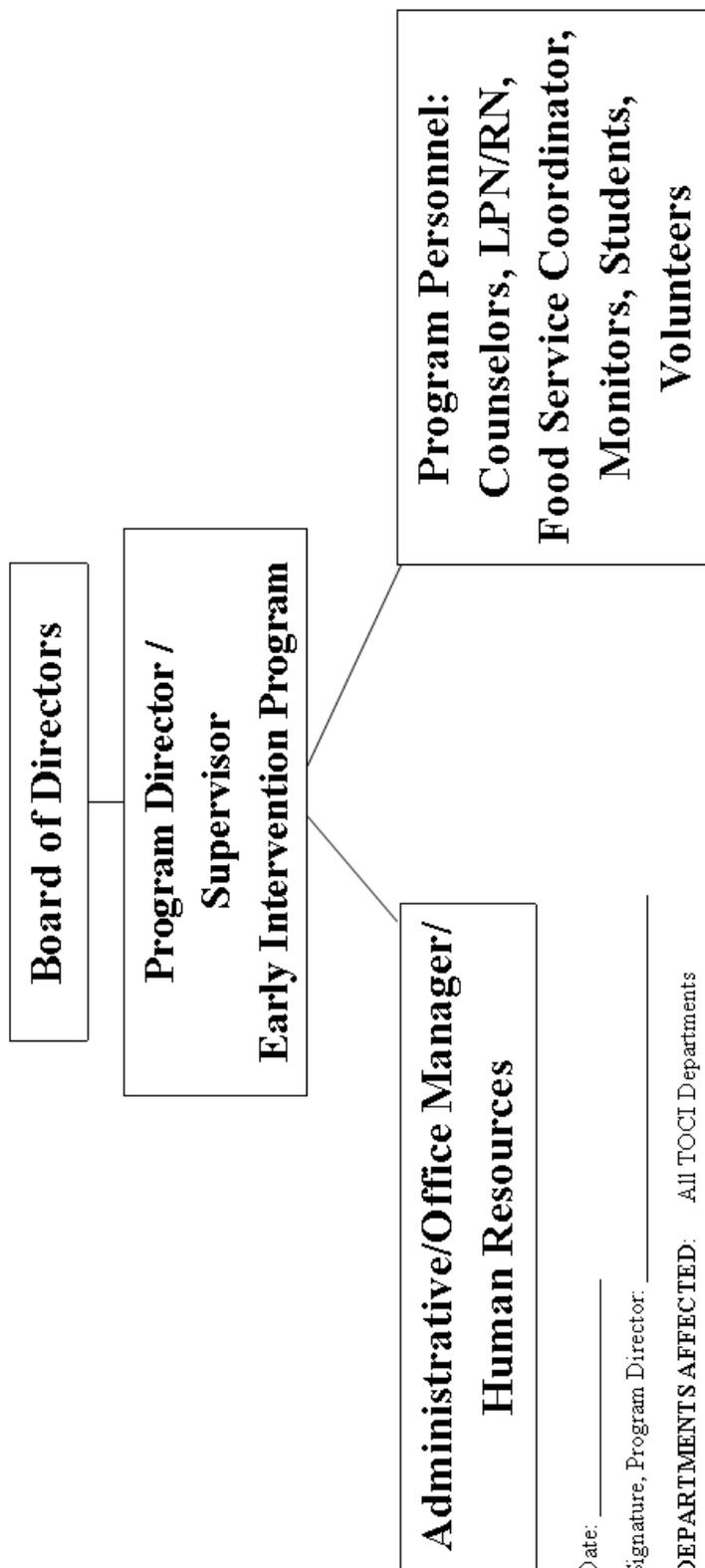
We have sent a copy of this letter to your representative as indicated in your power of attorney.

Sincerely,



Director, Exempt Organizations

TABLE OF ORGANIZATION



Date: _____
 Signature, Program Director: _____

DEPARTMENTS AFFECTED: All TOCID Departments
DATE OF ORIGIN: 11/17/14
APPROVED BY: Board of Directors (Dec. 2014)
EFFECTIVE DATE: 01/01/15
REVIEWED: Board of Directors (April 2015)
RENEWAL DATE: 04/01/15

APPENDIX C. FINANCIAL INFORMATION

**THREE OAKS CENTER, INC.
Organizational Budget 2015**

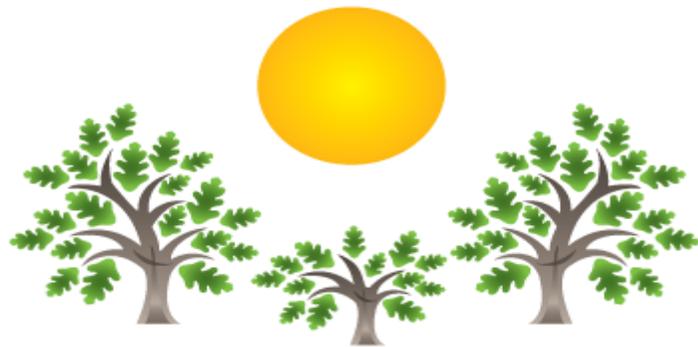
Organization Income	Weekly	Monthly	Annual
<u>Source</u>			
72-Hr. Program Fees \$400 x 14 People	\$1,292.31	\$5,600.00	\$67,200.00
48-Hr. Program Fees \$350 x 10 People	\$807.69	\$3,500.00	\$42,000.00
Individual Contributions	\$144.23	\$625.00	\$7,500.00
Total Revenues	\$2,244.23	\$9,725.00	\$116,700.00
Organization Expenses	Weekly	Monthly	Annual
<u>Program Weekend Totals</u>	\$1,936.71	\$8,392.40	\$100,708.80
12 Doubles @\$68.90ea x 3 Nights (Lodging @ DoubleTree Suites)	\$572.40	\$2,480.40	\$29,764.80
<u>Food</u>			
8 Meals x 30 People @\$7.00ea	\$387.69	\$1,680.00	\$20,160.00
Food Service Coordinator 10 hours @\$10	\$23.08	\$100.00	\$1,200.00
<u>Personnel</u>			
Chem. Dependency Counselors	\$346.15	\$1,500.00	\$18,000.00
Registered Nurse, 4 Sessions of 2 Hrs	\$36.92	\$160.00	\$1,920.00
Overnight Monitors (2), 8 Hrs @\$8 Hour	\$88.62	\$384.00	\$4,608.00
Director, 80 Hours @\$15 per Hour	\$276.92	\$1,200.00	\$14,400.00
Remedial Driving Instructor	\$46.15	\$200.00	\$2,400.00
<u>Programming</u>			
Participant Manuals	\$55.38	\$240.00	\$2,880.00
Computer Lab Rental	\$23.08	\$100.00	\$1,200.00
DUSI-R (screening tool)	\$55.38	\$240.00	\$2,880.00

TADD-5 (triage tool)	\$11.63	\$50.40	\$604.80
“Lessons Learned” Journal	\$13.29	\$57.60	\$691.20
<u>Program Materials: Start-up</u>			
<u>Expenses</u>	\$136.54	\$591.67	\$7,100.00
Advertising and Supplies	\$134.62	\$583.33	\$7,000.00
Director's Manuals, Counselor's Manuals	\$1.92	\$8.33	\$100.00
<u>Office Expense Totals</u>	\$56.54	\$245.00	\$2,940.00
Paper, Postage, Pens, Pencils, Supplies	\$40.38	\$175.00	\$2,100.00
Phone, Internet, Fax	\$16.15	\$70.00	\$840.00
<u>Professional Fees Totals</u>	\$96.15	\$416.67	\$5,000.00
Director & Officers Liability Insurance	\$19.23	\$83.33	\$1,000.00
Program Liability Insurance	\$19.23	\$83.33	\$1,000.00
Legal and Professional Fees	\$38.46	\$166.67	\$2,000.00
Marketing	\$19.23	\$83.33	\$1,000.00
Total Expenses	\$2,225.94	\$9,645.73	\$115,748.80
	Weekly	Monthly	Annual
Net Difference (Income – Expenses)	\$18.29	\$79.27	\$951.20

IP Weekend Sept. 2015 Budget Report

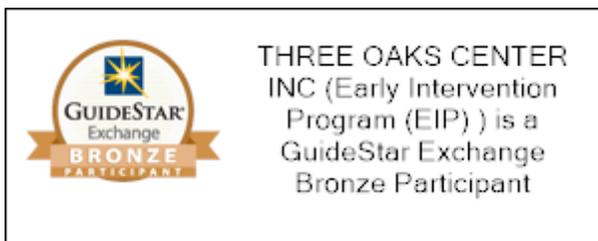
REVENUES:	WEEKEND	GRAND TOTALS
Participant Fees @ \$300 per person x 2 people	600	
Participant Fees @ \$200 per person x 1 person	200	
Scholarship @ \$100 per person x 1 person	100	
BMV Admin. Fee @ \$25 per person x 3 people	75	
Snacks, Lunch & Beverage Fee @ \$12 per person x 4 people	48	
Misc: Soft Drink	3	
TOTAL REVENUES	1026	1,026
EXPENSES:		
Lodging & Meals		
DoubleTree Suites Hotel, Miamisburg, OH 3 sleeping rooms x 3 nights; 2 dinner meals (9 people)	764.82	
Food		
Snacks, Beverages & 6 Meals	174.94	
Personnel		
Chemical Dependency Counselors - 1 x 18.5 hrs. x \$12 per hr.	222	
Registered Nurse - 4 sessions x 5.25 hrs. x \$20 per hr.	105	
Overnite Monitor - 1 x 30 hrs. x \$8.10 per hr.	243	
Driver's School Instructor	150	
Programming		
Participant's Folders - \$10 each x 3 participants	30	
DUSI-R: \$10 x 3 participants	30	
TADD-5: \$2.10 x 3 participants	6.3	
"Lessons Learned" Journal: \$2.40 x 3 participants	7.2	
Supplies for large & small groups	71.96	
Direct Costs (for weekend only)	1805.22	1805.22
Profit/Loss (weekend only)		-779.22
Donation	300	

Net Profit/Loss (weekend only)		-479.22
ITEMS NOT COVERED INCLUDE:		
Professional Fees		
Program Director's Wages		
Directors & Officers Liability Insurance		
General Liability Insurance		
Accounting/Auditing Fees		
Legal Fees		
Marketing		
Program Materials: start-up costs		
Logo; brochures, business cards, letterhead, Website, books, DVD's, DUSI-R		
Director's Manuals, Counselor's Manuals, etc.		



THREE OAKS CENTER, INC.

GIVE AS YOU LIVE!



There are several different ways in which people can support the work of **Three Oaks Center, Inc.** Simply by enrolling in one of the charitable giving or rewards programs identified below where you already do your shopping or giving, you can help further our mission!

Our mission is to provide opportunities for people to improve the quality of their emotional, mental, physical, relational and spiritual health through participation in our

faith-based Early Intervention Program (EIP) ~ a weekend early intervention program for those with alcohol and drug issues in which we help people sort through confusing questions and empower them to make self-enhancing choices that can change the course of their life!

All gifts are tax deductible (see note below). Please enroll today and ... ***GIVE AS YOU LIVE!***

Amazon Smile



When you shop at AmazonSmile, Amazon donates 0.5% of the purchase price to Three Oaks Center, Inc. In order for all your eligible shopping to benefit Three Oaks Center, Inc. please bookmark this link ~ <https://smile.amazon.com/ch/41-1880446>

Dorothy Lane Market



Three Oaks Center – Intervention Program has been added to the Good Neighbor Program. The program ID for our organization is 837. Simply complete one of the Good Neighbor Forms, designating our organization as the organization to which your purchases will be credited. You can find these forms at any of their stores or online at: <https://www.dorothyane.com/clubdlm/goodneighbor.pl>

Once completed, the form can be submitted to any of the Guest Services counters in any of their stores.

Kroger Community Rewards Program



We have enrolled in the Kroger Community Rewards Program; our Non-profit Organization (NPO) number is **96324**.

Kroger Community Rewards Program

We have enrolled in the Kroger Community Rewards Program; our Non-profit Organization (NPO) number is 96324.

TO USE THE KROGER COMMUNITY REWARDS PROGRAM:

- Simply encourage your members to register online at krogercommunityrewards.com
- Be sure to have your Kroger Plus card handy and register your card with your organization after you sign up.
- If a member does not yet have a Kroger Plus card, please let them know that they are available at the customer service desk at any Kroger.
- Click on Sign In/Register
- Most participants are new online customers, so they must click on SIGN UP TODAY in the 'New Customer?' box.
- Sign up for a Kroger Rewards Account by entering zip code, clicking on favorite store, entering your email address and creating a password, agreeing to the terms and conditions
- You will then get a message to check your email inbox and click on the link within the body of the email.
- Click on My Account and use your email address and password to proceed to the next step.
- Click on Edit Kroger Community Rewards information and input your Kroger Plus card number.
- Update or confirm your information.
- Enter NPO number or name of organization, select organization from list and click on confirm.
- To verify you are enrolled correctly, you will see your organization's name on the right side of your information page.
- REMEMBER, purchases will not count for your group until after your member(s) register their card(s).
- Do you use your phone number at the register? Call 800-576-4377, select option 4 to get your Kroger Plus card number.
- Members must swipe their registered Kroger Plus card or use the phone number that is related to their registered Kroger Plus card when shopping for each purchase to count.

Meijer Community Rewards Program



Enrolled members shop Meijer, simply paying with cash, PIN-based debit card or linked Meijer Credit Card. Purchases made with a linked Meijer Credit Card earn 1%. Purchases made with cash or PIN-based debit card and a swiped Meijer 1 CardSM earn 0.5%. Apply online at

www.meijer.com/rewards ... our 6-digit code number to use when joining is **727649**.

PayPal

· Utilize credit cards and PayPal on our website

The Dayton Foundation



Potential donors may make gifts to Three Oaks Center, Inc. through The Dayton Foundation (TDF). Donors who have established funds at the Foundation may make gifts to eligible not for profit organizations via their funds through TDF's regular process. Those donors with funds at the Foundation who want to support Three Oaks Center, Inc. are to contact The Dayton Foundation as they normally would do to make gifts and they will process these per the donor's instructions. Questions? Please contact Barbra A. Stonerock, Vice President, Community Engagement, The Dayton

Foundation, 40 N. Main Street, Suite 500, Dayton, OH, 45423; (937) 225-9951;
www.daytonfoundation.org.

Other Ways to Give

Contributions and donations may be given by check made payable to Three Oaks Center, Inc. and mailed to 6077 Far Hills Ave., #157, Centerville, OH 45459.

Three Oaks Center, Inc. is a non-profit organization according to the 501 (c) (3) Internal Revenue Code. Contributions are deductible under section 170 of the Code. Three Oaks Center, Inc. is also qualified to receive tax deductible bequests, devices, transfers or gifts under section 2055, 2106 or 2522 of the Code. A receipt will be provided for income tax purposes at the end of each year.

Thank you for your generosity in supporting our mission!

Our website utilizes these secure features:



SSL Certificates

Protects your transactions and our client's and donor's data.



SiteLock

Protects our website and keeps our clients and donors safe from hackers and other online threats.



Kevin R. Hoffman, President; D.Min. (cand.), LICSW (ret.), LCDC-II, ICADC
Certified Pastoral Counselor & Fellow, AAPC

Three Oaks Center, Inc., 6077 Far Hills Ave., #157, Centerville, OH 45459
Email: Kevin@ThreeOaksCenter.com Phone: 937-520-8496

APPENDIX D. PERSONNEL, POLICY, PROCEDURES, AND PROGRAM MANUAL

 <p>THREE OAKS CENTER, INC.</p>	<p>6077 Fair Hills Ave. #157 Centerville, OH 45459 937-520-8496 Kevring@ThreeOaksCenter.com ThreeOaksCenter.com</p>	<p>Early Intervention Program (EIP) Staffing Curriculum/Activities</p>
<p>THURSDAY (72-Hour Residential Program)</p>		
<p>Admissions/Registration Welcome/Introductions</p>	<p>4:00 - 6:00 pm 6:15 - 7:15 pm</p>	<p>Program Director 3:00pm-12:30am; Nurse PRN; Students 4:00pm-11:00pm (7 hours)</p>
<p>Alcohol/Substance Abuse Education - Movies: "Impaired Driving: Awareness" & "The Secret to a Satisfied Life" & "Chalk Talk on Alcohol"</p>	<p>7:15 - 10:15 pm 10:15 - 10:30 pm</p>	<p>Staffing for client education group sessions does not exceed an instructor to client ratio of 1:48. 12 Interviews @ 20-30 minutes each Hallway Monitor 12:15am-8:15am (8 hrs.)</p>
<p>Wrap Up</p>		
<p>FRIDAY (72-Hour; 48-Hour Residential Program begins in the evening)</p>		
<p>Breakfast Remedial Driving Class (72-Hour) Lunch (72-Hour) Remedial Driving Class (72-Hour) Admissions/Registration (48-Hour Group) Welcome/Introductions (48-Hour) Dinner (72-Hour) Break</p>	<p>7:30-8:00 am 8:00 - 12:15 pm 12:15 - 12:45 pm 1:00 - 5:30 pm 4:00 - 5:30 pm 5:30 - 6:15 pm 5:30 - 6:15 pm</p>	<p>Program Director 7:00am-10:30pm; Remedial Driving Instructor 8:00am-6:00pm; Nurse PRN; Students 8:00am-10:00pm (14 hours) 6 interviews @ 20-30 minutes each 6 interviews @ 20-30 minutes each</p>
<p>Alcohol/Substance Abuse Education & Traffic Safety Education - Movies: "Secret World of Recovery" & 20/20 "Drunk Driving"</p>	<p>6:30 - 7:30 pm</p>	<p>Staffing for client education group sessions does not exceed an instructor to client ratio of 1:48. 2 interviews @ 20-30 minutes each Staffing for client education group sessions does not exceed an instructor to client ratio of 1:48. 3 interviews @ 20-30 minutes each Hallway Monitors arrive to help with smoke break; 9:45pm-8:15am (10.5 hrs.)</p>
<p>Alcohol/Substance Abuse Education - Relational/Social/Familial Movie: "Home Run"</p>	<p>7:40 - 9:45 pm</p>	<p>Movies with discussion & life application Movies with discussion & life application</p>
<p>Wrap Up</p>	<p>9:45 - 10:00 pm</p>	

Client Evaluation Form

Counselor Names: _____ and _____

This questionnaire will help us improve the Early Intervention Program. There is no right or wrong answers. Please do not write your name on this form. Please answer all items. Place your completed survey in the box marked "Satisfaction Surveys" located on the table at the back of the meeting room.

1. Do you think the program was easily accessible?
 Very Accessible Accessible Somewhat Accessible Not at all accessible

2. Did you attend the
 72-Hour Program (Thursday – Sunday) 48-Hour Program (Friday – Sunday)

3. Was this the first time you completed the Early Intervention Program?
 Yes No If no, how many times have you completed the program? _____

4. What is your current age? _____

5. Which best describes you?
 African-American Asian Native American Caucasian Other

6. Think about your counselor. Did he/she seem to demonstrate an appropriate amount of respect and understanding for the ethnic and cultural diversity and sensibilities of the program participants?
 Very Competent Competent Incompetent Very Incompetent

7. Did you think that your counselor was interested in you as a person?
 Very Interested Interested Somewhat Interested Didn't seem to care

8. How appropriate and helpful do you think the following activities were in helping you examine your alcohol consumption or use of other mood altering substances?

	Very Helpful	Helpful	Somewhat Helpful	Not at all Helpful
Group Sessions				
The Movies				
The Lectures				
Celebrate Recovery				
Individual Sessions				

9. How satisfied were you with your meals?
 Very Satisfied Somewhat Satisfied Somewhat Dissatisfied Dissatisfied

10. How satisfied were you with your room accommodations?
 Very Satisfied Somewhat Satisfied Somewhat Dissatisfied Dissatisfied

11. Did you feel safe at the program?
 Yes Somewhat No

12. How would you describe EIPs personnel?
 Courteous Helpful Did not Care Domineering

13. How clear do you think the instructions given by the staff were?
 Clear Somewhat Clear Somewhat Confusing Very Confusing

14. Did the program help you learn anything about yourself?
 A Lot Some A Little Nothing

15. Did the program help you learn anything about alcohol/drug abuse?
 A Lot Some A Little Nothing
16. Did this program change your way of thinking when it comes to drinking/using and driving?
 A Lot Some A Little Nothing
17. Did this program have an effect on whether you will drink/use and drive in the future?
 A Lot Some A Little Nothing
18. All things considered, do you think the program was worthwhile?
 Very Worthwhile Worthwhile Somewhat Worthwhile Not Worthwhile
19. Would you recommend the program to someone who might have a problem?
 Definitely Probably Not Sure Definitely Not
20. Do you think that you will be in touch with any agency or program in the future about getting some more assistance/support?
 Definitely Probably Not Sure Definitely Not
21. Please tell us how you think we might improve this program? Do you have any additional comments or suggestions?

Referral Source Evaluation Form

Counselor Names: _____ and _____

- This questionnaire will help us improve the Early Intervention Program. There are no right or wrong answers.
 - Please do not write your name on this form.
 - Please answer all items.
1. Do you think the program was easily accessible for your client(s)?
 Very Accessible Accessible Somewhat Accessible Not at all accessible
 2. Which program did you refer your client(s) to:
 72-Hour Program (Thursday – Sunday) 48-Hour Program (Friday – Sunday)
 3. Was this the first time you referred your client(s) to the Early Intervention Program?
 Yes No If no, how many clients have you referred to the program? _____
 4. What is your current age? _____
 5. Which best describes you?
 African-American Asian Native American Caucasian Other
 6. Think about your client's experience with their counselor. How was the counselor able to demonstrate an appropriate amount of respect and understanding for the ethnic and cultural diversity and sensibilities of your client(s) as a program participant?
 Very Competent Competent Incompetent Very Incompetent
 7. How was their counselor able to demonstrate an appropriate amount of interest in program participants?
 Very Interested Interested Somewhat Interested Didn't seem to care
 8. How appropriate and helpful do you think the following activities were in helping your client(s) examine their alcohol consumption or use of other mood altering substances?

	Very Helpful	Helpful	Somewhat Helpful	Not at all Helpful
Group Session				
The Movies				
The Lectures				
Celebrate Recovery				
Individual Sessions				
 9. How satisfied were your client(s) with their meals?
 Very Satisfied Somewhat Satisfied Somewhat Dissatisfied Dissatisfied
 10. How satisfied were your client(s) with their room accommodations?
 Very Satisfied Somewhat Satisfied Somewhat Dissatisfied Dissatisfied
 11. Did your client(s) feel safe at the program?
 Yes Somewhat No
 12. How would your client(s) describe EIP's personnel?
 Courteous Helpful Did not Care Domineering
 13. How clear did your client(s) think the instructions given by the staff were?
 Clear Somewhat Clear Somewhat Confusing Very Confusing
 14. Did the program help your client(s) learn anything about themselves?
 A Lot Some A Little Nothing

15. Did the program help your client(s) learn anything about alcohol/drug abuse?
 A Lot Some A Little Nothing
16. Did this program change your client(s)' way of thinking when it comes to drinking/using and driving?
 A Lot Some A Little Nothing
17. Did this program have an effect on whether your client(s) will drink/use and drive in the future?
 A Lot Some A Little Nothing
18. All things considered, do you think the program was worthwhile for your client(s)?
 Very Worthwhile Worthwhile Somewhat Worthwhile Not Worthwhile
19. Would you recommend the program to other clients who might have a problem?
 Definitely Probably Not Sure Definitely Not
20. Do you think that your client(s) will be in touch with any agency or program in the future about getting some more assistance/support?
 Definitely Probably Not Sure Definitely Not
21. Please tell us how you think we might improve this program? Do you have any additional comments or suggestions?

Staff Evaluation Form

Counselor Names: _____ and _____

This questionnaire will help us improve the Early Intervention Program. There are no right or wrong answers. Please do not write your name on this form. Please answer all items.

1. Do you think the program was easily accessible?
 Very Accessible Accessible Somewhat Accessible Not at all accessible
2. Did you work in the:
 72-Hour Program (Thursday – Sunday) 48-Hour Program (Friday – Sunday)
3. Was this the first time you worked in the Early Intervention Program?
 Yes No If no, how many times have you worked in the program? _____
4. What is your current age? _____
5. Which best describes you?
 African-American Asian Native American Caucasian Other
6. Think about your work experience. How were you able to demonstrate an appropriate amount of respect and understanding for the ethnic and cultural diversity and sensibilities of the program participants?
 Very Competent Competent Incompetent Very Incompetent
7. How were you able to demonstrate an appropriate amount of interest in program participants?
 Very Interested Interested Somewhat Interested Didn't seem to care
8. How appropriate and helpful do you think the following activities were in helping you examine your alcohol consumption or use of other mood altering substances?

	Very Helpful	Helpful	Somewhat Helpful	Not at all Helpful
Group Session				
The Movies				
The Lectures				
Celebrate Recovery				
Individual Sessions				

9. How satisfied were you with your meals?
 Very Satisfied Somewhat Satisfied Somewhat Dissatisfied Dissatisfied
10. How satisfied were you with your group room accommodations?
 Very Satisfied Somewhat Satisfied Somewhat Dissatisfied Dissatisfied
11. Did you feel safe at the program?
 Yes Somewhat No
12. How would you describe EIPs personnel?
 Courteous Helpful Did not Care Domineering
13. How clear do you think the instructions given by the staff were?
 Clear Somewhat Clear Somewhat Confusing Very Confusing
14. Did the program help program participants learn anything about themselves?
 A Lot Some A Little Nothing
15. Did the program help program participants learn anything about alcohol/drug abuse?
 A Lot Some A Little Nothing

16. Did this program change program participant's ways of thinking when it comes to drinking/using and driving?
 A Lot Some A Little Nothing
17. Did this program have an effect on whether program participants will drink/use and drive in the future?
 A Lot Some A Little Nothing
18. All things considered, do you think the program was worthwhile?
 Very Worthwhile Worthwhile Somewhat Worthwhile Not Worthwhile
19. Would you recommend the program to someone who might have a problem?
 Definitely Probably Not Sure Definitely Not
20. Do you think that program participants will be in touch with any agency or program in the future about getting some more assistance/support?
 Definitely Probably Not Sure Definitely Not
21. Please tell us how you think we might improve this program? Do you have any additional comments or suggestions

INCIDENT REPORT

NAME OF CLIENT: _____

CASE NUMBER/COURT: _____

PROGRAM DATE: _____

Please provide all relevant details (including times) concerning the release of the above named individual.

Signature Credentials/Title/Date

STAFF GRIEVANCE POLICY PROCEDURE
TOCI-Organization-Wide Policy

Should you believe that you have a grievance, you will have the option of filing a grievance. Should another party on your behalf have a grievance, it may be filed at any time.

1. Grievances must be in writing, utilizing a form provided by the program.
2. The grievance must be dated/signed by the staff member or the individual filing the grievance on the behalf of the staff member.
3. The grievance must include the date, approximate time, and description of the incident, names of the individuals involved, and the location where the incident occurred.
4. All Grievance Forms are to be submitted to the Program Director.
5. A resolution decision on the grievance will be made within twenty-one (21) calendar days of receipt of the grievance. In the event that this time period will need to be extended due to extenuating circumstances, documentation will be made in the grievance file and written notification provided to the staff member or to the party filing a grievance on the staff member's behalf.
6. The Program Director will be available to assist a staff member or the party filing a grievance on the staff member's behalf, in the filing of a grievance.
7. Staff members have the option of filing a grievance at any time with outside organizations including:

Ohio Department of Alcohol and Drug Addiction Services (OMHAS)
30 E. Broad Street, 742
Columbus, Ohio 43215-3430
Phone: 614-466-3445

U.S. Dept. of Health & Human Services
Office for Civil Rights, Region V
105 W. Adams Street, 16th Floor
Chicago, IL 60603
Phone: 312-886-2359

Ohio Legal Rights Services
50 W. Broad Street, Suite 1400
Columbus, OH 43215
Phone: 614-466-7264

8. Written acknowledgement of receipt of the grievance will be provided to each grievant within three (3) working days from receipt and will include:
 - a. date the grievance was received,
 - b. summary of the grievance,
 - c. overview of the investigation process,
 - d. timetable for completion of the investigation and notification or resolution.
 - e. EIP contact information ~ Kevin R. Hoffman, Program Director/President, 6077 Far Hills Avenue, #157, Centerville, OH 45459; phone 937-520-8496.

DEPARTMENTS AFFECTED:	All TOCI Departments
DATE OF ORIGIN:	11/17/14
APPROVED BY:	Board of Directors (Dec. 2014)
EFFECTIVE DATE:	01/01/15
REVIEWED:	Board of Directors (April 2015)
RENEWAL DATE:	04/01/15

STAFF GRIEVANCE FORM

- 1) What is the name of the individual who has been grieved?

- 2) What is the social security number of the person named above? _____
- 3) What dates did this person participate in Early Intervention Program? _____
- 4) Who is filing this grievance on behalf of the person named above? _____
- 5) On what date did the incident or situation being grieved happen? _____
- 6) Approximately what time did the incident or situation happen? _____
- 7) Where did the incident or situation occur? _____
- 8) What is/are the name(s) of the person(s) who was/were involved in this incident or situation or was/were witness(es) to it? _____

9) Please describe the incident or situation that occurred:

Signature of person filing the grievance

Date of filing

CLIENT RIGHTS AND GRIEVANCES POLICY PROCEDURE
TOCI-Organization-Wide Policy

PURPOSE:

To outline client rights and grievance procedure and to ensure they are upheld according to state and/or federal law.

POLICY:

Three Oaks Center, Inc. (TOCI), in conjunction with all independent contractors, recognizes that each client is an individual with unique health care needs and, because of the importance of respecting each client's personal dignity, provides considerate, respectful care focused on the client's individual needs.

The client, or their legal representative as appropriate, has the Right to make decisions regarding their medical care, including the decision to discontinue treatment, to the extent permitted by law. Assistance is given to the client and family in the exercise of their Right to make informed decisions regarding their medical care.

Believing that mutual understanding between clients and health care personnel is important in the care and recovery process, TOCI defines below the following:

1. Client Rights Policy
2. Client Grievance Procedure
 - a. Client grievance records shall be maintained for at least two (2) years from resolution.
 - b. Each client grievance record shall include, at a minimum, the following:
 - i. Copy of the grievance
 - ii. Documentation reflecting process used and resolution/remedy of the grievance
 - iii. Documentation, if applicable, of extenuating circumstances for extending the time period for resolving the grievance beyond 21 calendar days

CLIENT RIGHTS POLICY

TOCI respects the Rights of clients and we provide information to our clients about their Rights. The organization's policies and practices address the Rights of clients to care, treatment, and services within its capability and mission and in compliance with law and regulation. Each client has a Right to have his or her cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected. The organization supports the Right of each client to personal dignity and accommodates the Right to pastoral and other spiritual services for clients.

Each TOCI organization must inform each client, or when appropriate, the client's representative (as allowed under State law), of the client's Rights, in advance of furnishing or discontinuing client care whenever possible. TOCI is committed to the resolution of any concerns the client may have.

We receive, review and, when possible, resolve complaints from the clients or their representatives, as outlined in the Client Grievance policy and this TOCI "Client Rights and Grievances" document.

The rights of clients for each program shall include the following:

- The right to be treated with consideration and respect for personal dignity, autonomy and privacy.
- The right to be informed of one's own condition.
- The right to be informed of available program services.
- The right to give consent or to refuse any service.
- The right of freedom from unnecessary physical restraint or seclusion.

- The right to be advised and the right to refuse observation by others and by techniques such as one-way mirrors, tape recorders, video recorders, television, movies or photographs.
- The right to consult with an independent specialist or legal counsel at one's own expense.
- The right of confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations.
- The right to have access to one's own client record in accordance with program procedures.
- The right to be informed of the reason(s) for terminating participation in a program.
- The right to be informed of the reason(s) for denial of a service.
- The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, sex, national origin, sexual orientation, socio-economic status, disability or HIV infection, whether asymptomatic or symptomatic, or AIDS.
- The right to know the cost of services, if applicable.
- The right to be informed of all client rights.
- The right to exercise one's own rights without reprisal.
- The right to file a grievance in accordance with program procedures.
- The right to have oral and written instructions concerning the procedure for filing a grievance.

CLIENT GRIEVANCE PROCEDURE

Should a client believe that their rights have been violated, they will have the option of filing a grievance. Should another party on the client's behalf have a grievance, it may be filed at any time.

1. Grievances must be in writing, utilizing a form provided by the program.
2. The grievance must be dated/signed by the client or the individual filing the grievance on the behalf of the client.
3. The grievance must include the date, approximate time, description of the incident, names of the individuals involved, and the location where the incident occurred.
4. All Grievance Forms are to be submitted to the Program Director.
5. A resolution decision on the grievance will be made within twenty-one (21) calendar days of receipt of the grievance. In the event that this time period will need to be extended due to extenuating circumstances, documentation will be made in the grievance file and written notification provided to the client or to the party filing a grievance on the client's behalf.
6. The Program Director will be available to assist a client or the party filing a grievance on the client's behalf, in the filing of a grievance.
7. Clients have the option of filing a grievance at any time with outside organizations including:

Ohio Department of Alcohol and Drug Addiction Services (OMHAS)
30 E. Broad Street, 742
Columbus, Ohio 43215-3430
Phone: 614-466-3445

U.S. Dept. of Health & Human Services
 Office for Civil Rights, Region V
 105 W. Adams Street, 16th Floor
 Chicago, IL 60603
 Phone: 312-886-2359

Ohio Legal Rights Services
 50 W. Broad Street, Suite 1400
 Columbus, OH 43215
 Phone: 614-466-7264

ADAMHS Board of Montgomery County
 (Alcohol, Drug Addiction & Mental Health Services)
 409 E. Monument Ave., Ste. 102
 Dayton, OH 45402-1226
 Phone: 937-443-041
 Client Rights: 937-853-4307

8. Written acknowledgement of receipt of the grievance will be provided to each grievant within three (3) working days from receipt and will include:
 - a. date the grievance was received,
 - b. summary of the grievance,
 - c. overview of the investigation process,
 - d. timetable for completion of the investigation and notification or resolution.
 - e. EIP contact information ~ Kevin R. Hoffman, Program Director/President, 6077 Far Hills Avenue, #157, Centerville, OH 45459; phone 937-520-8496.

DEPARTMENTS AFFECTED:	All TOCI Departments
DATE OF ORIGIN:	11/17/14
APPROVED BY:	Board of Directors (Dec. 2014)
EFFECTIVE DATE:	01/01/15
REVIEWED:	Board of Directors (April 2015)
RENEWAL DATE:	04/01/15

CLIENT RIGHTS HANDOUT

The Early Intervention Program is committed to treating all participants with respect and dignity. As such, this statement of your rights is offered as an expression of our philosophy and commitment to you.

Your rights

- The right to be treated with consideration and respect for personal dignity, autonomy and privacy.
- The right to be informed of one's own condition.
- The right to be informed of available program services.
- The right to give consent or to refuse any service.
- The right of freedom from unnecessary physical restraint or seclusion.
- The right to be advised and the right to refuse observation by others and by techniques such as one-way mirrors, tape recorders, video recorders, television, movies or photographs.
- The right to consult with an independent specialist or legal counsel at one's own expense.
- The right of confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations.
- The right to have access to one's own client record in accordance with program procedures.
- The right to be informed of the reason(s) for terminating participation in a program.
- The right to be informed of the reason(s) for denial of a service.
- The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, sex, national origin, sexual orientation, socio-economic status, disability or HIV infection, whether asymptomatic or symptomatic, or AIDS.
- The right to know the cost of services, if applicable.
- The right to be informed of all client rights.
- The right to exercise one's own rights without reprisal.
- The right to file a grievance in accordance with program procedures.
- The right to have oral and written instructions concerning the procedure for filing a grievance.

GRIEVANCE PROCEDURE HANDOUT

Should you believe that your rights have been violated, you will have the option of filing a grievance. Should another party on your behalf have a grievance, it may be filed at any time.

1. Grievances must be in writing, utilizing a form provided by the program.
2. The grievance must be dated/signed by the client or the individual filing the grievance on the behalf of the client.
3. The grievance must include the date, approximate time, and description of the incident, names of the individuals involved, and the location where the incident occurred.
4. All Grievance Forms are to be submitted to the Program Director.
5. A resolution decision on the grievance will be made within twenty-one (21) calendar days of receipt of the grievance. In the event that this time period will need to be extended due to extenuating circumstances, documentation will be made in the grievance file and written notification provided to the client or to the party filing a grievance on the client's behalf.
6. The Program Director will be available to assist a client or the party filing a grievance on the client's behalf, in the filing of a grievance.
7. Clients have the option of filing a grievance at any time with outside organizations including:

Ohio Department of Alcohol and Drug Addiction Services (OMHAS)
30 West Spring Street, 6th Floor
Columbus, OH 43215-2256
Phone: 614-466-3445

U.S. Dept. of Health & Human Services
Office for Civil Rights, Region V
105 W. Adams Street, 16th Floor
Chicago, IL 60603
Phone: 312-886-2359

Ohio Legal Rights Services
50 W. Broad Street, Suite 1400
Columbus, OH 43215
Phone: 614-466-7264

8. Written acknowledgement of receipt of the grievance will be provided to each grievant within three (3) working days from receipt and will include:
 - a. date the grievance was received,
 - b. summary of the grievance,
 - c. overview of the investigation process,
 - d. timetable for completion of the investigation and notification or resolution.
 - e. EIP contact information ~ Kevin R. Hoffman, Program Director/President, 6077 Far Hills Avenue, #157, Centerville, OH 45459; phone 937-520-8496.

GRIEVANCE FORM

- 1) What is the name of the individual who has been grieved?

- 2) What is the social security number of the person named above?

- 3) What dates did this person participate in Early Intervention Program?

- 4) Who is filing this grievance on behalf of the person named above?

- 5) On what date did the incident or situation being grieved happen?

- 6) Approximately what time did the incident or situation happen?

- 7) Where did the incident or situation occur?

- 8) What is/are the name(s) of the person(s) who was/were involved in this incident or situation or was/were witness(es) to it? _____

- 9) Please describe the incident or situation that occurred:

Signature of person filing the grievance Date of filing

CLIENT RESPONSIBILITIES POLICY
TOCI-Organization-Wide Policy

1. Clients are responsible for giving complete and honest information.

During orientation and upon admission, the client is responsible for providing accurate and complete information about their present complaints, past illnesses, allergies, organizations, medications (including over the counter), vitamins and herbal supplements, and other matters relating to their health.

2. Clients and their family are responsible for reporting perceived risks in their care, as well as any unexpected changes in their condition.

3. Clients are responsible for providing feedback about their service needs and expectations.

4. Clients are responsible for following care, service, or care plan instructions, for asking any questions and for accepting consequences of not following their plan of care.

The client and their family should express any concerns and ask any questions they may have about their ability to follow and comply with the proposed care plan. TOCI makes every effort to adapt the plan to the specific needs and limitations of the clients. When such adaptations to the care plan are not recommended, clients and their families are informed of the consequences of not following the proposed course. This is important as the client, and their family, are responsible for accepting the consequences and outcomes of the care plan if not followed.

5. Clients and their family are responsible for following organization rules and regulations concerning client care and conduct.

- Clients and their family must be considerate of the organization's staff and property.
- Clients and their family have the responsibility to cooperate to the best of their ability and to do so in a considerate and courteous manner with the organization personnel.
- Clients and their family have the responsibility to be considerate of the rights and privacy of other clients and organization personnel.

6. Clients have the responsibility to be considerate of other clients and their property, particularly in regard to noise, late night activities, and the adherence to the no smoking policy inside program facilities.

7. Clients are responsible for providing the organization with a copy of their Advance Directives, if they have these, and for informing their surrogate decision maker, and family as appropriate, of their health care wishes.

8. Clients are responsible for keeping appointments.

In order to assure continuity of their care, it is important for the client to keep their scheduled appointments and to cooperate with all personnel who are assisting in carrying out their health care plan.

9. Clients have the responsibility to settle organization bills promptly.

Clients and their family are responsible for promptly meeting any financial obligation agreed to with the organization.

10. Clients are responsible for any and all personal property brought in during their organization visit.

It is recognized that at times, clients have loss or damage of personal items. The organization cannot accept responsibility for the loss or damage of any personal items. Therefore, it is recommended that all valuables be left at home and not brought into the program weekend. All medications must be left at home or checked in with the organization's nurse upon arrival to the program weekend.

- All losses are to be reported from the respective client's program to the program director.
- The program director will investigate and attempt to retrieve the lost item. The client will be notified of the investigation or the recovery of the lost item.
- No staff member is to inform a client nor anyone else that they or the organization will take responsibility for paying for or replacing the item

RULES AND REGULATIONS HANDOUT

- The use of alcoholic beverages or any other type of drugs (not prescribed by a physician), and gambling will not be permitted for the duration of your attendance at the Early Intervention Program (EIP).
- Verbal and physical abuse or threats thereof will not be tolerated.
- You are a guest of the EIP. You will be fully respectful of all individuals with whom you come into contact. Any harassment or behaviors perceived to be harassment—which includes any sexually-oriented remarks; comments which may be so interpreted; whistles and similar sounds; inappropriate gestures, and the like—directed at others will not be tolerated.
- You will be confined to the premises for the duration of the weekend. No one is allowed to leave the assigned area unless authorized by program staff.
- You will be required to find your own transportation to and from the EIP.
- No cigarette machine is available. The facility is non-smoking. Smoking is permitted in a designated area outside and monitored by program staff.
- No newspaper box is available.
- While in any public area, shirt, shoes and name tag must be worn.
- There will be a designated EIP staff room that will be used for coordinating all activities.
- Notify EIP security personnel or the Program Director immediately upon arrival of any room damage or malfunction.
- You are to stay in your assigned room. No visiting or telephone calls to other rooms is allowed. TVs in all hotel rooms will not be operational. You may not loiter in the hallway.
- No phone calls may be made from your hotel room telephone as they will not be operational.
- Absolutely no outside deliveries of food or any other items are allowed.
- You may not receive telephone calls other than in cases of emergency and may not have visitors.
- Lights must be out, and all quiet by 11:30 pm every evening. Room check will be made each night.
- Housekeeping will empty trash and provide fresh towels only. You are responsible for keeping your room clean and orderly.
- You are responsible for getting yourself up on time. Set your alarm!
- At 7:15am Friday and at 7:45am Saturday & Sunday, you will receive a knock on your door. This is the signal that it is time to leave your room for the day. **Wear your name badge.**
- When leaving your hotel room, bring all items that will be needed for the entire day.
- Preferably, leave all valuables at home; or keep all valuables with you at all times. The EIP does not assume responsibility for any property that is left in your hotel room during the day.
- Do not attempt to remove anything that is not yours from the hotel; theft is prosecutable by law.
- Breakfast is provided at approximately 7:30am Friday and 8:00am Saturday and Sunday. Smokers will be taken outside by program staff for a short break prior to breakfast being served.
- All food and beverage is to be consumed in the area assigned.

IT IS YOUR RESPONSIBILITY TO COMPLY WITH THE ABOVE RULES AND REGULATIONS. FAILURE TO DO SO CAN, AND LIKELY WILL, RESULT IN YOUR SUSPENSION FROM THE EARLY INTERVENTION PROGRAM.

I have read and agree to comply with the above rules and regulations. I understand that any infraction of these rules will result in my suspension from the Early Intervention Program.

Participant's Signature

Printed Name

Date

EARLY INTERVENTION PROGRAM**FEDERAL CONFIDENTIALITY**

- I have been advised that participation in the Early Intervention is confidential and that each participant is protected under the federal law and regulations governing confidentiality of Alcohol and Drug Abuse Patient Records (42 U.S.C § 290dd-2; 42 C.F.R. Part 2). I am aware that sharing any information about any person (other than myself) who is participating in the program, including names, pictures and/or descriptions, is a violation of federal law.
- I hereby agree to refrain from sharing any information about other program participants or any use of a cell phone or any other electronic device in any manner that could jeopardize the confidentiality of other participants in the Early Intervention Program. Specifically, I understand that photographing and/or videotaping of any kind is strictly prohibited and will be considered a violation of federal law.
- Further, I fully understand that any violation of the federal law regarding confidentiality while participating in the program will result in my suspension from the Early Intervention Program and that any suspected or known violations will be reported to the appropriate authorities in accordance with Federal guidelines.
- In accordance with the above guidelines, if I have a cell phone or other electronic device in my possession at the Early Intervention Program, I understand that any inappropriate use of this device that compromises the confidentiality of other program participants in any way will result in my suspension from the Early Intervention Program.
- _____
Participant's Signature
- _____
Printed Name
- _____
Date

FEE AGREEMENT

- The program registration fee for attending the **72-Hour** session of the Early Intervention Program is \$400. The Defensive Driving Course is included in this session. Documentation of course completion can be provided to the Ohio Department of Public Safety/BMV to apply for the 2-point remedial course credit for an additional fee of \$25.
- The program registration fee for attending the **48-Hour** session of the Early Intervention Program is \$350. Clients attending the 48-Hour session have the **option** of attending the Defensive Driving Course which begins Friday morning at 8:00am. Cost of the class including submitting documentation of course completion to the Ohio Department of Public Safety/BMV to apply for the 2-point remedial course credit is \$55.
- Clients attending either the 72-Hour or 48-Hour session have the **option** of receiving a full alcohol/drug assessment for an additional fee of \$100. The assessment will be completed during the weekend. Please be aware that some courts require an assessment. Your attorney or the court referring you to the program can advise if this is required.
- The program registration fee covers your meals (after the first night), lodging in a double occupancy room, and all services you receive while you are a participant in the program. On a space available basis, a single occupancy room may be possible at an additional cost of \$70 per night. Arrangements must be made in advance.
- Should a change of your scheduled program date be necessary, a reschedule fee of \$25 will be charged. A five-business day grace period is granted from the time the notification of your enrollment is mailed from our office. Any schedule change made after that time will incur the reschedule fee.
- Your payment of the program fee outlined above at least two weeks prior to the scheduled session provides a guaranteed date for you.
- In the event that you reschedule your guaranteed program date within one week of the scheduled session or do not show up for the program you have guaranteed to attend, you will be responsible for the cost of food and lodging incurred by the Early Intervention Program on your behalf. The rescheduling fee will be \$140 for the 72-Hour participants and \$115 for 48-Hour participants. You will be required to pay this fee before a new date will be scheduled.
- If you are dismissed from the program for failing to comply with the program rules, a daily fee of \$75 for each day you must repeat will be assessed to cover the cost of additional food and lodging incurred. This fee must be paid prior to rescheduling.
- All reschedules are subject to approval from the referring court or agency.

I agree to remit the fees indicated above in order to guarantee my enrollment in the Early Intervention Program. I understand that registration fees are non-refundable.

Name (Please Print)

Signature

Date

**MANAGEMENT OF MEDICATIONS BROUGHT FROM HOME
TOCI-Organization-Wide Policy**

POLICY:

Medications that are brought into any program conducted by Three Oaks Center, Inc. (TOCI) by clients or their families must be identified by the nurse caring for the client. Medications that are going to be distributed for self-administration during the program must be properly identified and/or labeled by either a pharmacist or a physician.

Clients are prohibited from having prescription medications in their possession at the program site or while involved in program activities off site, unless required by physician for medical necessity, including, but not limited to:

- Prescription medications necessary to prevent potentially life threatening illnesses (i.e. inhaler, nitroglycerin or similar cardiac medication, anti-seizure medications, etc.).

Clients shall not be denied EIP (or driver intervention) services due solely to their use of prescribed psychotropic medications.

No individuals shall be admitted to any program who have any contagious illness(s) or who have wounds requiring medical treatment.

A basic First Aid Kit will be maintained on-site at all times and may be accessed by program staff as needed.

PROCEDURES:

1. Home medication not distributed during the program ~
 - a. After the medication has been identified and documented in the client record and is not to be used, it should:
 - a. Be sent home with a family member or friend of the client.
2. Procedures for obtaining and accounting for controlled substances from clients at the time of admission to, or upon entering, and return of same at discharge. The following procedure shall be followed for medications brought by the client from home that are to be distributed for self-administration during the program ~
 - a. A client's personal medications from home are only to be used upon order of a
 - a. physician.
 - b. Documentation: The nurse will enter a note in the client record on the Health and Medical Data Sheet (attached) that a home medication order has been received, keeping the note open and pending the order verification until the medication has been positively identified.
 - c. Nursing will initiate the following step to aid in the identification of the medication to be used from home:
 - i. Call the respective pharmacy and provide a verbal description of the medication.
 - d. Following verification with the respective pharmacist, the nurse will:
 - i. Document the positive identification of the drug, including manufacturer's lot number, when available.
 - ii. Close the note, first creating a comment following the format below.
 1. "Home Medication positively identified. Lot: ____"
 - e. Medication will be stored in a secure location (lock box) by the nurse.
 - f. All medications brought by the client from home shall be returned to the client upon discharge from the program.
 - g. Accountability: The nurse and the client shall sign and date the Health and Medical Data Sheet.
3. Medications will not be accepted from third-party or specialty pharmacies that are intended to be compounded and/or distributed in a TOCI facility. The only exceptions to this policy are medications that may be obtained through a third party for indigent clients; or medications obtained in association with a clinical research trial.
4. Medications or substances that are brought into the program by clients or their families and are thought to be illegally possessed must be processed according to program policy (attached).
5. The prescribing physician and client/family shall be notified with regard to any ordered medications to be used from home that cannot be used due to compromised integrity of product or lack of positive identification.

6. Clients who voluntarily refuse to take prescribed medications while enrolled as a participant in the EIP (driver intervention program) shall sign the Release From Liability form (attached).
7. Any and all theft or loss of over-the-counter (OTC) or prescription medication shall be reported to the program director, who will in turn contact law enforcement. A copy of the report completed by law enforcement will be made a part of the client record.

DEPARTMENTS AFFECTED: All TOCI Departments
DATE OF ORIGIN: 11/17/14
APPROVED BY: Board of Directors (Dec. 2014)
EFFECTIVE DATE: 01/01/15
REVIEWED: Board of Directors (April 2015)
RENEWAL DATE: 04/01/15

CLIENTS WITH ILLEGALLY POSSESSED CONTROLLED SUBSTANCES
 TOCI-Organization-Wide Policy

PURPOSE:

The illegal possession of any controlled drug or substance by a client or visitor is prohibited due to the severity of health risks associated with the inappropriate use of controlled drugs and chemical substances.

GUIDELINES:

A. The following steps will be taken while rendering medical care to a client, if a drug or substance which is not readily identifiable as a drug or substance which the person may legally possess is found:

If the substance is reasonably believed to be of the type and character (i.e. white powder, green leafy material) rendering the possessor guilty of a violation of law:

1. Law Enforcement will be called/notified.
2. The substance will be transported by the program director/president where it will be secured and held until the respective law enforcement agency notifies the organization as to what steps, if any, need to be taken.

DEPARTMENTS AFFECTED: All TOCI Departments
DATE OF ORIGIN: 11/17/14
APPROVED BY: Board of Directors (Dec. 2014)
EFFECTIVE DATE: 01/01/15
REVIEWED: Board of Directors (April 2015)
RENEWAL DATE: 04/01/15

RELEASE FROM LIABILITY

I, _____, hereby release Three Oaks Center, Inc. and all its divisions, the Early Intervention Program (hereafter referred to as EIP) and all its employees and agents (whether paid or volunteer) from any and all legal liability for any injuries that I may suffer as the result of my voluntary refusal to take prescribed medications while enrolled as a participant in the EIP program.

I acknowledge the following to be true:

- I have chosen to not bring my prescription medications to the program.
- I am no longer taking the prescription medication in question, against the advice of my physician.
- I am no longer taking the prescription medication in question, as my physician has discontinued that medication as part of my treatment.
- I have brought the medication to the Early Intervention Program, but did not bring the medication in a container that clearly indicated that it was prescribed to me.

I have been informed by the Early Intervention Program staff that I have the option of deferring my participation in the EIP (with the approval of the referring court) to a future date, when I would be able to have my medication in a manner that is in compliance with the EIP policies and Ohio Department of Alcohol and Drug Addiction Services regulations, or to have my medications brought here to me by a friend or relative.

Against this advice, I am entering the EIP today without my prescription medications. This release also binds anyone else claiming rights by or through injuries. This release is given in exchange for acceptance as a participant in the EIP program. I am over eighteen years old. I am not now under the influence of alcohol or drugs of any kind. I am signing this release freely and voluntarily.

Client Signature Date

Witness Signature Date



6077 Far Hills Ave., #157 Centerville, OH 45459
 937-520-8496
 Kevin@ThreeOaksCenter.com
 ThreeOaksCenter.com

Medical History Form

Directions: Please answer the following questions to the best of your knowledge

Your records are considered confidential. Your records will not be released to any party without your written consent.

Patient Information		
First Name	Last Name	Date of Birth
Primary Physician(s)		
Name	Name	Name
Address	Address	Address
Phone:	Phone:	Phone:

Medication Allergies? Yes No Substance or Food Allergies? Yes No
 If yes, what medication(s) _____ If yes, what substance(s) _____

Family History: Please check if your family has a history of the following

- Diabetes High Blood Pressure Heart Attack, Heart Disease Blood Clots or Stroke Tuberculosis
 Cancer Alzheimer's Family History Unknown Mental Illness Epilepsy/Seizure

Any other major conditions? _____

If you have answered YES to any of the above, please explain: _____

Are you currently being treated for medical conditions? Yes No If YES, please list: _____

Medications (List more on separate page if necessary)

Current Medications	For what condition?	Dosage	Frequency	Date started	Comments / Problems / Concerns

Past Medications / For what condition? (list sedatives, pain medications, sleeping pills, antidepressants, etc.)

History

- Yes No Do you smoke? If yes, how many cigarettes per day?
 Yes No Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)
 Yes No Have you ever had or would you like help now with an alcohol or drug problem?
 Yes No Would you like to discuss problems related to a rape or emotional / physical / sexual abuse?
 Yes No Are you now or have you ever been in a relationship where you have been physically hurt or threatened?

AUDIT-C : Please circle your response	0	1	2	3	4	Score
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
How often do you have more than five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

TOTAL

Medical History Form

Directions: Please answer the following questions to the best of your knowledge

Your records are considered confidential. Your records will not be released to any party without your written consent.

Review of Systems: Please ✓ if you currently have or have ever had the following

1. General

- Productive cough (3 weeks or more)..... Current Past
- Dry, unproductive cough (3 weeks or more) Current Past
- Shortness of breath..... Current Past
- Chest pain Current Past
- Recurrent night sweats, chills, fevers Current Past
- Swollen glands (neck, armpits or groin) Current Past
- Persistent weight loss without dieting..... Current Past
- Weight problem / eating disorder Current Past

- Unusual discharge (vaginal or from penis) Current Past
- Bloody or painful urination Current Past
- Dark, bloody or painful bowel movements..... Current Past
- Hepatitis A..... Current Past
- Hepatitis B..... Current Past
- Hepatitis C..... Current Past
- Chronic Fatigue..... Current Past
- Cancer..... Current Past

Tuberculosis: Ever tested? Yes No Date and result of last test: _____ If Positive, did you have a chest x-ray? _____

Ever treated? Yes No Date(s) and type(s) of treatment: _____

HIV: Ever tested? Yes No Would you like information regarding HIV / AIDS or testing sites? Yes No

2. Skin

- Allergies / Rash / Itching..... Current Past
- Psoriasis / Eczema Current Past

3. Eyes

- Vision problems Current Past
- Eye infections Current Past

4. Ears, Nose, Throat, Lungs

- Hearing problems..... Current Past
- Teeth / gum problems or disease..... Current Past
- Frequent nosebleeds..... Current Past
- Recurrent sinusitis..... Current Past
- Frequent sore throats..... Current Past
- Recurrent Pneumonia..... Current Past
- Asthma..... Current Past

5. Cardiac

- Palpitations / arrhythmia Current Past
- Heart disease / murmur Current Past
- High blood pressure / Low blood pressure..... Current Past
- High cholesterol..... Current Past
- Thrombophlebitis / blood clots Current Past

6. Neurologic

- Stroke..... Current Past
- Frequent headaches or migraines Current Past
- Seizures / Epilepsy Current Past
- Weakness / paralysis / unsteady walking..... Current Past
- Dizziness / confusion / wandering..... Current Past
- Forgetfulness / memory lapse / memory loss Current Past

Other conditions / problems not listed: _____

7. Gastrointestinal

- Recurrent nausea / vomiting / diarrhea Current Past
- Stomach / bowel problems Current Past
- Gall bladder disease Current Past
- Pancreatitis..... Current Past
- Diabetes / hyperglycemia / hypoglycemia..... Current Past
- Encopresis (incontinent of feces) Current Past

8. Genitourinary

- Bladder / kidney problems or infection Current Past
- Incontinence (unable to control bladder) Current Past
- Enuresis (bedwetting) Current Past
- Sexually transmitted disease:
 - Gonorrhea Syphilis Herpes
 - Chlamydia Trichomonas
 - HPV or genital warts

Females:

- Menstrual Difficulties..... Current Past
 - Cycle: Regular Irregular
 - Pre-Menopause Menopause
- Problems / infection of tubes / ovaries / uterus..... Current Past
- Abnormal Pap Smear(s) Current Past
- Number of pregnancies: _____
- Number of births: _____
- Problems with pregnancies / births (explain) _____

Breast disease / tumor / surgery (explain) _____

Miscellaneous:

- Anemia / blood disorder Current Past
- Arthritis..... Current Past
- Sleep disturbance..... Current Past

I certify that I have answered these questions to the best of my knowledge

Patient Signature: _____ Date: _____

Clinician's Notes	
Reviewed by (Clinician):	Date:



HEALTH AND MEDICAL DATA SHEET

THREE OAKS CENTER, INC.	Name:										EIP Program Date:							
Social Security Number:																		
All Medications: Frequency, Dosage, Reason taken, Route of administration	# Upon Admit	Date Time #	Date Time #	Date Time #	Date Time #	Date Time #	Date Time #	# Administered	# Upon D/C									
Client's Signature:												Date:						
Staff Signature:									Title:			Date:						

ADMINISTRATIVE/MEDICAL DISCHARGE CHECKLIST

Client's Name: _____

Case Number and Court: _____

ACTION

TIME COMPLETED

- 1. Contact Program Director to apprise of situation.
- 2. Arrange transportation or service. _____

What/Whom? _____

To Where? _____

- 3. Instructions to be given to client:

_____ Decisions regarding rescheduling or completion of weekend are up to the court.

_____ Permission to do weekend needed from physician (if appropriate)

_____ Call attorney first thing Friday or Monday (whichever is applicable)

_____ Call court first thing Friday or Monday (whichever is applicable)

_____ Contact us to pick up belongings during week, office hours 8:30-5:00, if applicable

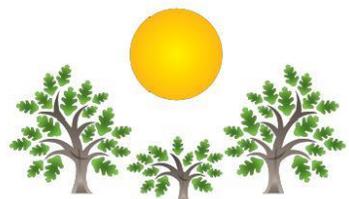
_____ Who would they like us to notify of this emergency?

_____ Note any relevant comments or reactions from client (note on attached sheet)

_____ If transported to hospital, contact hospital for disposition/status and document information on attached sheet.

- 4. Write incident report for file and attach to this form.

Signature Credentials/Title/Date _____



THREE OAKS CENTER, INC.

6077 Far Hills Ave., #157 Centerville, OH 45459
937-520-8496
Kevin@ThreeOaksCenter.com
ThreeOaksCenter.com

Registration Form

Referred by: _____

Name: _____ **Session Date:** _____
 First **Middle** **Last**

Address: _____ **EIP Number:** _____

_____ **Date of Birth:** _____
 City **State** **Zip**

Home telephone: _____ **Business/Work telephone:** _____

Gender: Male ___ Female ___ **Age** ___ **Ethnicity/Race:** _____ **Marital Status:** _____

Are you a smoker? Yes: ___ No: ___ **Social Security Number:** _____

Place of Employment: _____

Occupation: _____
Full-time ___ **Part-time** ___

Are you currently a student? ___ **If so, where?** _____

Emergency Contact: Name _____ **Relationship to you** _____

ADDRESS INCLUDING CITY, STATE, AND ZIP CODE **Telephone Number**

YOU MUST BRING PRESCRIPTION MEDICATIONS IN BOTTLES CLEARLY INDICATING THAT THEY HAVE BEEN PRESCRIBED TO YOU. BRING ONLY THE AMOUNT NEEDED TO GET THROUGH THE WEEKEND. NO OVER-THE-COUNTER ITEMS MAY BE BROUGHT TO THE PROGRAM INCLUDING TYLENOL, ADVIL, ASPIRIN, VITAMINS, SUPPLEMENTS, OINTMENTS, CREAMS, ETC. Please describe below any medical condition(s) you have and the medication(s) you are taking.

Please list all known allergies and/or food reactions.

Are you currently pregnant (females only)? If yes, how many months? List difficulties/problems, if any.

Do you have any special dietary requirements (e.g., gluten free, vegetarian, etc.) we should know about?

Please list any special (non-dietary) requirements you have.

***** FOR OFFICE USE ONLY *****

Luggage Searched By: _____

Registration Interviewer: _____

Date : _____

Driver's License Point Information

The Early Intervention Program has been designed with your best interests in mind, so we are really pleased to be able to offer you the chance to earn a two-point credit against the points charged against your driver's license.

As you may know, points are charged to your operator's license after some driving convictions. If you accumulate enough points, your driving privileges are suspended. Because we offer an Ohio Department of Public Safety/BMV certified Remedial Driving Program, those EIP clients who complete the remedial driving part of our program may be eligible for a two-point credit against those points charged to their licenses. Also, in some cases, completing the course may qualify you for lower insurance rates; you may want to check with your agent to see if you qualify.

This portion of the program will begin at **8:00 a.m. on Friday morning**. It concludes between 5:00-5:30 p.m.

We strongly encourage you to check with your attorney or call the Bureau of Motor Vehicles, License Information Center at (614) 752-7500, to determine your eligibility and whether applying for these points would be beneficial to you at this time.

72 Hour Clients Only

All clients completing the 72 Hour Early Intervention Program will attend the Remedial Driving Program as part of their Early Intervention Program attendance. For those individuals assigned to the 72 Hour Program and wishing to apply to the Ohio Department of Public Safety / BMV for the two-point credit, it is possible by following this simple procedure:

- Let us know you would like to apply for the credit by returning the attached form (at the bottom of this page) along with your registration materials.
- Send \$25.00 for administrative costs along with your program fees and registration material two weeks before you come to the program. (This is not part of the program registration fee.)

48 Hour Clients Only

For those individuals assigned to attend the 48-Hour (Fri-Sun) Early Intervention Program, it is also possible to participate in the Remedial Driving Program by following this simple procedure:

- Let us know if you would like to apply for the credit by returning the attached form (at the bottom of this page) along with your registration materials.
- Send \$55.00 for administrative costs along with your program fees and registration material two weeks before you come to the program. (This is not part of the program registration fee.)

The Early Intervention Program will be responsible for the paperwork and will apply for the credit for you. We will also maintain and store your records for three years. We'll be glad to answer any inquiries about your completion of the course for that period of time.

Once again, call your attorney or the Bureau of Motor Vehicles if you have any questions about your eligibility for the credit and its benefit to you. If you have any questions about our program, you can reach us Monday through Friday between the hours of 8:30 a.m. and 5:00 p.m. at (937) 520-8496.

(Tear off at dotted line and return to EIP.)

I am attending the: 72 Hour Program/\$25.00 48 Hour Program / \$55.00

Yes, I would like to take the Remedial Driving Program on Friday and apply to the Department of Public Safety / BMV for the two-point credit.

Name: _____

Program Date: _____

Remedial Driving Student Information

DL/Permit No:	<input type="text"/>	DOB	<input type="text"/>
		mm/dd/yyyy)	<input type="text"/>
First Name:	<input type="text"/>	MI:	<input type="text"/>
		Last Name:	<input type="text"/>
		Suffix:	<input type="text"/>
Street Address:	<input type="text"/>	City:	<input type="text"/>
State:	<input type="text" value="OHIO"/>	Phone No:	<input type="text"/>
	<input type="text"/>	-	<input type="text"/>
Zip Code:	<input type="text"/>	-	<input type="text"/>

Check Applicable Box: (For Remedial)

- Court ordered not for credit (this student was court ordered to take the remedial course and will not receive the 2 point credit). Forward certificate to court.
- This person is 19 years old or older but is taking the class because of a juvenile suspension that occurred before the age of 18.
- This course has been completed as a requirement for being eligible to retain or have my driver license returned due to being under the age of 21 and operating a vehicle with a prohibited level of alcohol in the blood, breath and urine as provided in R.C. 4511.19 (b) or a substantially similar municipal ordinance.
- I hereby apply to the Registrar of Motor Vehicles to credit two points on my driving record in accordance with Section 4510.037 (c). I am aware that I am not entitled to a two point credit if on this date the total points assessed against my record is less than 2 points or more than 11 points.
- This course has been completed as a requirement for being eligible to retain or have my driver license returned due to a twelve point suspension, Section 4510.038 (A).

Payment of Fees/Credit Card Form

You can charge your fees

If paying by credit card, complete form and return:

Early Intervention Program
 Three Oaks Center, Inc.
 6077 Far Hills Ave.
 #157
 Centerville, OH 45459

CARD NUMBER _____ - _____ - _____

CARD EXPIRATION DATE _____ / _____

CARD ID # OR 3 DIGIT VERIFICATION #
 (Appears on back of card)

NAME OF CLIENT (if different than Cardholder)

\$



AMT TO BE PAID

I hereby agree to pay the sum set forth above to the bank which issued my card in accordance with the terms of the credit card agreement for the purchase of goods and services. Your statement will reflect a charge to Three Oaks Center.

AUTHORIZED SIGNATURE _____ DATE _____

PRINT NAME (as it appears on card) _____

BILLING ADDRESS (of Cardholder) _____

PHONE NUMBER (of Cardholder) _____



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 ThreeOaksCenter.com

EARLY INTERVENTION PROGRAM CONSENT TO PARTICIPATE

I hereby agree to participate in the Early Intervention Program to be held at the DoubleTree Suites Hotel (the format and procedures of which has been explained to me) and voluntarily consent to any and all consultations, counseling, education, and emergency treatment that may be imparted or administered to me by the Three Oaks Center, Inc. or any of its employees, agents, and representatives.

I understand that the Early Intervention Program is bound by the federal law and regulations governing confidentiality of Alcohol and Drug Abuse Patient Records (42 U.S.C § 290dd-2; 42 C.F.R., Part 2) and that recipients of any information provided may redisclose it only in connection with their official duties. I understand, however, that the Early Intervention Program or any of its employees, agents, or representatives do not assume any responsibility for any breaches of confidentiality occasioned by actions of those not associated with the program, including other participants.

I also understand that the Early Intervention Program being offered by Three Oaks Center, Inc. is a faith-based Christian program in which passages of Scripture may be utilized as part of the treatment program and I voluntarily consent to participate in this weekend program.

I further release the said organization and its employees, agents, and representatives from all claims which I may have against them by reason of, or arising out of any treatment or other assistance I may receive while participating in the Program as long as such treatment and assistance are rendered in accordance with acceptable practice and without negligence.

To the best of my knowledge, I am not aware of any medical or psychological condition that could preclude my participation in the Early Intervention Program at this time.

I have read and agree to comply with the above rules and regulations. I understand that any infraction of these rules will result in my suspension from the Early Intervention Program. I further acknowledge that the fire and evacuation procedures for the DoubleTree Suites Hotel have been explained to me and that I have received the following:

- 1) The education curriculum for the Early Intervention Program.
- 2) The rules and/or expectations of participants in the program.
- 3) The Early Intervention Program's policies of client rights and client responsibilities.
- 4) The Early Intervention Program's client complaint and grievance procedures.
- 5) The Early Intervention Program's policy regarding federal confidentiality and electronics.
- 6) A written summary of the Federal laws and regulations regarding confidentiality of client records (42 C.F.R., Part 2).

 Participant's Signature

 Print Name

**CONSENT FOR AOD TREATMENT / FEE AGREEMENT /
RECEIPT OF FORMS**

Client Name: _____ **Client ID:** _____

Name of Agency Rendering Treatment / Services:

_____ provides services to individuals and/or their families who provides services to individuals and/or their families who have substance abuse / chemical dependency problems. The staff members are trained to provide appropriate treatment / services as needed in this area.

I have read and understand the information regarding consent to AoD treatment/ services. I have also received a copy of and understand the following:

I will pay \$_____ for each session

- Yes No Program rules and expectations
- Yes No Client rights policy and grievance procedures
- Yes No A written summary of the Federal Laws and regulations pertaining to the confidentiality of client records as required by 42 C.F.R., Part 2.
- Yes No Education materials on tuberculosis, hepatitis B and C and HIV/AIDS.

I agree to treatment offered by the above mentioned agency rendering treatment/ services for:

- Myself My Child _____ *(Or the person for whom I am legal guardian/custodian)*

Client Signature

Date

Legally Responsible Person Signature

Date

Staff Signature/Credentials

Date



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COMPLAINT POLICY & PROCEDURE

Should you feel that your rights have been violated you will have the option of filing a complaint. Should you, or another party on your behalf, have a complaint; it may be filed at any time. Assistance will be given to help file the complaint by the Program Director or designated Director-on-Site. A client complaint form provided by the program will be used and must include the following information:

1. The date of the incident/situation of the complaint;
2. The approximate time it occurred;
3. The location where the incident occurred;
4. The name(s) of the person(s) involved;
5. And a description of the incident/situation.

Complaints must be in writing and must be signed and dated by you or the person filing the complaint on your behalf.

All complaints will be settled within the following steps:

- Any complaint filed during the weekend is to be given to the Program Director, or the designated Director-on-Site. A complaint filed after the completion of the weekend is to be given to the Program Director. Written acknowledgement of receipt of the complaint will be provided within three working days from receipt and will include the date the complaint was received, a summary of the complaint, an overview of the investigation process, and a timetable for completion of the investigation and notification or resolution. You will also be provided with the name, address, and telephone number of the person you should contact with questions regarding the complaint.

A written statement of the results will be given to you within twenty-one calendar days of receipt of the complaint. In the event that this time period will need to be extended due to extenuating circumstances, documentation will be made in the complaint file and written notification provided to you.

- You have the option of filing a complaint at any time with outside organizations including:

Ohio Department of Mental Health & Addiction Services (OMHAS)
 30 E. Broad Street, 742
 Columbus, Ohio 43215-3430
 Phone: 614-466-3445

U.S. Dept. of Health & Human Services
 Office for Civil Rights, Region V
 105 W. Adams Street, 16th Floor
 Chicago, IL 60603
 Phone: 312-886-2359

Ohio Legal Rights Services
50 W. Broad Street, Suite 1400
Columbus, OH 43215
Phone: 614-466-7264

ADAMHS Board of Montgomery County
(Alcohol, Drug Addiction & Mental Health Services)
409 E. Monument Ave., Ste. 102
Dayton, OH 45402-1226
Phone: 937-443-041
Client Rights: 937-853-4307

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CLIENT RECORDS

The confidentiality of alcohol and drug abuse client records maintained by this program is protected by Federal laws and regulations. Generally, the program may not disclose to a person outside of the program that a client attends the program, or disclose any information identifying a client as an alcohol and drug abuser/user unless:

- 1) The client consents in writing;
- 2) The disclosure is allowed by a court order, or
- 3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal laws and regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. §290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 C.F.R., Part 2 for Federal regulations.)



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COMPLAINT FORM

- 1) What is the name of the individual who has the complaint? _____

- 2) What is the social security number of the person named above? _____

- 3) What dates did this person participate in Early Intervention Program? _____

- 4) Who is filing this complaint on behalf of the person named above? _____

- 5) On what date did the incident or situation being complained about happen? _____

- 6) Approximately what time did the incident or situation happen? _____

- 7) Where did the incident or situation occur? _____

- 8) What is/are the name(s) of the person(s) who was/were involved in this incident or situation or was/were witness(es) to it? _____

- 9) Please describe the incident or situation that occurred: _____

Signature of person filing the complaint

Date of filing

Early Intervention Program (EIP)
Program Overview

Type of Program	# Hours Screening / Individual Contact	# Hours of AoD Education / Traffic Safety (Required: Not exceed a staff to client ratio of 1:48)	# Hours of Small Group (Required: Not exceed a staff to client ratio of 1:15)
72-Hour Program	1-Hour Required	15-Hours Required	5-Hours Required
	Pre-program Orientation/Screening = 2-Hours	Thurs. night = 3-Hours	Sat. morning = 2-Hours
	Thurs. night/Fri.day = .5-Hour	Fri. day = 8-Hours	Sat. afternoon = 1.5-Hours
	Sat. day = .5-Hour	Fri. Night = 3.25-Hours	Sat. night = 1.5-Hours
		Sat. day = 2.75-Hours	Sun. morning = 2-Hours
		Sat. night = 3.25-Hours	
		Sun. morning = 2.5-Hours	
		Sun. afternoon = 1-Hour	
		Plan: not exceed a staff to client ratio of 1:25	Plan: not exceed a staff to client ratio of 1:6-8
Totals:	3-Hours	23.75-Hours	7-Hours
48-Hour Program	1-Hour Required	10-Hours Required	5-Hours Required
	Pre-program Orientation/Screening = 2-Hours	Fri. Night = 3.25-Hours	Sat. morning = 2-Hours
	Thurs. night/Fri.day = .5-Hour	Sat. day = 2.75-Hours	Sat. afternoon = 1.5-Hours
	Sat. day = .5-Hour	Sat. night = 3.25-Hours	Sat. night = 1.5-Hours
		Sun. morning = 2.5-Hours	Sun. morning = 2-Hours
		Sun. afternoon = 1-Hour	
		Plan: not exceed a staff to client ratio of 1:25	Plan: not exceed a staff to client ratio of 1:6-8
Totals:	3-Hours	12.75-Hours	7-Hours

ATTENDANCE LOG / SIGN-IN SHEET / EDUCATION FORM

Program Date _____ Program Time _____

Please read and sign the following:

This is a residential (live-in) program. The court requires that we inspect your possessions for alcohol, other drugs, weapons, or other contraband. You have the right to refuse such an inspection. However, you will not be admitted to the program without such an inspection.

1.	_____	_____	14.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
2.	_____	_____	15.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
3.	_____	_____	16.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
4.	_____	_____	17.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
5.	_____	_____	18.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
6.	_____	_____	19.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
7.	_____	_____	20.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
8.	_____	_____	21.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
9.	_____	_____	22.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
10.	_____	_____	23.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
11.	_____	_____	24.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
12.	_____	_____	25.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name

ATTENDANCE LOG / SIGN-IN SHEET / SMALL GROUP

Program Date _____ Program Time _____

Please read and sign the following:

This is a residential (live-in) program. The court requires that we inspect your possessions for alcohol, other drugs, weapons, or other contraband. You have the right to refuse such an inspection. However, you will not be admitted to the program without such an inspection.

1.	_____	_____	9.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
2.	_____	_____	10.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
3.	_____	_____	11.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
4.	_____	_____	12.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
5.	_____	_____	13.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
6.	_____	_____	14.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
7.	_____	_____	15.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name
8.	_____	_____	16.	_____	_____
	Signature	Print Last Name		Signature	Print Last Name

Impaired Driving: Awareness
Discussion Questions / Answer Key

Summary:

Impaired Driving: Awareness takes a close-up view of impaired driving offenses and their widespread impact.

Based on the key elements of the nation's most widely replicated impaired driver education model, it integrates content that research has shown helps people change their drinking and driving behaviors. Viewers will hear how an impaired driving offender made changes to the behavior that led to his arrest and consider how they can turn a negative experience into an opportunity for change.

Discussion Questions:

1. Why am I here? What happened?
 - a. How many people get arrested for impaired driving in the U.S. per year?
More than 1.4 Million each year
 - b. How many times on average does a person drive impaired before getting pulled over?
300-2,000 times
 - c. How many 1st time offenders get arrested a 2nd or 3rd time?
1 out of 3
2. How do people change ~
 - a. Think about a change you made in your life ... How did you succeed?
 - b. Who helped you?
 - c. If you had a set back, how did you get back on track?
 - d. What does the change process and climbing a mountain have in common?
Takes time & effort; take breaks; use different/variety of skills

3. Alcohol, Other Drugs, Driving and You ...
 - a. How much alcohol impairs an individual's ability to drive safely?
Any amount, even small amounts can be dangerous! 1 drink = 12 oz. beer, 5 oz. glass of wine, 1.5 oz. shot glass of 80-proof liquor/whiskey has the same alcohol content; danger of super-sized drinks ... 1 drink can = 2 or 3!
 - b. What amount of alcohol is safe to consume and then drive?
None!
 - c. How is time a factor?
Takes 1-2 hours for the body to rid itself of the alcohol in one standard drink
 - d. What parts of the body get slowed down when consuming alcohol?
Alcohol is a depressant drug & slows down the body (response time) & mind ~ (central nervous system), judgment & reason are both affected ... even after 1 drink decisions can become poor & risky
4. Change vs. Consequences ...
 - a. What are some of the costs or losses you have experienced?
Towing, jail time, loss of driver's license, attorney fees, court costs, fines, loss time off from work, increase in insurance rates (SR-22 requirement), community service, loss time/impact on family/significant relationships, program costs & requirements, time, stress, etc.
 - b. Is it worth it to continue to drive impaired?
 - c. What will you do to keep yourself from getting in this situation again?

CHALK TALK ON ALCOHOL
Fr. Joseph C. Martin

Discussion Questions / Answer Key

Summary:

This no-nonsense guide to understanding and recovering from alcoholism provides new hope for alcoholics, their families, and friends. Hard-won experiences -- Father Martin is a recovering alcoholic -- underlies this thorough yet always clear presentation. *Chalk Talks* sheds new light upon the complex problems of alcoholism, which affects the mind, body, soul, and emotions. Father Martin does not preach or moralize, but remains practical in discussing attitudes toward, and reasons for, alcoholism; the physiological/psychological effects; health problems; symptoms; intervention; treatment and support; and where to turn for further information and assistance. *Chalk Talks* is not a scientific treatise but a message of hope to all persons concerned with America's number-one health problem.

Discussion Questions:

1. What are your attitudes about alcohol? About alcoholics?

Personal response ...

2. How many people are affected by one (1) individual who has an alcohol problem?

Four to six (4-6)

3. Where do our attitudes come from?

Family, culture, media ...

4. What are some of the reasons that people drink various beverages?

Curiosity, custom, conviviality (social), escape, pain management ...

5. In terms of chemistry, what is alcohol considered?

Solvent, stimulant (incorrectly), antiseptic, anesthetic, sedative drug

...

6. What parts of the brain are affected?

All!

ETHER vs. ALCOHOL

dryness of the throat

euphoria

excitement

intellect: judgment/reason

emotions

motor functions

nausea
pre-anesthesia
anesthesia
death

semi-voluntary functions
involuntary functions
vital functions
death

$$\frac{I}{E} + \text{drug} = \frac{E}{I}$$

7. What do parents have that they can give their children regarding decisions about the use of alcohol?

Healthy attitudes and positive values ...

8. What are some of the types of alcoholics? (parallels the six stages of drunkenness/intoxication)

Jocose = humorous, playful
Verbose = talkative, wordy
Bellicose = aggressive, hostile
unconscious

Morose = sullen, ill-tempered
Lachrymose = tearful, crying
Comatose = passed out,

9. What are some ways alcohol can cause death?

Alcohol poisoning, malnutrition, liver disease, cardiac problems, respiratory problems, accidents ...

10. What are some of the signs/symptoms of alcohol abuse?

Excessive drinking pattern = too much; disease of the mind

Blackouts, gulping/sneaking drinks, loss of control, alibi system, eye opener, drinking alone, change patterns/attempts to control or cut down, anti-social behavior, loss of friends/jobs/family, frequent visits to doctors/hospitals, drinking benders/binges, tremors, protecting the supply/hiding bottles, unreasonable resentments, nameless fears & anxieties, collapse of alibi system ...

11. If someone has a problem with alcohol, what are their choices?

Moment of truth ~ insanity of reasoning comes to an end, either surrender to:

- **Addiction = incarceration, insanity, death ...**
- **Help = treatment, ongoing support through a 12-Step Program like AA, NA, CA, CR (“I can’t, God can, I’ll let Him”) ...**



OMHAS_DIP Cklist_Par. (WW) (1-4)

6077 Far Hills Ave., #157 Centerville, OH 45459
 937-520-8496
 Kevin@ThreeOaksCenter.com
 ThreeOaksCenter.com

Early Intervention Program (EIP)

Traffic Safety Education

Remedial Driving Course Overview and Objectives

The course is designed around seven (7) individual instructional units. The units are designed to assist adult remedial students with updating their knowledge of current driving laws and to identify and correct errors and attitudes about driving that lead to poor driving records.

In order to be in compliance with the Ohio Department of Public Safety (ODPS), this remedial driving course providing traffic safety education is not to exceed an instructor to client ratio of 1:25.

Unit	Description	Time
1	<ul style="list-style-type: none"> • Introductions and general overview of the course objectives. • Pretest and general discussion of material covered 	8:00-8:45am :45
2	<ul style="list-style-type: none"> • Characteristics of good and bad drivers: <ul style="list-style-type: none"> ○ How driver attitude affects driving ○ Aggressive driving ○ Road rage ○ Distracted driving • Being physically and mentally ready to drive. 	8:45-9:30am :45
	Break	9:30-9:45am :15
	Video – Streets of Fury– and related group discussion	9:45-10:00am :15
3	<ul style="list-style-type: none"> • Safe driving Techniques. • Managing space, time and visibility to decrease driver errors. • Using SEE (search, evaluate, execute). • Intersections • Roundabouts • Sharing the roadway • Communicating with others 	10:00-10:45am :45

	Video – Roundabouts and Related Discussion	10:45-10:55am :10
	Video – Sharing the Road – and related discussion	10:55-11:10am :15
4	<ul style="list-style-type: none"> • Vehicle Technology Issues • Restraint systems • Handling vehicle emergencies • The dynamics of a car crash • What to do at the scene of a collision. 	11:10am-12:10pm :60
	Video – Car Crashes – It’s Basic Physics	
	Lunch Break	12:10-12:40pm :30
5	<p>Drugs and Alcohol</p> <ul style="list-style-type: none"> • Alcohol • Illegal drugs • Prescription drugs • Tolerance • The Synergistic Effect • DUI - The law and the consequences 	12:40-2:40pm 2 hrs (120 min)
	Video – Tragedy and Hope – And Related Group Discussion	2:40-3:00pm :20
	Video – Dead in Five Seconds – And Related Group Discussion	
	Break	3:00-3:15pm :15
6	<ul style="list-style-type: none"> • Financial Responsibility • Insurance requirements • SR22 bonds • Signs • Signals 	3:15-4:00pm :45

	<ul style="list-style-type: none"> Roadway Markings 	
7	<p>Driving Characteristics</p> <ul style="list-style-type: none"> City Rural Freeway Assessing and Adjusting Speed 	4:00-4:30pm :30
7	<p>Driving Characteristics (continued ...)</p> <ul style="list-style-type: none"> Braking and Negotiating Curves <p>Conclusion:</p> <ul style="list-style-type: none"> Final Exam / review incorrect answers Issue Certificates Sign Sheet 	4:30-5:00pm :30

Total 8 Hours (480 minutes)

***Provided by independent vendor Cognitians LLC, Dayton, OH**

THE SECRET WORLD OF RECOVERY VIEWERS GUIDE

From the Producers

When we needed help as a family struggling with alcoholism fifteen years ago, the stigma, and the lack of openness about the disease, made recovery difficult. Alcoholics and addicts were negatively portrayed in the media, and cultural challenges to recovery seemed insurmountable. We didn't know recovery was working for millions of families, and that life in recovery would bring us acceptance, compassion and joy we hadn't expected.

As filmmakers we wanted to show what recovery looks like, what it takes for families to heal. We wanted to normalize the concept of sober living and show that recovery isn't a punishment, or life without pleasure and laughter. The truth is recovery from alcoholism or addiction is like any hero's journey with its own set of challenges, setbacks, and soaring triumphs. Join us and meet the people who are changing their lives.

Faces & Voices of Recovery Study Guide:

For decades people with addiction and their loved ones have been exploited in the media as a source of voyeuristic fascination. We have labeled and discriminated against them, denying them access to care and life-saving support while keeping them in the dark about the solution—recovery.

Times have changed. More people are offering hope by telling their stories, speaking out to end discriminatory public policies and organizing to build supportive communities. There are also exciting new tools and voices available to address misconceptions. *The Secret World of Recovery* is one of those important new voices that take a unique, pragmatic approach to addressing one of the world's leading public health problems—addiction to alcohol and other drugs.

The story of real people in *The Secret World of Recovery* directly engages families, friends and neighbors, as well as policymakers and the media, in a much-needed dialogue. This documentary offers a framework for wider discussions to bring new understanding, create demand for improved policies, and help families and communities to heal. The Viewers' Guide is designed to encourage dialogue among a wide variety of audiences. Use the questions and topics to spur community discussion, aid in your own recovery, or to help those you love. And get inspired to advocate for the recovery cause.

OVERVIEW

Everyone knows someone—a family member, colleague, or friend—who has been challenged at one point or another by addiction. An unknown and surprising fact is that over 20 million Americans are in long-term recovery from addiction. That means that they have stopped using alcohol and other drugs, and are building new lives free from addiction. Recovery from addiction, however, is more than not using alcohol or other drugs. It is also restoring family life; getting a job or going back to school; finding safe and affordable places to live; receiving social and peer support; creating a sense of belonging—and regaining purpose.

The good news is there are many paths to recovery. Recovery can begin in a doctor's office, treatment center, church, prison, peer support meeting, or in one's own home. The journey can be guided by faith, spiritual experience or secular teachings. Recovery happens every day and there are many effective solutions.

At the same time, over 23 million Americans continue to struggle with addiction. In our society, too many end up in the criminal justice system. Of the 9 million people incarcerated at any one moment in the United States, 80% were arrested for crimes relating to their alcohol and drug problems. The vast majority of people in prison with alcohol and drug problems don't receive care while incarcerated. And for those who do receive care, there's very little help for them once they are released. But positive changes are coming. When the Affordable Care Act goes into effect in January 2014, millions of Americans for the first time will be eligible for addiction care in the health and criminal justice systems.

DISCUSSION QUESTIONS

1. 20 million Americans are in long-term recovery from addiction to alcohol and other drugs, why is the world of recovery so "Secret?" Why doesn't everyone know about it?
2. With so many people going to jail, why isn't there more public outcry demanding help for people to keep them out of the criminal justice system?

3. Media coverage focuses on the horrors of addiction and exploits the “downfall” of celebrities. Why is the story of the solution and the success of long-term recovery missing from the public discourse? Should we do something about it?
4. When people are struggling with addiction, why are they so often afraid to ask for help?
5. What would you say to someone you just found out was in recovery?

ISSUE: SAYING GOODBYE TO ADDICTION

It’s been said that recovery is a process and a journey, not an event. The growth and transformation that happens after people stop using alcohol and other drugs is a lifelong process. As people move forward in their recovery journey, they experience new opportunities, achievements, and lessons. Along with these come challenges and setbacks. During these times, they may need to seek out extra help and support. This often helps to secure their recovery and prevent relapse. Sustaining recovery requires cultivation, so that individuals don’t fall back into old ways or active addiction.

Scientists have confirmed what many people in recovery knew all along: addiction is a chronic condition. This means that, just like with other chronic conditions including heart disease, hypertension, and diabetes, there is not a cure that will make addiction go away completely. Addiction is a health condition that can be managed through a process of changing how people think, behave, and reassemble their lives. Most cannot do it alone, so they seek out others to help support and cultivate their recovery journey. Recovery doesn’t just automatically happen, it evolves and changes over time as people grow and mature.

DISCUSSION QUESTIONS

1. Have you ever heard the expressions “hitting bottom” or “denial” when talking about addiction? Do you think that people need to “hit bottom” before they can get help and recover?
2. Are there places in your community where people can go for help with alcohol and other drug problems? What about family members? Do people know about these places and what happens there?
3. What do you say to people who tell you that they believe addiction is a moral weakness and issue, not a health condition?
4. Why is it important for people seeking, or in, recovery to be able to talk with and work with people who are also no longer using alcohol or other drugs?
5. Are there other health conditions where people have trouble managing a chronic illness?

ISSUE: SOBER LIVING

Once someone stops using alcohol and other drugs, there’s a whole new world to navigate on their recovery journey. For many, a diverse network of community-based, mutual aid support has helped them find and maintain recovery.

Many communities have embraced recovery-supporting institutions and programs, like recovery residences, sober living homes and recovery community centers, where alcohol and other drugfree activities that are open to the community are held and recovery support services are delivered. Recovery high schools and collegiate recovery programs are places where young people can continue their education and receive support. Young people in recovery are building new social lives in a culture that often revolves around the use of alcohol and other drugs.

DISCUSSION QUESTIONS

1. What difference does it make if someone stops drinking and drugging as a teenager or as an adult?
2. Why do you think neighborhood residents would object to having people who are no longer using alcohol or other drugs living in their neighborhood?
3. How does your high school, community college or college support young people in recovery?

4. Does your community host recovery celebrations/have “First Night” and other alcohol and drug-free events that welcome families?
5. What would you say to friends or family seeking advice about intervention or help. What steps should people take to address the problem?

ISSUE: FAMILY COMPONENT

There is a diverse network of community-based, mutual aid support available to family members, who need help understanding what their child/partner/spouse/parent has been doing to get well and to learn about how to take care of themselves and build new lives. Every family is different. In most cases, relationships will change, as everyone seeks and develops new ways to live. Because approximately one-third of Americans continue to view addiction as a sign of lack of will power or self-control, increasing family members’ understanding of addiction as a chronic health condition from which people can and do recover helps them on their recovery journey.

DISCUSSION QUESTIONS

1. How important is it for family members to get help while a loved one is struggling with addiction or is in recovery?
2. Should parents change how they socialize if a teenager is in recovery?
3. Do you know families who talk about their recovery journey together, and to friends, openly?
4. Do you know employers who are supportive of family members whose children/parents/spouses/partners are struggling with addiction?
5. Are addiction and recovery subjects that people should feel comfortable talking about in the workplace, at school, in church, or around the dinner table at home?

ISSUE: HEALTHY LIVING

For people in or seeking recovery, some health problems develop naturally, because they have the same health and wellness concerns as everyone else. In addition, they may face other health conditions that come up either as a result of their addiction or of low health literacy or self-care like neglecting sleep, nutrition, basic hygiene, and dental needs as well as having HIV or Hepatitis C. Some people don’t or didn’t have a doctor and only went to emergency rooms in a crisis. Healthy eating, physical activity and restful sleep are important parts of overall health. Connecting socially, having supportive people to share experiences with, giving back and belonging to a community play a major role in initiating and sustaining recovery.

DISCUSSION QUESTIONS

1. Why is being of service to others an important component of the recovery journey for many people?
2. Can a person’s attitude about healthy eating and physical activity make a difference for people in recovery?
3. Why do so many people in active addiction end up in emergency rooms?
4. Have you heard it said that people in recovery substitute one addiction for another? What does that mean? Are all addictions bad?
5. Is it possible to have fun in recovery?

ISSUE: AWARENESS AND CELEBRATION

Across the country there’s a growing network of community-based organizations and individuals who are speaking out publicly about recovery, advocating for improved public policies and offering recovery support services. They are offering hope to individuals and families who are still struggling as well as letting elected and appointed officials know that there is a solution to addiction and that resources need to be invested to help people get and stay well.

They are also advocating for the right to effective, respectful, nondiscriminatory care when needed in the health and criminal justice systems. Each September is National Recovery Month, when people in recovery, family members and allies organize and attend walks, rallies and public awareness events across the nation and the world.

Knowing and understanding public attitudes toward people with addiction and people in longterm recovery is important to inform education and awareness campaigns. In public opinion research two-thirds of the public revealed that they believe that a stigma exists toward people in recovery from addiction to alcohol and other drugs. Overwhelming majorities said that discrimination against people in recovery is a problem.

Not surprisingly, language matters. In a recent survey of health professionals, researchers found that changing the words used to describe someone struggling with alcoholism or drug addiction may significantly alter the attitudes of health care professionals, even those who specialize in addiction treatment. They found that reducing the use of stigmatizing terms could help diminish the shame, guilt and embarrassment that act as barriers, keeping people from seeking help.

DISCUSSION QUESTIONS

1. Are there people in your community who are public about their or a family members' recovery from addiction?
2. Can media—social media, news, and entertainment, be tool for social change around perception of sober living and addiction Why don't more people talk about their addiction and recovery? What can you do in your community to raise awareness about and advocate for recovery?
3. Is your school or office supportive of people who are receiving treatment or in recovery? Do people know where to go for help at work or school?
4. Do you think public attitudes toward people with addiction will change because addiction will be covered like any other health condition under the Affordable Care Act?

20/20: A DEADLY DRUNK DRIVING ACCIDENT**DISCUSSION QUESTIONS WITH ANSWER KEY**

Jessica Rasdall killed her best friend, Laura Gorman, when she crashed her car while driving drunk after a night of partying in 2006. In the three years since that fateful night, Rasdall has confessed her crime to more than 15,000 people, both young and old, in a speech that never varies, describing the minute details of that tragic night. Rasdall's story is a cautionary tale of love and loss, of overwhelming regret and remorse.

Even as she tries to atone for what happened, she faces accusations of hypocrisy from the Gorman family, who say that her public speaking is merely an attempt to win leniency from the courts. She also has been accused of a pattern of dangerous behavior, of having mixed alcohol and driving in the past. Is she telling her story to save other teens, or is it a calculated speech to save herself from prison?

Discussion Questions

(Answers are provided in bold below each question)

1. How often do people die as the result of someone's impaired driving?
**Every 40 minutes in the U.S., 36 per day, 13,000 per year!
Most of them are teenagers ...**
2. If an individual drives while impaired, and their driving results in taking a life, causing a death, should they be punished? Why or why not?
3. Do you think Jessica Rasdall is sincere in her speeches regarding the incident? Why or why not?
4. Put yourself in the place of Laura Gorman's dad and mom: Do you think justice was served in this case? Why or why not?

HOME RUN:**DISCUSSION QUESTIONS WITH ANSWER KEY****Summary:**

Baseball all-star Cory Brand knows what it takes to win in the big leagues. But off the field, with memories of his past haunting him, his life is spiraling out of control. Hoping to save her client's career and reputation after a DUI and a team suspension, Cory's agent sends him back to the small town where he grew up. Forced to coach the local youth baseball team and spend eight weeks in the only recovery program in town, Cory can't wait to return to his old life as quickly as possible. As his young players help him experience the joy of the game, Cory discovers his need to find freedom from his past and hope for his future ... and win back the love he left behind. With this unexpected second chance, Cory finds himself on a powerful journey of transformation and redemption.

Discussion Questions:

1. How was Cory's life spiraling out of control? How can you relate to this? Similarities / Differences?

Increased drinking, hiding alcohol, intoxicated at work, lots of unresolved anger, increased violent behavior, more risk-taking behaviors, driving drunk, negative attitudes, blaming others, unresolved issues from the past, car crash injuring self & brother, legal problems, financial problems ... personal answer ...

2. What was Cory's "wake up call?" Consequences? How do you identify with this?

Accident with brother, DWI, suspension from baseball, fines, donation to Young Life, community service, 12-Step program/Celebrate Recovery ... personal answer ...

3. What was the turning point for Cory?

"I can't make myself stop ..." He asked for help, called J.T. from Celebrate Recovery ...

4. What does this quote mean to you: "Nothing great happens when you hold back."

Need to completely surrender to the new direction you want to take in life ...

5. What is it going to take for you to have a "second chance" and write your own "new story?" **(Personal answer)**

28 DAYS:**DISCUSSION QUESTIONS WITH ANSWER KEY****Summary**

Gwen Cummings (Sandra Bullock), a successful N.Y. journalist and ultimate party girl, loves to have a good time! Trouble is, she never can tell when she's had enough. When she borrows her sister's (Elizabeth Perkins) wedding limo and plows it into someone's front porch, the wild life she shares with her boyfriend, Jasper (Dominic West), comes to a screeching halt. She earns herself a DUI and a 28-day stretch in rehab. There, she faces an unthinkable set of rules (no cell phones!) and some strange rituals, like chanting and (gulp!) sharing her feelings. Joining up with an eccentric group of fellow rehabbers led by the inimitable Counselor Cornell (Steve Buscemi), Gwen embarks on a touching and often hilarious road to recovery where she learns that life is not always a party and that real happiness comes from within.

Discussion Questions

(Answers are provided in bold below each question)

1. What is Gwen's idea of a "good time?" How do you identify with her in this regard?
Drinking excessively, using drugs, partying ...
2. How does her idea of a "good time" turn out for her?
Arrives drunk and late for her sister's wedding, makes an embarrassing toast at the wedding reception, dancing drunk & knocks over wedding cake table, steals limo, crashes limo into a house, gets DWI, gets arrested, has to go to rehab. for 28 days ...
3. As Gwen begins rehab., what are some attitudes, emotions, and behaviors you observe about her? Which ones have you personally experienced?
Anger, blaming, denial, hatred, justifying, minimizing, projecting, rationalizing, resistance, running away emotionally, stuffing ...
4. What was the turning point for Gwen?
Admits she needs help & that she can't do it alone; connects her past to her present & makes decisions about her future ...
5. What decisions did Gwen make after rehab. to support her recovery?
Decided that she needed to make changes regarding people, places, & things in her life ... broke up with boyfriend Jasper, stop hanging out with using friends at using locations, went to buy a plant ...

Celebrate Recovery: Dayton, Ohio Area Meetings

Monday 7:00 pm-----→

Fairhaven Church Multipurpose Activity Center (MAC)

Contact: Jim Futrell
637 East Whipp Road
Centerville, OH 45459
937.434.8627
jfutrell@fairhavenchurch.org
www.fairhavenchurch.org

Light Dinner @ 6:30 pm
Large Group @ 7:00 pm
Nursery – Infants, Toddlers, Preschoolers
Celebration Place – Kindergarten – 5th Grade
Small Groups @ 8:00 pm
Men's Addictions
Men's Anger & Co-Dependency
Men's Sexual Issues
Women's Addictions
Women in a relationship with a sexually addicted man
Women's Co-Dependency #1
Women's Co-Dependency #2
Women Survivors of Abuse & Co-Dependency
Men's Step Studies (call for schedule)
Women's Step Studies (call for schedule)

Monday 7:00 pm-----→

First Christian Church of Huber Heights

The Forge (across parking lot from main bldg.)
Contact: Mike Lawson
6114 Fishburg Road
Huber Heights, OH 45424
cr@fcch.org
www.fcch.org

Celebration Café @ 6:15 pm
Large Group @ 7:00 pm
Small Groups @ 8:00 pm
Child Care Provided: 6:45 – 9:15 pm @ the church
The Landing: 6th – 12th Grade Students

Tuesday 7:00 pm-----→

Assembly of God Church – Gym

Contact: Herb Hutchinson
2250 E. Stroop Road
Kettering, OH 45429
937.298.6221
herbedi@netscape.com
www.ketteringag.com

Large Group @ 7:00 pm
Small Groups @ 8:00 pm
Childcare – ages 10 & under
Men's Group – Hurts, Hang-ups, Habits
Women's Group – Hurts, Hang-ups, Habits

Wednesday 7:00 pm-----→

Riverside Church of the Nazarene

Contact: Jason McCauley
2552 Bushnell Avenue
Dayton, OH 45404
937.372.0708
jasonmccauley@xenianaz.org
www.riversidenaz.org

Community Meal @ 6:00 pm
Large Group @ 7:00 pm

Wednesday 7:00 pm-----→

First Church of Christ

Contact: Wayne Kersey
441 Ledbetter Road
Xenia, OH 45385
937.372.7687
CR@fccxenia.org
www.fccxenia.org

Meal @ 5:45 pm
Large Group @ 6:30 pm
Small Group @ 7:30 pm

Thursday 7:00 pm-----→

Linden Avenue Baptist Church

Contact: Holly Lewis
101 Linden Avenue

Large Group @ 7:00 pm
Small Group @ 8:00 pm

Dayton, OH 45403
937.902.1656
hollylewis76@yahoo.com
www.lindenavebaptistchurch.org

Friday 6:30 pm----->

Patterson Park Church

Contact: Dan Sietman
3655 East Patterson Road
Beavercreek, OH 45430
937.427.0130
dsietman@pattersonpark.org
bobwheeler1654@gmail.com
www.pattersonpark.org

Fellowship & Refreshments @ 6:30 pm
Large Group @ 7:00 pm
Child Care: up to 10 years old
Pre-teen/Teen Group: ages 10 & older
Newcomer's Group (as needed)
Men's Substance Abuse Group
Men's Other Issues Group
Women's Substance Abuse Group
Women's Family of Addicts Group
Women's Other Issues Group
Dessert Fellowship 9-9:30 pm

Friday 7:00 pm----->

Upper Room Worship Center

Contacts: Greg & Patty Simmons
648 North Hyatt Street
Tipp City, OH 45371
937.667.5585
pastorg@theur.net
www.theur.net

Men's Group
Women's Group

Dayton Area Christian Recovery Meetings

Monday 6:30 pm
A House of Prayer (AHOP)
Freedom Church
 Contact: Greg Delaney
 282 Stelton Road
 Xenia, OH 45385
 937.372.1600, ext. 106
gdelaney8@yahoo.com
www.ahopxenia.com

Monday 7:00 pm
SouthBrook Christian Church
Recovery Ministry
Men's & Women's 12 Step Groups
Men's Group
 Contact: J.R. Eaton, 937.361.3594
Women's Group
 Contact: Chris Eaton, 937.287.9595
 9095 Washington Church Road
 Miamisburg, OH 45342
 937.435.9966
paul.wilkens@southbrook.org
www.southbrook.org

Tuesday 7:30 pm
Ginghamsburg Church -
Fort McKinley Campus
Bondage Breakers, Room 201
 Contact: Jon Morgan
 3721 West Siebenthaler Avenue
 Dayton, OH 45415
 937.277.7484
jmorgan@ginghamsburg.org
www.ginghamsburg.org

Tuesday 6:30 pm
New Hope Church
Family Christian 12 Step - Cafe
 Contact: Jeff Cartwright
 536 Xenia Ave.
 Dayton, OH 45410
 937. 253-7551
www.newhopedayton.org

Thursday 7:00 pm
SouthBrook Christian Church
Next Step Recovery Discussion Group

Contact: Jeff Lett
 9095 Washington Church Road
 Miamisburg, OH 45342
 937.901.0874
paul.wilkens@southbrook.org
www.southbrook.org

Saturday Salvation 6:30 pm
Salvation Army A.R.C.
A.A. Open Discussion Meeting
 865 South Patterson Boulevard
 Dayton, OH 45402
 937.461.2769
www.satruck.com/rehabilitation-program

Saturday 7:00 pm
SouthBrook Christian Church
Men's Sexual Purity Group
 Contact: J.R. Eaton, 937.361.3594
Women's Discussion Group
 Contact: Chris Eaton, 937.287.9595
 9095 Washington Church Road
 Miamisburg, OH 45342
 937.435.9966
paul.wilkens@southbrook.org
www.southbrook.org

Saturday 7:00 pm
Ginghamsburg Church - Main Campus
Next Step Recovery Worship Celebration
 Contact: Mike Martin
 6759 South County Road 25A
 Tipp City, OH 45371-2468
 937.667.1069
nextstep@ginghamsburg.org
www.ginghamsburg.org

Faith & Spirituality: Biblical Understanding of Foundations, Attachments, and Responsibilities (Participant's Handout)

Foundations: What is the foundation of your life?

Improper Foundations

Proper Foundation

Attachments: What are your attachments?

Idolatrous False Attachments Leading to Slavery

Healthy True Attachments Leading to Freedom

Responsibilities: How do you face personal responsibility/responsibilities?

Backward to Repair

Forward to Rebuild

Conclusion

**Faith & Spirituality: Biblical Understanding Of Foundations, Attachments, And Responsibilities
(Presenter's Notes)**

Foundations: What is the foundation of your life?

- Bldg. motif > footings and foundations (i.e. supporting groundwork, permanence, strength)

Improper Foundations – Matthew 7:24-27

- Sand – foolishness, false (i.e. empty/hollow profession, going through the motions, intrinsic blockages & barriers; choose a false substitute—an idol—a disorientation creating movement away from God).
- Rock – wisdom, true (i.e. genuine relationship from the heart; surrender & subjection to Christ. The concept of heart in Scripture refers to the totality of one's inner life—emotional, intellectual, psychological, and volitional—which directs the trajectory of one's life. The difficulty in the heart of humanity concerns desire. It always describes the inner motivation rather than focusing on the object of desire/urge/passion).
- In summary, Scripture contrasts a solid foundation with an unstable one. The solid foundation is built upon wisdom from and obedience to God and is marked by true discipleship, which flows out of a genuine relationship with and subjection to Jesus Christ. The unstable foundation is built upon the foolishness of disobedience to God and is marked by a false discipleship, which flows out of no relationship with God. The unstable foundation allows the individual to live in subjection to oneself and whatever idol he or she chooses to place at the center life.

Proper Foundation

A proper foundation has God as its architect (Prov. 8:29-31; Heb. 11:10).

- God expresses the fullness of His righteousness in the context of covenantal relationship, a connection that calls humanity into alignment with God's will through the vehicle of obedience—an impossibility without a proper foundation.
- VanVonderen, Ryan, and Ryan illustrate the consequences of a lack of a solid spiritual foundation: “No one sets out to build a spiritual house on sand. Rather than building on the stable rock of God's love and grace, many build on the unstable soil of fear and shame. When self-reliance and religious striving are driven by fear and shame, one's life shows predictable patterns of spiritual dysfunction.”²¹⁶
- Ultimately, the development of a proper foundation entails growth in one's capacity to receive God's love and grace, “these gifts of love and grace are not for us only. They are given to us so that we can pass them on through the spiritual disciplines of forgiveness and service.”²¹⁷ With the establishment of firm foundation rooted in right relationship with God, one's attention shifts can focus on attachments.

Attachments: What are your attachments?

- Having the foundation of one's life firmly established in right relationship with God, one must also make a thorough examination of one's attachments. Paul issues a warning about one's attachments: “Those who weep or who rejoice or who buy things should not be absorbed by their weeping or their joy or their possessions. Those who use the things of the world should not become attached to them. For this world as we know it will soon pass away. I want you to be free from the concerns of this life” (1 Cor. 7:30-32a, NLT).
- In other words, attachments to anything outside of a relationship with God that becomes the central focus of one's life can become an idol—an unchecked desire that forms a stumbling block and leads to disconnection or sin (separation from God and others; Ezek. 14:4-5; Gal. 5:19-21).
- Idolatry parallels addiction because it sets up a false attachment. Addiction often intersects with the ideas of disconnection and disorientation. Addiction contributes to disconnection and disorientation due to the disloyalty and disinclination of one's heart and entire life away from centralization in God.

²¹⁶ Jeffrey VanVonderen, Dale Ryan, and Juanita Ryan, *Soul Repair: Rebuilding Your Spiritual Life* (Colorado Springs, CO: InterVarsity Press Books, 2008), 10-12.

²¹⁷ Idib., 174-175.

- Addiction presents a spiritual sense or basis to the understanding of attachments. Don Williams affirms this perspective: “If we do not worship the living God, we will worship someone or something else. Compulsivity is not simply biologically or psychologically driven; it is a spiritual issue. Stuffing chemicals or passions or people into it will never ultimately satisfy. The Bible says we become like what we worship (Jer. 2:5; Hos. 9:10).”²¹⁸ Human beings worship the focus of their attachments.
- Tim Clinton and Joshua Straub add, “Researchers are finding that we have a system built into the very fabric of our DNA that explains the longing every one of us has for meaning and purpose greater than ourselves—a longing that usually comes alive in times of crisis.”²¹⁹
- Clinton and Straub report: “New research described in the neurobiological and psychological literature is now suggesting that we have a ‘Seeking System’ experienced as restlessness, longing, or an unformed need state—a thirsting for God—that is both a conscious and an unconscious process that has roots in development, leading to an object-seeking relationship with a Transcendent One.”²²⁰
- At some point in everyone’s life, whether amidst a crisis of faith or at some other juncture, each person will face the need for something beyond one’s self.

***Clients complete “Discovering Your Attachment Style” followed by discussion...

Idolatrous False Attachments Leading to Slavery

- False spirituality occurs when one lives in loyalty to an idol that takes God’s rightful place as the center and focus of one’s life.
- In creating false attachments, loyalty disintegrates into disloyalty, one’s true identity in God fragments into a false identity, and one’s disorientation leads to other wrongdoing or sin.
- False attachments come because of rebellion against God; they serve as a replacement of the true God with gods—idols, if you will, who fail miserably in comparison to the God who loves humanity and provides for its redemption and reconciliation.
- In the midst of one’s crisis of faith, each individual retains the power to choose one’s allegiance or attachment. The good news that Paul declares to his hearers champions God as the source of the effectual power to choose.

Healthy True Attachments Leading to Freedom

- The healthiest attachment is one’s attachment to the Creator God who hardwired humanity to connect in relationships, especially to the One who created them. Healthy true attachments lead to freedom.
- Paul addresses the issues of slavery to sin, obedience from the heart, and freedom as slaves of righteousness, resulting in sanctification (Rom. 6:17-19). Paul implies freedom from sin requires obedience to God from the heart. A person’s slavery transitions from destructive sin to righteousness—or right living—as he or she yields to God’s power, released by the Holy Spirit. One must first get free from the negative influences of sin.
- 2 Pet. 2:19 ... The New Living Translation renders the last part of this verse, “For you are a slave to whatever controls you,” while the God’s Word translation renders the phrase as, “A person is a slave to whatever he gives in to.” Peter provides astute clarity: individuals become slaves of destructive habits when they become attached to something other than God. In turn, this misappropriated attachment conquers or controls them because they give in to or yield to its power rather than embracing God’s power.
- A right relationship with God, plus right attachments in one’s life, produces right living.

²¹⁸ Don Williams, *12 Steps with Jesus: How Filling the Spiritual Emptiness in Your Life Can Help You Break Free from Addiction* (Ventura, CA: Regal Books, 2004), 26.

²¹⁹ Tim Clinton and Joshua Straub, *God Attachment: Why You Believe, Act, and Feel the Way You Do About God* (New York: Howard Books, 2010), 33.

²²⁰ *Ibid.*, 43.

- In other words, whatever an individual chooses to serve becomes the central focus of one's life; whatever one focuses on, grows. If an individual has a right relationship with God, attaches to biblical principles that support and deepen that relationship, an abundant and full life follows in this life as well as in eternity.
- Therefore, a right relationship with God, plus healthy attachments and implementation of God's principles, yields right living.
- Conversely, false attachments and a focus on wrongdoing or sin produce slavery.
- The connection between addiction and attachment lies in what one chooses to do with his or her desires. Gerald G. May offers an interesting perspective: "While repression stifles desire, addiction attaches desire, bonds and enslaves the energy of desire to certain specific behaviors, things, or people. The word attachment has long been used by spiritual traditions to describe this process. It comes from the old French *attaché*, meaning 'nailed to.' Attachment 'nails' our desire to specific objects and creates addiction."²²¹
- Addiction, as used by May, attaches desire to whatever human beings allow as the intrinsic locus of control for living. May continues to explain: "Addiction exists wherever persons are internally compelled to give energy to things that are not their true desires. To define it directly, addiction is a state of compulsion, obsession, or preoccupation that enslaves a person's will and desire. Addiction sidetracks and eclipses the energy of our deepest, truest desire for love and goodness. We succumb because the energy of our desire becomes attached, nailed, to specific behaviors, objects, or people. Attachment, then, is the process that enslaves desire and creates the state of addiction."²²²
- Giving in to false desires—a substitute for our true deepest desires—can lead to an addictive process in one's life.
- Getting free from addiction as bondage to sin does not imply that one can simply choose to stop (like some might imply). A person cannot overcome addictions through willpower alone. Surrendering one's will to God and inviting God to release His power into one's life provides the pathway for God's grace to create the freedom from bondage that one cannot achieve through mere human effort.
- Freedom from sin and true life in Christ only occurs as an individual appropriates God's free gift of salvation. In order to maximize the freedom from bondage that Christ provides, one must seriously consider the role of responsibilities.

Responsibilities: How do you face personal responsibility/responsibilities?

- After establishing a solid foundation built upon the bedrock of a right relationship with God and guarding the attachments of one's heart to ensure continuance in that sacred relationship, an individual must take responsibility for all the issues in his or her life. With the rise of the disease model of addiction, taking responsibility for one's choices often gets blamed on the disease. Ultimately, a person must guard his or her heart and take full responsibility for personal actions. Before moving forward into the rebuilding process, an individual must look backward to repair the broken areas of one's life.

Backward to Repair

- King David penned one of the most powerful reflections of a contrite sinner's prayer for pardon and forgiveness in all of Scripture. Nathan the prophet confronted David, who murdered Uriah and committed adultery with Uriah's wife, Bathsheba (2 Sam. 12:1-15). Later, upon reflection, David writes, "Be gracious to me, O God, according to Your loving kindness; According to the greatness of Your compassion blot out my transgressions. Wash me thoroughly from my iniquity and cleanse me from my sin" (Ps. 51:1-2).
- God desires to heal the brokenness caused by sin; a repentant heart and a moldable will are necessary ingredients in this healing process, as humanity cannot achieve this healing without God's involvement.

²²¹ Gerald G. May, *Addiction and Grace: Love and Spirituality in the Healing of Addictions* (New York, NY: Harper One, 2007), 3.

²²² *Ibid.*, 14.

- Brokenness, a contrite heart, and humility, together with a repentant heart and a moldable will, comprise the necessary elements for repairing the damage wrought by sin in one's life. David models the components of good repair work: a broken and contrite heart, humility, personal confession, and repentance.
- As clearly stated in James 1:13-15, sin comes as a result of giving in to temptation: "Let no one say when he is tempted, 'I am being tempted by God;' for God cannot be tempted by evil, and He Himself does not tempt anyone. But each one is tempted when he is carried away and enticed by his own lust. Then when lust has conceived, it gives birth to sin; and when sin is accomplished, it brings forth death." God does not tempt people to do evil, but rather temptations come as a result of what is in each individual's heart.
- The propensity toward sin flows from what comprises one's heart. David recognized the wickedness of his own heart and repeatedly prayed for God to search his heart: "Put me on trial, Lord, and cross-examine me. Test my motives and my heart" (Ps. 26:2), and "Search me, O God, and know my heart; test me and know my anxious thoughts" (139:23). The wisdom literature encourages individuals to "Keep your heart with all diligence, for out of it spring the issues of life" (Prov. 4:23). When one does not guard the heart, desires arise that either provide the opportunity to move towards God or away from God.
- Desires urge one toward wrongdoing or sin, especially when coupled with one's own will and choice to move away from God.
- Assuming personal responsibility for wrongdoing or sin serves as a crucial step toward healing.
- The repair work requires each individual to take responsibility for his or her condition of living as one who is morally and spiritually bankrupt and invest one's life in a faith relationship with Jesus Christ.

Forward to Rebuild

- Having looked backward to repair, one can move forward to rebuild. In Ephesians 2:4-10, Paul vividly contrast humanity's condition prior to a relation with God as having moved from being "dead in transgressions" to being "alive together with Christ." The new believer, because of God's mercy and compassion, is saved by grace (Eph. 2:4-7).
- The most important part of the repair process is repairing one's broken relationship with God, damaged by sin and healed by the provision of Christ's substitutionary death on the cross—the most incredible expression of God's love evidenced through the attributes of mercy, compassion, and grace.
- Salvation is by grace, as Paul admonishes: "For by grace you have been saved through faith; and that not of yourselves, it is the gift of God; not as a result of works, so that no one may boast. For we are His workmanship, created in Christ Jesus for good works, which God prepared beforehand so that we would walk in them" (Eph. 2:8-10).
- Clearly, salvation is a gift from God that a person cannot earn and does not deserve; consequently, God alone receives the credit—the glory and praise (Eph. 1:4-14).
- In summary, the basis of salvation is God's grace most clearly demonstrated through Christ's sacrifice on the cross and commensurate resurrection. In this act, Christ purchased humanity's deliverance from the power of sin and death, and infused humanity with resurrection power and new life.
- In Galatians 5:1, 13, Paul provides a solemn warning: "It was for freedom that Christ set us free; therefore keep standing firm and do not be subject again to a yoke of slavery ... For you were called to freedom, brethren; only do not turn your freedom into an opportunity for the flesh, but through love serve one another."
- Thus, the rebuilding process includes both a release *from* something—from sin—to something, a new freedom in love to serve others.
- The rebuilding process means making a transition from living as slaves, serving the brokenness of sin, to living as bond slaves, serving the One who is the "light of the world" (John 8:12) and "the way, the truth, and the life" (John 14:6).
- The biblical process of transitioning from slavery to sin toward slavery to Christ is through repentance ... biblical repentance includes turning from sin and turning to God.

- Borrowing from the dynamics of mission therapy, repentance involves four stages. Howard Clinebell identifies these stages as “crisis, preparation, surrender-acceptance, and consolidation.”²²³ Often crisis serves as the catalyst to move one towards the need for repentance. God prepares humanity through the circumstances of life, which can lead to surrender-acceptance if one chooses, resulting in consolidation of renewed heart and mind with right living (or God-produced righteousness).
- As slaves of Christ, believers should serve one another out of love (Gal. 5:13b).
- In the rebuilding process, one must take personal responsibility for engaging in a transformational journey that leads to a deep abiding faith in God, resulting in a new trajectory away from the brokenness of sin toward the abundant life promised by God for all followers of Jesus Christ (John 10:10).

***Clients complete the “Reinert S-Scale” followed by discussion ...

Conclusion

- A strong Judeo-Christian faith, yielding a close connection to God in the person of Jesus Christ, is imperative in the healing of addictions. Separation from God comes as a result of sin. When separated from God, humanity yields to evil, thereby producing increased brokenness that flows from sin.
- The necessary healing of addictions begins by replacing improper foundations with proper foundations. An orientation toward wrongdoing produces false attachments leading to greater slavery to sin. However, an orientation toward God, through the vehicle of a right relationship with God, produces healthy true attachments leading to freedom.
- In order to maximize the freedom from bondage that Christ provides, one must seriously consider the role of responsibilities. The importance of having a solid foundation built upon the bedrock of a right relationship with God, along with guarding the attachments of one’s heart to ensure continuance in that sacred relationship includes the necessity of taking responsibility for all the issues in one’s life. It is imperative to guard one’s heart and take full responsibility for all of one’s actions and relationships—including a look backwards with a view to repair damage, followed by moving forward to rebuild by journeying through the steps of true biblical repentance—once a commitment to such a process dominates daily living, a person can experience a transformed trajectory for life.
- Invitation to Prayer for freedom!

²²³ Howard Clinebell, *Understanding and Counseling Persons with Alcohol, Drug, and Behavioral Addicts: Counseling for Recovery and Prevention Using Psychology and Religion*, rev. and enl. ed. (Nashville: Abingdon Press, 1984), 176.

Discovering Your Attachment Style Questionnaire²²⁴

It's helpful to think about relationship styles as four distinct categories, and it's natural to ask, "What style am I?" In reality, however, only some people are clearly just one relationship style. Most folks are different shades of all four styles. You may, for instance, discover that you are predominantly one style, but that you have a few traits from each of the other three styles.

It is also important to note that your relationship style can change depending on the relationship you are in. In fact, your relationship style is not always in operation. It appears only in more intimate relationships, such as close friendships and romantic relationships. But your style with your best same-sex friends can be different from your style in your romantic relationships. Also, your style can change as a relationship changes.

Despite all that we've just said, the following survey can help you get to know yourself a little better. As you take the survey, consider how you typically feel about and relate to people you're in relationship with. We know it's tempting to answer these questions according to how you *would like* to relate to people rather than how you *actually do* relate. So you must really work at being honest with yourself as you read through the checklists.

Circle the numbers next to those statements that generally describe you. Go with your first instinct; don't overthink the statements.

The Avoidance Attachment Style

1. I don't like sharing my feelings with others.
2. I don't like it when my partner wants to talk about his/her feelings.
3. I have a hard time understanding how other people feel.
4. When I get stressed, I try to deal with the situation all by myself.
5. My partner often complains that I don't like to talk about how I feel.
6. I don't really need close relationships.
7. I highly value my independence and self-sufficiency.
8. I don't worry about being alone or abandoned.
9. I don't worry about being accepted by others.
10. I tend to value personal achievements and success over close, intimate relationships.

The Anxious Attachment Style

1. I really like sharing my feelings with my partner, but he/she does not seem as open as I am.
2. My feelings can get out of control very quickly.
3. I worry about being alone.
4. I worry about being abandoned in close relationships.
5. My partner complains that I am too clingy and too emotional.
6. I strongly desire to be very intimate with people.
7. In my closest relationships, the other person doesn't seem as desirous of intimacy and closeness as I am.
8. I worry a great deal about being rejected by others.
9. I tend to value close, intimate relationships over personal achievement and success.
10. When I get stressed, I desperately seek others for support, but no one seems as available as I would like them to be.

The Fearful Attachment Style

1. My feelings are very confusing to me, so I try not to feel them.
2. My feelings are very intense and overwhelming.
3. I feel torn between wanting to be close to others and wanting to pull away.
4. My partner complains that sometimes I'm really needy and clingy and other times I'm distant and aloof.

²²⁴ Tim Clinton and Joshua Straub, *God Attachment: Why You Believe, Act, and Feel the Way You Do About God* (New York, NY: Howard Books, 2010), 79-82. Used with author's permission.

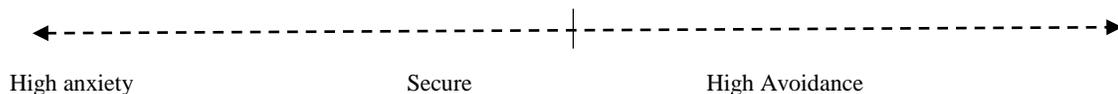
5. I have a difficult time letting others get close to me, but once I let them in, I worry about being abandoned or rejected.
6. I feel very vulnerable in close relationships.
7. Sometimes I feel very disconnected from myself and my feelings.
8. I can't decide whether or not I want to be in close relationships.
9. Other people can really hurt you if you let them get too close.
10. Close relationships are difficult to come by because people tend to be unpredictable in their actions and behaviors.

The Secure Attachment Style

1. I find it easy to share my feelings with people I'm close to.
2. I like it when my partner wants to share his/her feelings with me.
3. I am comfortable getting close to others, but I also feel comfortable being alone.
4. I expect my partner to respect who I am.
5. I expect my partner to respond to my needs in a sensitive and appropriate way.
6. Building intimacy in relationships come relatively easy to me.
7. I let myself feel my emotions, but I'm rarely, if ever, overwhelmed by them.
8. I am able to understand and respond sensitively to my partner's feelings.
9. I do a decent job balancing my need for intimacy with my need for achievement and success.
10. When I am stressed, I feel comfortable seeking comfort from my partner and/or close friends.

Now that you've finished the survey, note the distribution of your circled numbers. What styles do you exhibit two or three traits from? Does one style emerge as dominant? What about your results, if anything, surprised you?

CONSIDER THIS: What relationship style do you see yourself fitting into? On the continuum of anxiousness and avoidance below, place an X on where you see yourself. How has your relationship style affected the way you interact with those you love? Your spouse? Your children? Your closest friends? God?



HIGH ANXIETY: Highly preoccupied about abandonment; extremely anxious in relationships

HIGH AVOIDANCE: Highly avoidant in relationships, overly self-reliant, downplay intimacy

Visit www.Godattachmentbook.com for a message on your specific relationship style.

Reinert S-Scale

Instructions: In each of the following pairs of attitudes, choose the one that you MOST AGREE with. Mark your answer by writing EITHER A or B in the space provided. Only mark ONE ANSWER for each attitude pair, and please DO NOT skip any items.

- 1) A If a few key people would change, I would be a lot happier.
B I need to change some things about myself if I am going to be happier.
- 2) A I know some people who could make an effort to understand me better.
B There are times when I could make an effort to understand other people better.
- 3) A I have not changed very much over the years.
B I am more peaceful now than I used to be.
- 4) A I have good reasons when I am very critical with others.
B Sometimes I have been disappointed in myself for being very critical with others.
- 5) A I tend to adjust fairly easily to an unexpected change in my plans.
B I tend to get frustrated or upset when I have to unexpectedly change my plans.
- 6) A A God is probably actively involved in the events of the world.
B A God is probably not involved in the events of the world.
- 7) A I have made sense of life for myself.
B Life itself has meaning which I discover.
- 8) A The advances that the world has seen in past years make the future look promising.
B Anyone can see that the world is in a more hopeless condition than it was years ago.
- 9) A I tend to accept life as it is.
B I tend to struggle with life.
- 10) A Some things in my life are beyond my control.
B I am the one who is in control of my life.
- 11) A I don't think things bother me as much now as they used to.
B I don't think anyone realizes the stress I am under.
- 12) A People can do anything they want, provided they don't hurt others.
B When people hurt themselves, they affect the rest of us also.
- 13) A I take some time in my schedule to relax or play.
B So many people count on me that I do not have time to relax or play.
- 14) A When I feel lonely, I find that I need someone to talk to.
B When I feel lonely, I find that I am strong enough to handle it by myself.
- 15) A If I feel inferior, I have lost sight of my positive qualities.
B If I feel inferior, I remind myself that I am superior to others.
- 16) A I am less critical of myself now than I used to be.
B I tend to be very critical of myself.
- 17) A Not everything has a logical explanation, so I do some things on faith.
B There is a logical explanation for everything, so I have a reason for everything I do.

- 18) A I have gone through some pain and suffering; I have grown because of it.
B I have gone through some pain and suffering; I have emotional scars to prove it.
- 19) A I deserve all the fun and excitement I can get.
B I am willing to give up some of my fun and excitement to help someone with a problem.

Place an (X) near the answer that is closer to your experience.

- 20) I have had a spiritual experience which changed my life.
True _____ False _____ Don't know _____
- 21) I have surrendered my life to a purpose much bigger than myself.
True _____ False _____ Don't know _____
- 22) I have had an experience that made me feel like everything was going to be okay.
True _____ False _____ Don't know _____
- 23) I have gone through serious crises which have changed me for the better.
True _____ False _____ Don't know _____
- 24) It is important for me to be in control of the events of my daily life.
True _____ False _____ Don't know _____
- 25) I believe I need to relate to a power outside myself in order to manage my life.
True _____ False _____ Don't know _____

Thank you for your interest in surrender scale, Reinert S Scale. Our psychometric studies suggest that the 25-item scale is the best version to date.²²⁵

Score in the surrender direction (1 point) these items marked "A":
Items: 5, 6, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18

Score in the surrender direction (1 point) these items marked "B":
Items: 1, 2, 3, 4, 7, 12, 19

Score in the surrender direction (1 point) these items marked "True"
(score any other answer 0):
Items: 20, 21, 22, 23, 25

Score in the surrender direction (1 point) these items marked "False"
(score any other answer 0):
Item: 24

One point is given for each item marked in the surrender direction. The total score on the instrument is the sum of the responses in the surrender direction.

²²⁵ Duane F. Reinert, "The Surrender Scale: Reliability Factor Structure, and Validity," *Alcohol Treatment Quarterly* 15, vol. 3 (1997): 15-32. Used with author's permission.



6077 Far Hills Ave., #157 Centerville, OH 45459
 937-520-8496
 Kevin@ThreeOaksCenter.com
 ThreeOaksCenter.com

**EARLY INTERVENTION PROGRAM
 CERTIFICATE OF COMPLETION**

This is to certify that _____ has
 successfully met all requirements for completion of the Early Intervention Program (EIP).

The Early Intervention Program staff has made the following recommendations for additional
 service: _____

I understand that these recommendations will be reported to the court/judge that referred me
 to the Early Intervention Program.

Client _____
 Counselor _____
 Counselor _____
 Date _____

Distribution: Original Certificate to Client



OMHAS_DIP Cklist_Par. (MM) (1)

6077 Lar Hills Ave., #157 Centerville, OH 45459
937 520 8496
Kevin@ThreeOaksCenter.com
ThreeOaksCenter.com

**AUTHORIZATION TO DISCLOSE
CLIENT INFORMATION**

Date:
Client Name: Date of Birth:

The following program(s) is authorized to: Disclose Receive Exchange information as noted below

Program Authorized to Make Disclosure:

Authorized Individual / Organization to Whom Disclosure is Made:

Referral Source:

to coordinate treatment to gather assessment information for treatment planning
 to gather information for ongoing treatment Other:

Type of Information to be Disclosed:

progress notes diagnostic assessment information lab results HIV/AIDS testing or status diagnosis
 progress in treatment urine testing attendance information on mental illness and/or treatment
 prenatal care pregnancy testing Other:

Amount of Information to be Disclosed:

information covering the previous three months information covering the most recent admission
 Other:

 Signature of Client or Other authorized person to permit disclosure Date

 Signature of Staff or Witness Date

Revocation: This authorization is subject to written revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it.

I hereby revoke consent: _____
 Signature of Client or Other authorized person to permit disclosure Date

 Signature of Staff or Witness Date

This authorization expires (specify event, date, and/or condition)

Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. Drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R., parts 160 and 164. [These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.]



OMHAS_DIP Cklist_Par. (MM) (3)

6077 Far Hills Ave., #157 Centerville, OH 45459
 937 520 8496
 Kevin@ThreeOaksCenter.com
 ThreeOaksCenter.com

**CRIMINAL JUSTICE RELEASE
 OF CONFIDENTIAL INFORMATION:
 CRIMINAL JUSTICE SYSTEM REFERRAL**

Name of Agency:

I, hereby consent to communication between AoD program
(Name of client/defendant)

and
(Alcohol/Drug Treatment Program) (Court, probation, parole and/or referring agency)

The purpose of and need for the disclosure is to inform the criminal justice agency(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and

I understand that this consent will remain in effect and cannot be revoked by me until: there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

(Specify other time when consent can be revoked and/or expires)

I also understand that any disclosure made is bound by the federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records [42 U.S.C 290dd-2; 42 C.F.R. Part 2] and that recipients of this information may re-disclose it only in connection with their official duties.

[Signature of defendant/client]
Date

[Signature of parent, guardian, or authorized representative if required]
Date

REPORT TO REFERRAL SOURCE POLICY PROCEDURE
TOCI-Organization-Wide Policy

PURPOSE:

To provide a description of the process for sending a report to the court or a client's referral source in the Early Intervention Program (which includes the Driver Intervention Program) of Three Oaks Center, Inc. (TOCI).

POLICY:

The process for sending a report to the court or a client's referral source shall include, at a minimum, the following:

1. Results of two screening instruments and screening interview.
2. Observations of the client during screening, client education on alcohol and drug abuse and addiction group sessions.
3. Recommendations for additional services.

PROCEDURE:

A completed release of information form, properly executed with the client, shall be obtained prior to releasing any report. Each disclosure made with the client's written consent must be consistent with 42 C.F.R., Part 2, by including the following written statement: "This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R., Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient."

DEPARTMENTS AFFECTED:	All TOCI Departments
DATE OF ORIGIN:	02/10/15
APPROVED BY:	Board of Directors (April 2015)
EFFECTIVE DATE:	05/01/15



**48 HOUR RESIDENTIAL EIP
COMPLETION REPORT**

THREE OAKS CENTER, INC.
6077 Far Hills Ave., #157 Centerville, OH 45459
937-520-8496
Kevin@ThreeOaksCenter.com
ThreeOaksCenter.com

THREE OAKS CENTER, INC.

Client Name: _____		
Dates client attended: _____		
The person named in this report participated in at least 16 hours of alcohol and drug addiction programming that included at a minimum: ___ hour of screening and individual contact ___ hours of client education on alcohol and drug abuse and addiction including traffic safety education ___ hours of small group discussion		
A screening interview was conducted with the client named above in which the results of the screening instruments, recommendations and referrals made to the referring court were discussed <div style="text-align: center;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div>		
Summary of client's participation:		
_____ _____ _____ _____		
Results and Recommendations of the screenings:		
_____ _____ _____ _____		
Disclosure of information form attached?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Referrals made to alcohol and drug addiction treatment programs and any referrals made to other organizations:		
_____ _____ _____		
Recommendations made to court or other organization:		
_____ _____ _____		
Dated signature and credentials of staff making recommendations		

FAX COVER SHEET

From Three Oaks Center, Inc.

**Confidential Health
Information Enclosed**

Health Care Information is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the client or under circumstances that do not require client authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional client consent or as permitted by law is prohibited. Unauthorized redisclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

Date: _____ Pages: ___ (including cover page)

To: _____ FAX: _____
Phone: _____

From: Kevin R. Hoffman, President; D.Min.
cand., LICSW (retired),
LCDC-II, ICADC FAX: 937-428-5821
Phone: 937-520-8496
Email: Kevin@ThreeOaksCenter.com
Web: ThreeOaksCenter.com

Address: 6077 Far Hills Ave., #157
Centerville, OH 45459

RE: _____ Comments: _____

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you have received this message by error, please notify us immediately and destroy the related message.

From Three Oaks Center, Inc.

A very
juicy fax.



Date:	Pages: ___ (including cover page)
To:	FAX: Phone:
From: Kevin R. Hoffman, President; D.Min. cand., LICSW (retired), LCDC-II, ICADC	FAX: 937-428-5821 Phone: 937-520-8496 Email: Kevin@ThreeOaksCenter.com Web: ThreeOaksCenter.com
	Address: 6077 Far Hills Ave., #157 Centerville, OH 45459
RE:	Comments:

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message by error, please notify us immediately and destroy the related message.

If you do not receive all of these pages, please call 937-520-8496.



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 937-520-8496
 Kevin@ThreeOaksCenter.com
 ThreeOaksCenter.com

Early Intervention Program (EIP): Personnel Acknowledgement

Name of Program:

Employee **Contract Staff** **Volunteer**

Name:

- Yes No I have received and agree to abide by federal regulations on confidentiality of AoD abuse patient records (42 CFR, Part 2).
- Yes No I have received and agree to abide by the EIP's personnel policies and procedures.
- Yes No I have received and agree to abide by the EIP's client abuse/neglect policy.
- Yes No I have received and agree to abide by the EIP's client rights policy.
- Yes No I have received and agree to abide by the EIP's client grievance procedure.
- Yes No I have received and agree to abide by the EIP's instructions on fire evacuation procedures for the program site.

 Signed By

Date

Early Intervention Program (EIP) Group Documentation Sheet

Group One (Introduction / Legal / Financial)

Client Participation: _____

Staff Signature: _____

Date/Time: _____

Group Two (Physical / Medical / Vocational / Educational)

Client Participation: _____

Staff Signature: _____

Date/Time: _____

Group Three (Family / Recreational / Relational / Social / Mental / Spiritual)

Client Participation: _____

Staff Signature: _____

Date/Time: _____

Group Four (Plan)

Client Participation: _____

Staff Signature: _____

Date/Time: _____

BOARDWORK

Legal

Financial

Physical / Medical

Vocational / Educational

Family

**Recreational / Relational
Social**

Mental / Spiritual

Degree of Severity / Admission (ASAM) Criteria

Identify the specific criteria in each dimension relative to the client. A client must meet Four of Six Dimensions for any specific Level of Care (or a higher level of care) in order to be referred to that Level of Care.		
Levels of Care	Criteria	
Acute Intoxication		
Non-Intensive Outpatient Treatment	<input type="checkbox"/> -No need for detox, Low risk of withdrawal, Medical management not required.	
Intensive Outpatient Treatment	<input type="checkbox"/> -Low to moderate withdrawal risk, Medical management not required	
Day Treatment	<input type="checkbox"/> -Low to moderate withdrawal risk, not at high risk for severe withdrawal	
Non-Medical Community Residential Treatment	<input type="checkbox"/> - Low to moderate withdrawal risk, 24-hour medical management not needed	
Medical Community Residential Treatment	<input type="checkbox"/> -Moderate risk of severe withdrawal, Needs medical monitoring 24 hours per day	
Ambulatory Detoxification	<input type="checkbox"/> -Detoxification can be conducted on an outpatient basis, Withdrawal symptoms are severe, medication or monitoring can be conducted outpatient	
23-Hour Observation Bed	<input type="checkbox"/> -Moderate to high risk of severe withdrawal, requires daily medical management, has used substances in past two weeks.	
Sub-Acute Care	<input type="checkbox"/> -Serious risk of severe withdrawal, requires daily medical management and monitoring	
Acute Hospital Detoxification	<input type="checkbox"/> -Serious risk of withdrawal, requires inpatient medical management, other symptoms require hospital setting.	
Biomedical Conditions / Complications		
Non-Intensive Outpatient Treatment	<input type="checkbox"/> -No BMC/C beyond capacity of milieu, BMC/C stable and do not distract from treatment.	
Intensive Outpatient Treatment	<input type="checkbox"/> -BMC/C are being addressed, BMC/C do not interfere with treatment	
Day Treatment	<input type="checkbox"/> -BMC/C low to moderate, professional supervision is needed, BMC/C do not require daily medical monitoring.	
Non-Medical Community Residential Treatment	<input type="checkbox"/> -BMC/C minimal to moderate, BMC/C do not require 24 hour medical monitoring, BMC/C are being addressed.	
Medical Community Residential Treatment	<input type="checkbox"/> -BMC/C requires 24 hour medical monitoring, BMC/C can be addressed at this level.	
Ambulatory Detoxification	<input type="checkbox"/> -Health seriously damaged by addiction, BMC/C can be safely monitored at this level.	
23-Hour Observation Bed	<input type="checkbox"/> -Moderate BMC/C, Sustained medical management required, Close medical management required, BMC/C could interfere with treatment in the absence of treatment and medical management.	
Sub-Acute Care	<input type="checkbox"/> -BMC/C or pregnancy needs medical monitoring for detox, Recurring seizures require medical care, other complications require medical care.	
Acute Hospital Detoxification	<input type="checkbox"/> - BMC/C or pregnancy needs medical stabilization and treatment, Recurring seizures require medical management, other complications require medical treatment.	
Emotional / Behavioral / Cognitive Conditions / Complications		
Non-Intensive Outpatient Treatment	<input type="checkbox"/> -No EBC/C, Some EBC/C but does not interfere with treatment, Cognitive impairment, non-interfering with treatment and minimal risk of harm to self or others.	
Intensive Outpatient Treatment	<input type="checkbox"/> -Low to moderate conditions, EBC/C can be addressed at this level, Not at risk to harm self or others.	
Day Treatment	<input type="checkbox"/> -EBC/C do not interfere with treatment in this level, Co-existing disorders do not require 24 hour treatment.	
Non-Medical Community Residential Treatment	<input type="checkbox"/> -EBC/C do not interfere with treatment in this level, Co-existing disorders do not require 24 hour treatment.	
Medical Community Residential Treatment	<input type="checkbox"/> -EBC/C do not interfere with treatment, EBC/C are moderate to high and require 24 hour structured treatment, Requires residential treatment to manage EBC/C.	
Ambulatory Detoxification	<input type="checkbox"/> -EBC/C do not interfere with treatment, EBC/C interferes with recovery, treatment referral after detoxification required, EBC/C are a problem and can be monitored at this level.	
23-Hour Observation Bed	<input type="checkbox"/> -EBC/C do not interfere with treatment, EBC/C requires sustained medical management, EBC/C requires additional medical evaluation before disposition plan can be made.	
Sub-Acute Care	<input type="checkbox"/> -EBC/C unstable, structured monitoring needed, Cognitive impairment needs 24 hour monitoring, Potential for harm to self or others, Mental confusion requires monitoring, Other EBC/C; post detoxification treatment required.	
Acute Hospital Detoxification	<input type="checkbox"/> -EBC/C requires medical assessment and treatment, Stabilization and medical treatment needed, High risk behaviors, potential harm to self or others, Other conditions require medical management	

Treatment Acceptance Resistance		
Non-Intensive Outpatient Treatment	<input type="checkbox"/>	-Aware of problem, willing to engage in treatment, Resistant but can be motivated to engage in treatment.
Intensive Outpatient Treatment	<input type="checkbox"/>	-Resistance requires structured treatment, Intensive clinical treatment needed to motivate client for treatment.
Day Treatment	<input type="checkbox"/>	-Denial/Resistance requires intense structured treatment, Client motivated for treatment.
Non-Medical Community Residential Treatment	<input type="checkbox"/>	-Motivated to receive structured treatment 24 hours per day, Moderate resistance to treatment requires motivation 24 hours per day.
Medical Community Residential Treatment	<input type="checkbox"/>	- Motivated to receive structured treatment 24 hours per day, Moderate resistance to treatment requires motivation 24 hours per day, History of non-compliance at a less intensive level of care.
Ambulatory Detoxification	<input type="checkbox"/>	-Minimal awareness of addiction, treatment referral after detoxification is required, potential to be motivated if additional interventions are provided.
23-Hour Observation Bed	<input type="checkbox"/>	- Resistance to treatment, requires medical treatment for acute addiction symptoms, Acceptance, resistance requires additional evaluation and medical supervision.
Sub-Acute Care	<input type="checkbox"/>	- Minimal awareness of addiction, treatment referral after detox required, some awareness of addiction, yet requires intensive inpatient intervention.
Acute Hospital Detoxification	<input type="checkbox"/>	- Acute crisis, referral after detoxification required, Resisted treatment at lower level of care, Some awareness of addiction, but intensive interventions needed.
Relapse Potential		
Non-Intensive Outpatient Treatment	<input type="checkbox"/>	-Moderate to high risk without treatment, Low relapse potential
Intensive Outpatient Treatment	<input type="checkbox"/>	-Moderate to high relapse risk without treatment, close monitoring needed to prevent relapse.
Day Treatment	<input type="checkbox"/>	-Moderate to high relapse risk without Day Tx, Client has history of relapse in a less structured setting.
Non-Medical Community Residential Treatment	<input type="checkbox"/>	-Moderate to high risk without 24 hour treatment, Client has history of relapse in less intensive level of care.
Medical Community Residential Treatment	<input type="checkbox"/>	-Moderate to high risk without 24 hour supervision, Client has history of relapse in a less intensive level of care.
Ambulatory Detoxification	<input type="checkbox"/>	-Acute addiction crisis, no immediate recovery potential without treatment referral after detoxification, History of repeated complicated detoxifications.
23-Hour Observation Bed	<input type="checkbox"/>	-Symptoms require immediate medical management in a structured setting, Relapse potential requires medical evaluation and management.
Sub-Acute Care	<input type="checkbox"/>	-Acute addiction crisis, needs treatment to prevent relapse, has a history of relapse.
Acute Hospital Detoxification	<input type="checkbox"/>	-Acute addiction crisis requires immediate treatment, History of relapse at a lower level of care.
Recovery Environment		
Non-Intensive Outpatient Treatment	<input type="checkbox"/>	-Supportive environment, Has access to peer and social support, Treatment will help client cope with environment, Environment does not interfere with treatment at this level.
Intensive Outpatient Treatment	<input type="checkbox"/>	-Environment supportive, Needs regular reinforcement to cope with environment, Environment not supportive, Treatment can increase coping skills.
Day Treatment	<input type="checkbox"/>	-Environment interfering with Tx progress, needs structured tx, Environment unstable, ongoing reinforcement needed.
Non-Medical Community Residential Treatment	<input type="checkbox"/>	-Environment does not support recovery, Environment has deteriorated; 24 hours per day residential treatment is required immediately.
Medical Community Residential Treatment	<input type="checkbox"/>	-Environment does not support recovery, Environment has deteriorated and 24 hour stabilization is necessary, No means of developing a support system.
Ambulatory Detoxification	<input type="checkbox"/>	-Environment stable, supportive, can follow detoxification regimen on outpatient basis, Environment poor for recovery, yet is able to cope at this level.
23-Hour Observation Bed	<input type="checkbox"/>	-Environment not supportive of recovery, needs stabilization elsewhere, Diagnostic evaluation indicates a need to remove client from environment.
Sub-Acute Care	<input type="checkbox"/>	-(Not applicable for this Level of Care)
Acute Hospital Detoxification	<input type="checkbox"/>	-(Not applicable for this Level of Care)
Summary	Number of Dimensions	Indicate Appropriate Level of Care
Non-Intensive Outpatient Treatment		<input type="checkbox"/> Non-Intensive Outpatient Treatment
Intensive Outpatient Treatment		<input type="checkbox"/> Intensive Outpatient Treatment
Day Treatment		<input type="checkbox"/> Day Treatment
Non-Medical Community Residential Treatment		<input type="checkbox"/> Non-Medical Community Residential Treatment
Medical Community Residential Treatment		<input type="checkbox"/> Medical Community Residential Treatment
Ambulatory Detoxification		<input type="checkbox"/> Ambulatory Detoxification
23-Hour Observation Bed		<input type="checkbox"/> 23-Hour Observation Bed
Sub-Acute Care		<input type="checkbox"/> Sub-Acute Care
Acute Hospital Detoxification		<input type="checkbox"/> Acute Hospital Detoxification



OMHAS_DIP Cklist_Par. (Q) (6) and (R) (4)

6077 Far Hills Ave., #157 Centerville, OH 45459
 937-520-8496
 Kevin@ThreeOaksCenter.com
 ThreeOaksCenter.com

CLIENT EVALUATION FORM

Counselor Names: _____ and _____

This questionnaire will help us improve the Early Intervention Program. There is no right or wrong answers. Please do not write your name on this form. Please answer all items. Place your completed survey in the box marked "Satisfaction Surveys" located on the table at the back of the meeting room.

1. Do you think the program was easily accessible?
 Very Accessible Accessible Somewhat Accessible Not at all accessible
2. Did you attend the
 72-Hour Program (Thursday – Sunday) 48-Hour Program (Friday – Sunday)
3. Was this the first time you completed the Early Intervention Program?
 Yes No If no, how many times have you completed the program? _____
4. What is your current age? _____
5. Which best describes you?
 African-American Asian Native American Caucasian Other
6. Think about your counselor. Did he/she seem to demonstrate an appropriate amount of respect and understanding for the ethnic and cultural diversity and sensibilities of the program participants?
 Very Competent Competent Incompetent Very Incompetent
7. Did you think that your counselor was interested in you as a person?
 Very Interested Interested Somewhat Interested Didn't seem to care
8. How appropriate and helpful do you think the following activities were in helping you examine your alcohol consumption or use of other mood altering substances?
 Group Sessions: Very Helpful Helpful Somewhat Helpful Not at all Helpful
 The Movies: Very Helpful Helpful Somewhat Helpful Not at all Helpful
 The Lectures: Very Helpful Helpful Somewhat Helpful Not at all Helpful
 Celebrate Recovery: Very Helpful Helpful Somewhat Helpful Not at all Helpful
 Individual Sessions: Very Helpful Helpful Somewhat Helpful Not at all Helpful
9. How satisfied were you with your meals?
 Very Satisfied Somewhat Satisfied Somewhat Dissatisfied Dissatisfied
10. How satisfied were you with your room accommodations?
 Very Satisfied Somewhat Satisfied Somewhat Dissatisfied Dissatisfied

11. Did you feel safe at the program?

Yes Somewhat No

12. How would you describe EIPs personnel?

Courteous Helpful Did not Care Domineering

13. How clear do you think the instructions given by the staff were?

Clear Somewhat Clear Somewhat Confusing Very Confusing

14. Did the program help you learn anything about yourself?

A Lot Some A Little Nothing

15. Did the program help you learn anything about alcohol/drug abuse?

A Lot Some A Little Nothing

16. Did this program change your way of thinking when it comes to drinking/using and driving?

A Lot Some A Little Nothing

17. Did this program have an effect on whether you will drink/use and drive in the future?

A Lot Some A Little Nothing

18. All things considered, do you think the program was worthwhile?

Very Worthwhile Worthwhile Somewhat Worthwhile Not Worthwhile

19. Would you recommend the program to someone who might have a problem?

Definitely Probably Not Sure Definitely Not

20. Do you think that you will be in touch with any agency or program in the future about getting some more assistance/support?

Definitely Probably Not Sure Definitely Not

21. Please tell us how you think we might improve this program? Do you have any additional comments or suggestions?



Alcohol Use Disorder: A Comparison Between DSM-IV and DSM-5

In May 2013, the American Psychiatric Association issued the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). Although there is considerable overlap between DSM-5 and DSM-IV, the prior edition, there are several important differences:

Changes Disorder Terminology

- » DSM-IV described two distinct disorders, alcohol abuse and alcohol dependence, with specific criteria for each.
- » DSM-5 integrates the two DSM-IV disorders, alcohol abuse and alcohol dependence, into a single disorder called alcohol use disorder (AUD) with mild, moderate, and severe sub-classifications.

Changes Diagnostic Thresholds

- » Under DSM-IV, the diagnostic criteria for abuse and dependence were distinct: anyone meeting one or more of the “abuse” criteria (see items 1 through 4) within a 12-month period would receive the “abuse” diagnosis. Anyone with three or more of the “dependence” criteria (see items 5 through 11) during the same 12-month period would receive a “dependence” diagnosis.
- » Under DSM-5, anyone meeting any two of the 11 criteria during the same 12-month period would receive a diagnosis of AUD. The severity of an AUD—mild, moderate, or severe—is based on the number of criteria met.

Removes Criterion

- » DSM-5 eliminates legal problems as a criterion.

Adds Criterion

- » DSM-5 adds craving as a criterion for an AUD diagnosis. It was not included in DSM-IV.

Revises Some Descriptions

- » DSM-5 modifies some of the criteria descriptions with updated language.

DSM History and Background

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) initially developed out of a need to collect statistical information about mental disorders in the United States. The first attempt to collect information on mental health began in the 1840 census. By the 1880 census, the Bureau of the Census had developed seven categories of mental illness. In 1917, the Bureau of the Census began collecting uniform statistics from mental hospitals across the country.

Not long afterwards, the American Psychiatric Association and the New York Academy of Medicine collaborated to produce a “nationally acceptable psychiatric nomenclature” for diagnosing patients with severe psychiatric and neurological disorders. After World War I, the Army and Veterans Administration broadened the nomenclature to include disorders affecting veterans.

In 1952, the American Psychiatric Association Committee on Nomenclature and Statistics published the first edition of the *Diagnostic and Statistical Manual: Mental Disorders* (DSM-I). The DSM-I included a glossary describing diagnostic categories and included an emphasis on how to use the manual for making clinical diagnoses. The DSM-II, which was very similar to the DSM-I, was published in 1968. The DSM-III, published in 1980, introduced several innovations, including explicit diagnostic criteria for the various disorders, that are now a recognizable feature of the DSM. A 1987 revision to the DSM-III, called the DSM-III-R, clarified some of these criteria and also addressed inconsistencies in the diagnostic system. A comprehensive review of the scientific literature strengthened the empirical basis of the next edition, the DSM-IV, which was published in 1994. The DSM-IV-TR, a revision published in 2000, provided additional information on diagnosis. Since 1952, each subsequent edition of the DSM aimed to improve clinicians’ ability to understand and diagnose a wide range of conditions.



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National Institute on Alcohol Abuse and Alcoholism
www.niaaa.nih.gov • 301.443.3860

A Comparison Between DSM-IV and DSM-5

DSM-IV		DSM-5	
In the past year, have you:		In the past year, have you:	
Any 1 = ALCOHOL ABUSE	Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?	1	Had times when you ended up drinking more, or longer, than you intended?
	More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?	2	More than once wanted to cut down or stop drinking, or tried to, but couldn't?
	More than once gotten arrested, been held at a police station, or had other legal problems because of your drinking? **This is not included in DSM-5**	3	Spent a lot of time drinking? Or being sick or getting over other aftereffects?
	Continued to drink even though it was causing trouble with your family or friends?	4	Wanted a drink so badly you couldn't think of anything else? **This is new to DSM-5**
Any 3 = ALCOHOL DEPENDENCE	Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?	5	Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?
	Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?	6	Continued to drink even though it was causing trouble with your family or friends?
	Had times when you ended up drinking more, or longer, than you intended?	7	Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?
	More than once wanted to cut down or stop drinking, or tried to, but couldn't?	8	More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?
	Spent a lot of time drinking? Or being sick or getting over other aftereffects?	9	Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?
	Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?	10	Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?
	Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?	11	Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?
		<p>The presence of at least 2 of these symptoms indicates an Alcohol Use Disorder (AUD).</p> <p>The severity of the AUD is defined as:</p> <p>Mild: The presence of 2 to 3 symptoms</p> <p>Moderate: The presence of 4 to 5 symptoms</p> <p>Severe: The presence of 6 or more symptoms</p>	



Six Dimensions of Multidimensional Assessment²²⁶

AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT		
ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:		
1	DIMENSION 1	Acute Intoxication and/or Withdrawal Potential Exploring an individual's past and current experiences of substance use and withdrawal
2	DIMENSION 2	Biomedical Conditions and Complications Exploring an individual's health history and current physical condition
3	DIMENSION 3	Emotional, Behavioral, or Cognitive Conditions and Complications Exploring an individual's thoughts, emotions, and mental health issues
4	DIMENSION 4	Readiness to Change Exploring an individual's readiness and interest in changing
5	DIMENSION 5	Relapse, Continued Use, or Continued Problem Potential Exploring an individual's unique relationship with relapse or continued use or problems
6	DIMENSION 6	Recovery/Living Environment Exploring an individual's recovery or living situation, and the surrounding people, places, and things

²²⁶ American Society of Addiction Medicine, "How ASAM Criteria Works," ASAM.org, accessed December 12, 2015, <http://www.asam.org/publications/the-asam-criteria/about>.



DUSI-R™

Drug Use Screening Inventory–Revised®

The DUSI-R™ (Drug Use Screening Inventory - Revised ©) is a 159 - item questionnaire that quantifies ten domains of psychosocial health. It can be administered by computerized web based self-report. Administration of the Inventory to individuals whose literacy is below the fifth grade level is not recommended. The DUSI-R takes approximately 20 minutes to complete.

Measurement Domains

The DUSI-R evaluates adjustment in 10 domains, measuring severity of disturbances that precede and co-occur with alcohol and drug use. In addition, the DUSI-R provides screening and prediction of 6 Mental Health Disorders, 8 Adverse Outcomes, and has a validity (Lie) scale that gauges honesty.

Domain IA	Drug & Alcohol Use Frequency	Frequency of use of 20 substances
Domain IB	Substance Use	Degree of Involvement, Severity of Consequences
Domain II	Behaviour Pattern	Social Isolation, Anger, Acting Out, Self-control
Domain III	Health Status	Accidents, Injuries, Illnesses
Domain IV	Psychiatric Disorder	Anxiety, Depression, Antisociality, Psychotic Symptoms
Domain V	Social Competence	Social Interactions, Social Skills, Refusal Skills
Domain VI	Family System	Dysfunction, Conflict, Parental Supervision, Marital Agility
Domain VII	School Performance	Academic Performance, School Adjustment
Domain VIII	Work Adjustment	Work Competence, Motivation
Domain IX	Peer Relationship	Social Network, Gang Involvement, Quality of Friendships
Domain X	Leisure/Recreation	Quality of Activities During Leisure Time

Screening & Prediction of Mental Health Disorders: Attention Deficit/Hyperactivity Disorder, Conduct Disorder (up to age 16), Antisocial Personality Disorder, Depression Disorder, Anxiety Disorder, Substance Use Disorder.

Prediction of Adverse Outcomes: head injury, treatment for injury after a fight, sexually transmitted disease, giving someone drugs for sex, driving under the influence, car accident while alcohol or drugs in system, sell or deal drugs.

1

¹ YourHealthCheck.org, “DUSI-R Handout,” accessed December 14, 2015, <http://www.yourhealthcheck.org/sites/default/files/docs/DUSI-R%20Brochure.pdf>; Your HealthCheck.org, “Instrument Summaries,” accessed December 14, 2015, <http://www.yourhealthcheck.org/sites/default/files/docs/DUSI-R%20SAMHSA%20Listing.pdf>; YourHealthCheck.org, “Drug Use Screening Inventory (revised), (DUSI-R),” accessed December 14, 2015, http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/InstrumentPDFs/32_DUSI-R.pdf.

Scoring of the DUSI-R

Two profiles are obtained: (1) Absolute Problem Density Profile, and, (2) Relative Problem Density Profile.

Absolute Problem Density Profile

Scoring Procedure: Each Domain yields an Absolute Problem Density score. The score for each domain is calculated by counting the number of endorsements (“yes” responses) and dividing this value by the number of items in the domain. The resulting quotient is then multiplied by 100 to obtain the Absolute Problem Density score for the domain. The Lie Score items in each domain are not included when computing these scores. The range of scores that could be obtained is between 0–100%.

Example: There are 20 items in Domain VII (School Performance). The number of “yes” responses by the client for items 23 – 49 is “X”. The following formula is used to compute the absolute problem density score:

$$\frac{X}{20} \times 100 = \text{_____}\%$$

Overall Problem Density Index - This index reflects the general severity of adjustment over all domains.

Divide the total number of “yes” responses obtained in the whole inventory by the total number of items in all domains used (normally the Work Adjustment domain will not apply to youth, the School Performance domain will not apply to adults). Multiply the quotient by 100. The Lie Scale items in each domain are not included when calculating these scores. The range of scores that could be obtained is between 0 - 100%.

Relative Problem Density Profile

After calculating the Absolute Problem Density scores, the following procedure is used to calculate the Relative Problem Density score for each domain. The resulting profile reflects the proportional severity of adjustment. It describes each client’s unique configuration of adjustment.

Scoring Procedure: Count the total number of “yes” responses (with the exception of the Lie Scale) obtained in the whole inventory. This number is the denominator in all subsequent calculations. The numerator is the number of “yes” responses (not counting the Lie Scale) in each domain. Obtain the quotient for the domain and multiply it by 100. The same procedure is performed for all domains used (normally Work domain will not apply to youth, School domain will not apply to adults). The sum of all Relative Problem Density scores is 100%.

Lie Score

The score on the Lie Scale is determined by counting the number of no responses to the last item in each domain. The range of scores on this scale is between 0 and 10.

A score of 5 or higher should alert the examiner to possible invalidity of results due to deliberate deception by the client. These 10 items are not used in calculating the Absolute and Relative Problem Density scores.



Interpreting the DUSI-R

DUSI-R scores reflect gradations of severity. Consequently, cut-off scores for evaluation are not provided. Consideration for intervention should be made in the context of all available assessment information and characteristics of the client in relation to the identified preferences for intervention mode and to the type and accessibility of intervention resources. The decision to implement an intervention should be made in consultation with the client and the practitioner. As a general guide, an Overall Problem Density index exceeding 15% is considered significant.

Versions of the DUSI-R

Youth (10 - 16 years) & Adult (17 + years) Versions are available to provide information within four time frames. The same scales are used in the youth and adult versions to enable longitudinal tracking.

Version 1 - Lifetime **Version 2 - Past Year** **Version 3 - Past Month** **Version 4 - Past Week**

The DUSI is available in Chinese, Danish, Dutch, English, Finnish, French, German, Norwegian, Portuguese, Russian, Spanish, Swedish and Turkish. Additional language translations are available upon request.

Applications of the DUSI-R

The DUSI-R provides practical information by assessing problem severity and objectively determining intervention needs. The DUSI-R is currently used in clinics, social service agencies, schools, legal settings for youths and adults, and clinical/pharmaceutical research for the following purposes:



Recommended uses of the DUSI-R

- Detection of high risk youths
- Intake evaluation
- Intervention monitoring
- Outcome assessment
- Program evaluation
- Clinical trials

The DUSI-R is designed to yield practical information by quantifying severity of problems in multiple domains of health, behaviour, psychosocial, and school adjustment. Areas that require intervention are efficiently identified. By documenting severity of problems across 9 different domains using a common scale, you can determine the type and intensity of resources needed to maximize success of intervention.

Repeated testing enables monitoring change during prevention, treatment or youth development.

Aggregate analysis enables determination of group or program characteristics. It can be administered to individuals whose reading level is at the fifth grade level or higher. Adult and Youth Versions are available in 13 languages.

The DUSI-R is designed to evaluate adjustment within lifetime, one-year, one month, or one week time frame and repeated assessment should be administered in the same time period.

Data collection options include anonymous population based measures for school/district or region profiles or individual client profiles, paper based and online administration.

Online Computer Administration

The DUSI-R can be administered from any web accessible computer and scoring is automatic. In addition, each client's profile is stored to allow monitoring of changes across repeated assessments or to characterize the population profile. Aggregate and individual results can be printed for easy reference. Access to client data is restricted to the systems users with assigned permissions.

SSL encryption ensures confidentiality and protection of your data

- eCenter products are web-based applications developed using open source tools (PHP/MySQL)
- eCenter use SSL encryption for fully secure transactions. (SSL certificate required for site servers)
- Data can be downloaded for importing into statistical analysis software such as Oracle, SPSS, S-Plus, etc...
- System hosting is provided through state-of-the-art Class A server facility offering multi-homed ISP network with three backbone connections (T3 WorldCom connection, burstable OC3 Bell Nexia connection, burstable OC3 AT&T connection. Aggregate backbone bandwidth of 335 Mbps)

Consulting and Professional Development Services

Professional Development Workshops

Full day Professional Development Workshops are available upon request. Workshops include, but are not limited to, the following topics:

- DUSI-R design (psychometric properties, administration, scoring, reporting)
- Interpretation of results and applications of the DUSI-R
- Intervention and treatment planning
- Treatment Program design, effectiveness monitoring, and evaluation

All workshops are tailored to meet the specific needs of your organization.

Ralph Tarter, Ph.D., is Director of the Center for Education and Drug Abuse Research funded by the National Institute on Drug Abuse where he is Professor of Pharmaceutical Sciences, Psychiatry and Psychology

Dr. Tarter has published 10 books, over 350 scientific articles and 70 book chapters. He lectures widely on the cause and prevention of substance abuse.

Needs Assessment & Program Evaluation Services

Needs Assessment

Maximizing resources allocation is highly dependent on understanding and aligning your services capacity with the needs of the organization, community, or region you are serving. eCenter Research staff have extensive experience conducting needs assessment, recommending service delivery models, recommending program evaluation protocols, and providing customized information systems that create organizational efficiency.

Program Evaluation

eCenter Research staff provide unparalleled expertise in program evaluation. The DUSI-R is ideally suited to evaluate intervention efficacy and program effectiveness. The DUSI-R provides objective quantitative scores in multiple areas of health, behavior and social functioning that can help determine who is most likely to benefit from a particular type of service or treatment. Program evaluations conducted by eCenter Research provide:

- timely identification of modifications needed to improve service delivery
- feedback regarding the impacts of services delivery personnel
- justification for current funding or compelling rationale for increase in funding

Psychometric Properties & Publications

The DUSI-R has been extensively researched using a cohort of approximately 800 families enrolled in a long-term research project. Publications document predictive, concurrent, construct and discriminative validity as well as test-retest and internal reliability.

Since 1991 The CEDAR (Center for Education and Drug Abuse Research, University of Pittsburgh) has produced over 40 DUSI research publications. In addition, there have been multiple studies and publications where the DUSI has been utilized as the assessment of choice.

Tarter, R. & Hegedus, A. (1991). The Drug Use Screening Inventory: Its application in the evaluation and treatment of alcohol and drug abuse. *Alcohol, Health and Research World*, 15, 65 – 75.

Tarter, R., Ott, P., & Mezzich, A. (1991). Psychometric assessment in drug abuse. In R. Frances & S. Miller (Eds.), *The Clinical Textbook of Addictive Disorders*. New York: Guilford Press.

Tarter, R. (1990). Evaluation and treatment of adolescent substance abuse: A decision tree method. *American Journal of Drug and Alcohol Abuse*, 16, 1 – 46.

Contact Information

For more information about the DUSI-R and related research, or to purchase assessments, contact:

Dr. Steve Weatherbee
eCenter Research Inc.
1-866-480-2716
ecrsales@ecenterresearch.com

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DUSI-R Frequently Asked Questions¹

Q: MEASURES & INTERPRETATION. What measures does the DUSI-R provide?

A: The DUSI-R is the most comprehensive instrument available today. The DUSI-R yields 26 scales measuring severity of problems as well as predictive scales for mental health disorder, adverse outcomes, and violence proneness. Additional scales for risk of relapse (drug/alcohol) and risk of recidivism (DUI, legal involvement/reoffending, etc.), and decision tree model for type and intensity of treatment are currently in development). Measures include:

1. Overall Problem Density
2. Absolute Problem Density (Substance Use, Behavior Pattern, Health Status, Psychiatric Disorder, Social Competence, Family System, School Performance, Work Adjustment, Peer Relationship, Leisure/Recreation)
3. Relative Problem Density (ranking order of severity to inform treatment priority)
4. Prediction of Mental Health Disorder (ADHD, Conduct/Anti-Social Personality Disorder, Depression Disorder, Anxiety Disorder, Substance Use Disorder)
5. Prediction of Adverse Outcomes (Driving under the influence, Car accident while drugs or alcohol in system, Sell or deal drugs, Head injury, Treatment for injury after a fight, Sexually transmitted Disease, Giving someone drugs for sex)
6. Prediction of Violence Proneness

Q: MEASURES & INTERPRETATION. Does the DUSI-R cover both Substance Use and Mental Health?

A: The DUSI-R is one of few multivariate validated instruments that capture both substance use and mental health measures in one instrument. Combined with a self-report completion time of only 20 minutes, the DUSI-R is the most efficient and cost effective instrument available.

Q: MEASURES & INTERPRETATION. How do I interpret the results?

A: The DUSI-R measures severity of problems on scales ranging from 0-100%. The scales measure problems in multiple areas that compromise adjustment. In general, scores greater than 15% represent significant problems. A Lie Scale score of 5 or greater should alert the examiner to possible invalidity of results due to deliberate deception by the client.

Q: MEASURES & INTERPRETATION. Can the DUSI-R differentiate between substance abuse and chemical dependency?

A: Substance “use” and “abuse” are terms that describe the behavior of drug consumption. The term “Substance Use Disorder” is a DSM-IV diagnostic category. The term “chemical dependency” is a generic version of SUD but has no official scientific reference.

The DUSI evaluates consumption behavior and is predictive of SUD (as evidenced in the DUSI-R publications) and, can now be used as a screen to detect SUD (Frequency of Use Scale = use, Substance Use Domain scale = problems; SUD, Overall Problem Density score used to calculate SUD).

Q: MEASURES & INTERPRETATION. How was the Brief 2 minute screen and Short 8 minute assessment developed?

A: Factor analysis we used to create the Short version of the DUSI-R. First, reliability analysis was run for each domain. Items with high item–total test score correlation were selected ($r=.4$). Factor analysis was then applied to each domain (number of items left in that domain) and items with high factor loadings ($.4$) were selected, others were eliminated. To create the 10-item 2-minute Brief Screening test, an item with the highest factor loading was selected.

¹ YourHealthCheck.org, DUSI-R Frequently Asked Questions,” accessed December 14, 2015, <http://www.yourhealthcheck.org/sites/default/files/docs/DUSI-R%20FAQ.pdf>.

Q: MEASURES & INTERPRETATION. How are the lie scale questions scored and what does it mean? When clients complete the follow-up assessments the instructions say answer these questions for the past 30 days, but then some questions say “Have you ever told a lie?” Is that question (and others with the word “ever”) asking in the last 30 days or “ever?”

A: The Lie Scale questions do cause some confusion. The lie scale questions are based on in 'their life/lifetime' and not specific to the time frame of the initial assessment (past year) or follow up assessments (past month/week). Generally, once it is confirmed a client is being honest at initial intake assessment, trust continues to build with the clinician and lying isn't usually a concern going forward.

Q: MEASURES & INTERPRETATION. How are the subscales scored? What do they mean?

A: Sub-scales within each domain are not score/not quantified like Absolute Problem Density scores for each domain. Questions in each domain are used to calculate an Absolute Problem Severity score for the domain. The sub-scales, and related questions, are for clinical decision and help guide specific conversations and decision in terms of the unique configuration of problems for each client in each domain. Sub-scales, and related questions, are not intended to measure breadth and depth of specific problems, but can be used as specific symptom/indicators of areas of challenge for that particular client.

Q: VERSIONS - LENGTH. Is the DUSI-R available in shorter versions?

A: There are multiple versions of the DUSI-R to accommodate a wide variety of uses:

1. DUSI-R Full (20 min) yields scores for all 16 scales and is ideal for comprehensive client intake screening
2. DUSI-R Short (10 min) yields the Overall Problem Density and Absolute Problem Density scores for each domain and is ideal for monthly or weekly follow up to monitor the clients response to treatment
3. DUSI-R Brief (2 min) yields the Overall Problem Density and is ideal for large scale client/population screening to determine who may be at high risk for follow up screening and evaluation

Q: VERSIONS – VALIDATION PROCESS. What methods were used to create the Brief Screen and Short Assessment versions of the DUSI-R?

A: Factor analysis was used to create the Brief and Short versions of the DUSI-R. First reliability analysis was run for each domain. Items with high item – total test score correlation were selected ($r=.4$). Factor analysis was then applied to each domain (whatever number of items left in that domain) and items with high factor loadings were selected (.4) and others were eliminated. To create the 10-item Brief Screening test, an item with the highest factor loading was selected. Correlations are greater than .93. More detailed analysis methods and results are available upon request.

Q: VERSIONS – TIME FRAMES. What time frame(s) is the DUSI-R based on?

A: Four timeframes are available for measurement: Lifetime (intake), Past Year (intake – current baseline scores), Past Month (monitoring during intervention/treatment), and Past Week (frequent monitoring for intensive daily intervention/treatment)

Q: VERSIONS - YOUTH/ADULT. Is the DUSI-R available in a youth and adult versions?

A: The Youth and Adult versions of the DUSI-R have the same scales to allow for seamless comparisons during transition into adulthood and for long-term intervention or monitoring.

Q: LANGUAGES. What languages is the DUSI-R available in?

A: The DUSI-R is available in 13 languages: English, Danish, Dutch, Finnish, French, German, Norwegian, Portuguese, Spanish, Swedish, Chinese, Russian, Turkish (Tarama Formu), Belgian French and Flemish are currently under development.

Q: PUBLICATIONS. Are there publications that provide validity measures and psychometric properties of the DUSI-R?

A: Since 1989 there are numerous peer-reviewed publications involving the DUSI that highlight it's utility in research and practice. Research and publication are ongoing as new predictive scales are developed using the current DUSI-R items. A list of publications can be found at <http://www.yourhealthcheck.org/organization/dusi>. If you have questions, please contact Dr. Steve Weatherbee at steve@ecenterresearch.com.

Q: ADMINISTRATION. How is the DUSI-R administered?

A: The DUSI-R is a self-report inventory. No special training is required for administration. It can be administered in paper format, however in that method automated scoring and the predictive mental health, adverse outcomes, and violence proneness scales scores are not available. The online version provides automated scoring. Offline computer administration for mobile administration on laptop computers (no internet connection required) and an adaptive computer version are currently under development.

Q: SCORING. How is the DUSI-R scored? Is special training required for scoring? Can the Drug & Alcohol Frequency of Use be combined into a single scale score? How are missing answers handled for the calculation of the absolute problem density score?

A: No special training is required for scoring. Using the paper version takes 5-10 minutes. The online version includes immediate automated scoring and printable PDF Report generation. The drug and alcohol use frequency data can be used separately for each drug or combined/averaged into one index, there are publications using both methods. Missing answers requires changing the denominator in the calculations however if 30% of the items on a scale have no answer validity becomes dubious.

Q: NORM REFERENCING. Is the DUSI-R norm referenced? Are there norms available by Race?

A: The object is to screen for problems by using cut off scores. Similar to diagnostic interviews, the intention is to determine the presence of problems. The DUSI-R provides a common scale of 0-100% for quantifying problem severity in multiple areas of disturbance that require detection and intervention. Differences attributed to race are almost always due to socioeconomic factors. In addition, the crosscultural versions show the DUSI is not biased by culture. Norm referencing can be provided for your population where needed.

Q: CROSS CULTURAL USE. Is the DUSI-R appropriate for use in different cultures?

A: The DUSI-R has been used for research and in clinical settings in many cultures in North America, South America, Europe, South Africa, etc. The DUSI-R was designed to measure 'problems/problem severity' in functional areas in everyone's life regardless of culture. Differences attributed to race are almost always due to socioeconomic factors. In addition, the cross cultural/language versions show the DUSI is not biased by culture. Norm referencing can be provided for your population where needed. The DUSI-R can also be adapted by removing items that have no chance of endorsement in a given culture (e.g. DUSI-R Turkish version).

Q: CLINICAL USE/SETTINGS. What settings is the DUSI-R used in and how is it being used?

A: The DUSI-R is widely used for many purposes and in many settings throughout the world. It is most frequently used in social, clinical, school and legal settings for client intake assessment, mental health disorder and violence proneness prediction, addictions and substance abuse treatment monitoring. In addition, the DUSI-R has been used extensively for research in numerous countries and for numerous purposes, including clinical trials in pharmaceutical research.

Q: PROGRAM EVALUATION. Can the DUSI-R provide program outcome measures?

A: The DUSI-R can be used to measure change from pre to post treatment at the individual level and for a whole program. In this manner, improvements in each of the measurement domains and overall problem density are precisely quantified. In addition, repeated measures (monthly or weekly versions) provide critical feedback on client progress during intervention/treatment.

Q: SENSITIVITY. How sensitive are the DUSI-R scales for picking up intervention/treatment effects?

A: Each of the DUSI-R scales was selected for inclusion on the basis of two criteria: 1) The measurement domains are the most frequently involved contributors to adjustment problems and substance abuse; and, 2) the problems are modifiable. Accordingly, the scales can detect change following an intervention.

Q: SUICIDE PREDICTION. Does the DUSI-R provide predictive measures for suicide?

A: No; it can't be done by the DUSI-R or any other instrument. The prevalence of suicide is too low and the number of factors too large to enable accurate prediction.

Q: TRAINING & PROFESSIONAL DEVELOPMENT. Is there training available for use of the DUSI-R and interpretation of findings, program planning, program evaluation, etc...?

A: Yes; please contact eCenter Research (866-480-2716 ext. 201 Dr. Steve Weatherbee) to inquire about professional development workshops and seminars.

Q: COMPARISON TO OTHER INSTRUMENTS. How does the DUSI-R compare to other assessments in terms of versatility, efficiency, and comprehensiveness?

A: The DUSI-R is used in many settings as an intake screening/assessment tool and to measure treatment effects at both the individual and program level. It is also used to monitor change during the course of treatment. Several scales are validated to detect psychiatric disorder diagnosis, thus pointing to the need for possible referral.

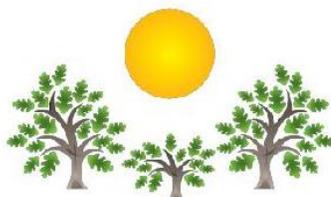
The DUSI-R was designed to measure the practical overt aspects of the person's behavior, health and adjustment. There are 16 scales and an overall problem severity score. Unlike other instruments the DUSI-R is not intended to measure the latent or presumed aspects of psychological functioning pertinent to substance abuse. Rather it measures what can be potentially changed by a treatment or prevention facility. It also prioritizes severity in the multiple domains of measurement so that intervention resources can be calibrated to magnitude of each problem. In addition some instruments do not specify when in life the problem was or is present and has no indication of whether the person is telling the truth. The DUSI-R has about 30 scientific publications documenting its reliability, validity and practical utility. Research is always ongoing and active, including international projects.

Q: COMPARISON TO OTHER INSTRUMENTS. How does the DUSI-R compare to personality assessments?

A: Instruments that measure personality characteristics are very difficult to validate due to the dispositional characteristics of personality. Generally, personality measures are not effective instruments for assessing treatment needs and/or measuring change in clients during treatment.

Q: COMPARISON TO OTHER INSTRUMENTS. How does the DUSI-R compare to other addiction/substance abuse assessments?

A: The DUSI-R captures and quantifies current social functioning in multiple domains, which can be target for change through intervention/treatment rather than capture social history, which cannot be changed. Many substance abuse screening/assessments take significant time to administer, often require special training, and yield limited information beyond an index of drug problem or severity. The DUSI-R goes beyond this measure (it is provided by the OPD (Overall Problem Density) score and measures Absolute Problem Severity of 10 domains within a time frame. The DUSI-R also includes predictive scales for mental health disorder, adverse outcomes, and violence proneness. All of the scales are on a common metric so you can evaluate the relative severity for treatment planning, prioritize treatment resources, and monitor client progress/gains during treatment.



THREE OAKS CENTER, INC.
6077 Far Hills Ave., #157 Centerville, OH 45459
937-520-8496
Kevin@ThreeOaksCenter.com
ThreeOaksCenter.com

SCREENING INSTRUMENTS ADMINISTERED

First screening instrument used:	
<hr/>	
Results	
<hr/>	
Second screening instrument used:	
<hr/>	
Results	
<hr/>	
Recommendations for referral, if applicable, for a comprehensive assessment to determine the extent and severity of alcohol and other drug abuse problems and need for treatment:	
<hr/>	
Signature/credentials	Date

02] Describe Past and Present use of alcohol and other drugs.

SUBSTANCE USE:

Substance (Mark <input type="checkbox"/> for any substance used)	Age of Onset	Initial Pattern of Use	Current Pattern of Use (Past Six Months)	In Past 30 Days, how many days has the client used:		Date of Last Use
<input type="checkbox"/> ALCOHOL	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	Less than 5 Drinks? _____	5 or More Drinks? _____	_____
<input type="checkbox"/> Marijuana or Hash	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____	_____
<input type="checkbox"/> Powder Cocaine	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____	_____
<input type="checkbox"/> Crack Cocaine	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____	_____
<input type="checkbox"/> Hallucinogens (Like LSD, PCP, psilocybin, ketamine)	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____	_____
<input type="checkbox"/> Inhalants (Like whippets, glue, amyl nitrite, poppers)	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____	_____

SUBSTANCE USE (Continued):					
Substance (Mark <input type="checkbox"/> for any substance used)	Age of Onset	Initial Pattern of Use	Current Pattern of Use (Past Six Months)	In Past 30 Days, how many days has the client drank:	Date of Last Use
<input type="checkbox"/> Heroin	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____
<input type="checkbox"/> Other Opiates (Like Morphine, Demerol, Oxycotin, Vicodin, Dilaudid, Methadone)	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____
<input type="checkbox"/> Tranquilizers or Barbiturates (Like Xanax, Librium, Valium, Quaaludes, Seconal, Nembutal)	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____
<input type="checkbox"/> Amphetamines (Like Adderall, Ritalin)	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____
<input type="checkbox"/> Methamphetamines (Like crank, speed, crystal meth)	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____
<input type="checkbox"/> MDMA (Like ecstasy, X, XTC)	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____

Prior AOD Tx YES NO (If yes, Describe client's history of treatment for Alcohol or other Drugs.)

Types of Treatment	Tx Type	Treatment Provider	Dates of Tx	Completed (YES / NO)
1. Detox				YES / NO
2. Residential				YES / NO
3. Partial Hospitalization				YES / NO
4. Intensive Outpatient				YES / NO
5. Standard Outpatient				YES / NO
6. Education				YES / NO
7. Intervention				YES / NO
8. Self-Help				YES / NO

PSYCHIATRIC HISTORY

Is the client currently receiving treatment, including medication, for any Mental Health concern? YES NO
 Does the client have any history of Diagnoses, Hospitalizations, Treatments, and / or Medications, related to Mental Health Issues? (Psychiatric Medications are specified in MEDICAL section) If yes:

Diagnostic Categories	Dx Cat	Diagnosis	Treatment/ Hospitalization	Medication	Dates
1. Childhood Disorder			1. Case Management	YES / NO	
2. Cognitive Disorder			2. Outpatient		
3. Psychotic Disorder			3. Hospitalization		
4. Mood Disorder			1. Case Management	YES / NO	
5. Anxiety Disorder			2. Outpatient		
6. Somatoform Disorder			3. Hospitalization		
7. Factitious Disorder			1. Case Management	YES / NO	
8. Dissociative Disorder			2. Outpatient		
9. Sexual/Gender Identity			3. Hospitalization		
10. Eating Disorder			1. Case Management	YES / NO	
11. Sleep Disorder			2. Outpatient		
12. Impulse Control Disorder			3. Hospitalization		

Does the Client have any medical problems? YES NO

Is the client taking any medications? YES NO

(If yes, to either question, please provide detail below.)

Types of Medical Condition	Medical Condition	Date of Onset	Type of Treatment	Prescribed Medication(s) YES/NO - Name of Medication	Compliant YES / NO
1. Anemia			<input type="checkbox"/> Medication	YES / NO (If yes, list meds)	YES / NO
2. Arthritis / Rheumatism			<input type="checkbox"/> Surgery		
3. Asthma			<input type="checkbox"/> Therapy		
4. Bladder Problems			<input type="checkbox"/> None		
5. Bronchitis			<input type="checkbox"/> Medication	YES / NO (If yes, list meds)	YES / NO
6. Cancer			<input type="checkbox"/> Surgery		
7. Cataracts			<input type="checkbox"/> Therapy		
8. Diabetes			<input type="checkbox"/> None		
9. Gall Bladder Trouble			<input type="checkbox"/> Medication	YES / NO (If yes, list meds)	YES / NO
10. Heart Disease / Heart Attack			<input type="checkbox"/> Surgery		
11. High Blood Pressure			<input type="checkbox"/> Therapy		
12. Kidney Trouble			<input type="checkbox"/> None		
13. Liver Trouble			<input type="checkbox"/> Medication	YES / NO (If yes, list meds)	YES / NO
14. Lung Disease			<input type="checkbox"/> Surgery		
15. Migraine Headaches			<input type="checkbox"/> Therapy		
16. Repeated Seizures			<input type="checkbox"/> None		
17. Repeated Stomach Problems			<input type="checkbox"/> Medication	YES / NO (If yes, list meds)	YES / NO
18. Repeated Neck, Back, or Spine Trouble			<input type="checkbox"/> Surgery		
19. Stroke			<input type="checkbox"/> Therapy		
20. Tuberculosis			<input type="checkbox"/> None		
21. Ulcer			<input type="checkbox"/> Medication	YES / NO (If yes, list meds)	YES / NO
22. Psychiatric / Mental Health			<input type="checkbox"/> Surgery		
23. Other: (Specify)			<input type="checkbox"/> Therapy		
			<input type="checkbox"/> None		

Is the client currently using any over the counter medications or remedies? YES NO

If yes, please provide detail below:

OTC Medications, Remedies (Name of Medication/Remedy)	Purpose	Date of Onset	Compliant YES / NO
			YES / NO
			YES / NO

Is the client pregnant? YES NO Client is male, question does not apply

If yes, indicate the number of months client is pregnant: 1 2 3 4 5 6 7 8 9

Does the client have food allergies? YES NO Drug reactions/allergies? YES NO

If yes, describe client allergies:

Name of Substance	Adverse Reaction	Date First Occurred	Date Last Occurred

08] Indicate any Disabilities of the client:

- | | | |
|--|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Epileptic | <input type="checkbox"/> YES <input type="checkbox"/> NO Deaf/Hearing Impaired | <input type="checkbox"/> YES <input type="checkbox"/> NO Speech Impaired |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Vision Impaired | <input type="checkbox"/> YES <input type="checkbox"/> NO Mental Illness | <input type="checkbox"/> YES <input type="checkbox"/> NO Other Unknown Disability |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Diabetic | <input type="checkbox"/> YES <input type="checkbox"/> NO Dyslexic / Learn Dis | <input type="checkbox"/> YES <input type="checkbox"/> NO English as Second Language |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Neuro Dysfunction | <input type="checkbox"/> YES <input type="checkbox"/> NO MR / DD | |

Vocation

Is Client currently employed? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If YES: Type of Work:	Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/>
Place of Employment / Position:	
Describe job duties:	
How long has client been in this position?	Does the client have health insurance?

Legal History

Does the client have any AOD related driving charges YES NO

If YES, List All AOD related driving charges-including index / (Most recent first)

Types of Charges	Charge	Date	Penalties / Consequences / Incarceration / Fines
1. DWI			
2. DUI			
3. OMVI			
4. OVI			
5. DWI reduced to RO			
6. DUI reduced to RO			
7. OMVI reduced to RO			
8. OVI reduced to RO			
9. DWI reduced to FTC			
10. DUI reduced to FTC			
11. OMVI reduced to FTC			
12. OVI reduced to FTC			
13. RO			
14. FTC			
15. Other: (Specify)			

Does the client have any AOD related non-driving charges YES NO
 If YES, List All AOD related non-driving charges / (Most recent first)

Types of Charges	Charge	Date	Penalties / Consequences / Incarceration / Fines
1. Disorderly Conduct			
2. Public Intoxication			
3. Open Container			
4. Underage Possession / Consumption			
5. Indecent Exposure			
6. Drug Possession			
7. Drug Abuse			
8. Drug Paraphernalia			
9. Drug Trafficking			
10. Shoplifting / Vandalism			
11. Forgery			
12. CCW / Other Weapons Charge			
13. Burglary / Larceny / B & E			
14. Robbery			
15. Assault			
16. Domestic Violence			
17. Arson			
18. Rape			
19. Homicide / Manslaughter			
20. Prostitution / Solicitation			
21. Probation Violation			
22. Contempt of Court			
23. Other: (Specify)			

Does the client have any non-AOD related charges YES NO
 If YES, List All AOD non-related charges / (Most recent first)

Types of Charges	Charge	Date	Penalties / Consequences / Incarceration / Fines
1. Disorderly Conduct			
2. Indecent Exposure			
3. Shoplifting / Vandalism			
4. Forgery			
5. CCW / Other Weapons Charge			
6. Burglary / Larceny / B & E			
7. Robbery			
8. Assault			
9. Domestic Violence			
10. Arson			
11. Rape			
12. Homicide / Manslaughter			
13. Prostitution / Solicitation			
14. Probation Violation			
15. Contempt of Court			
16. Driving Under Suspension			
17. Other: (Specify)			

SYMPTOMATOLOGY

Increased Tolerance: YES NO If yes, _____

Blackouts: YES NO If yes, _____

Preoccupation / Supply Anxiety: YES NO If yes, _____

Attempts to hide use: YES NO If yes, _____

Hangovers: YES NO If yes, _____

Uncontrollable: YES NO If yes, _____

Self-Medication of Stress / Depression / etc.: YES NO If yes, _____

Prior Attempts to Control Use / Abstain: YES NO If yes, _____

Other Symptomology to Support Referral: _____

PRELIMINARY Recommendations

- _____ No further Recommendation
- _____ Comprehensive AOD Assessment
- _____ Currently in Treatment (_____)

Signature/Credentials of Staff Member

Date/Time

PLAN offered by client in final group: _____

FINAL Recommendations (Changes from Preliminary Recommendations Must Be Approved)

- _____ No further Recommendation
- _____ Comprehensive AOD Assessment
- _____ Currently in Treatment (_____)

Signature/Credentials of Services Supervisor (if needed)

Date/Time

Client Reaction to Recommendations

LEVEL OF PARTICIPATION (Defenses noted during the weekend)

- Denial Anger Changing subject Minimizing Silence Inattentive
- Rationalizing Lying Observed Sleeping Compliance Humor

Did the defenses persist through the weekend? No Yes Explain: _____

Overall Participation: Minimal (ignored, refused, silent) Adequate Active

Questions/Comments: None Some Frequent and appropriate

Benefit from Program: Minimal Some Seemed to Help Great Deal

Openness to feedback from staff and other clients: Minimal Some Great Deal

02] Describe Past and Present use of alcohol and other drugs.

SUBSTANCE USE:

Substance (Mark <input type="checkbox"/> for any substance used)	Age of Onset	Initial Pattern of Use	Current Pattern of Use (Past Six Months)	In Past 30 Days, how many days has the client used:		Date of Last Use
				Less than 5 Drinks?	5 or More Drinks?	
<input type="checkbox"/> ALCOHOL	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____	_____
<input type="checkbox"/> Marijuana or Hash	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____	_____
<input type="checkbox"/> Powder Cocaine	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____	_____
<input type="checkbox"/> Crack Cocaine	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____	_____
<input type="checkbox"/> Hallucinogens (Like LSD, PCP, psilocybin, ketamine)	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____	_____
<input type="checkbox"/> Inhalants (Like whippets, glue, amyl nitrite, poppers)	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____	_____

SUBSTANCE USE (Continued):					
Substance (Mark <input type="checkbox"/> for any substance used)	Age of Onset	Initial Pattern of Use	Current Pattern of Use (Past Six Months)	In Past 30 Days, how many days has the client drank:	Date of Last Use
<input type="checkbox"/> Heroin	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____
<input type="checkbox"/> Other Opiates (Like Morphine, Demerol, Oxycontin, Vicodin, Dilaudid, Methadone)	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____
<input type="checkbox"/> Tranquillizers or Barbiturates (Like Xanax, Librium, Vallium, Quaaludes, Seconal, Nembutal)	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____
<input type="checkbox"/> Amphetamines (Like Adderall, Ritalin)	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____
<input type="checkbox"/> Methamphetamines (Like crank, speed, crystal meth)	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____
<input type="checkbox"/> MDMA (Like ecstasy, X, XTC)	_____	<input type="checkbox"/> Once <input type="checkbox"/> One to four times per year <input type="checkbox"/> One time per month <input type="checkbox"/> Two times per month <input type="checkbox"/> Three times per month <input type="checkbox"/> Weekly <input type="checkbox"/> Two times per week <input type="checkbox"/> Three to four times per week <input type="checkbox"/> Daily <input type="checkbox"/> More than one time per day Amt Used: _____	<input type="checkbox"/> Never/None <input type="checkbox"/> < One time per month <input type="checkbox"/> One to three times per month <input type="checkbox"/> About one time per week <input type="checkbox"/> Two to five times per week <input type="checkbox"/> Daily Amt Used: _____	_____	_____

Prior AOD Tx YES NO (If yes, Describe client's history of treatment for Alcohol or other Drugs.)

<u>Types of Treatment</u>	Tx Type	Treatment Provider	Dates of Tx	Completed (YES / NO)
1. Detox				YES / NO
2. Residential				YES / NO
3. Partial Hospitalization				YES / NO
4. Intensive Outpatient				YES / NO
5. Standard Outpatient				YES / NO
6. Education				YES / NO
7. Intervention				YES / NO
8. Self-Help				YES / NO

Does the Client have any medical problems? YES NO

Is the client taking any medications? YES NO

(If yes, to either question, please provide detail below.)

Types of Medical Condition	Medical Condition	Date of Onset	Type of Treatment	Prescribed Medication(s) YES/NO - Name of Medication	Compliant YES / NO
1. Anemia			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
2. Arthritis / Rheumatism			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
3. Asthma			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
4. Bladder Problems			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
5. Bronchitis			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
6. Cancer			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
7. Cataracts			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
8. Diabetes			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
9. Gall Bladder Trouble			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
10. Heart Disease / Heart Attack			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
11. High Blood Pressure			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
12. Kidney Trouble			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
13. Liver Trouble			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
14. Lung Disease			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
15. Migraine Headaches			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
16. Repeated Seizures			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
17. Repeated Stomach Problems			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
18. Repeated Neck, Back, or Spine Trouble			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
19. Stroke			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
20. Tuberculosis			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
21. Ulcer			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
22. Psychiatric / Mental Health			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO
23. Other: (Specify)			<input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy <input type="checkbox"/> None	YES / NO (If yes, list meds)	YES / NO

Is the client currently using any over the counter medications or remedies? YES NO

If yes, please provide detail below:

OTC Medications, Remedies (Name of Medication/Remedy)	Purpose	Date of Onset	Compliant YES / NO
			YES / NO
			YES / NO
			YES / NO

Is the client pregnant? YES NO Client is male, question does not apply
 If yes, indicate the number of months client is pregnant: 1 2 3 4 5 6 7 8 9

Does the client have food allergies? YES NO Drug reactions/allergies? YES NO
 If yes, describe client allergies:

Name of Substance	Adverse Reaction	Date First Occurred	Date Last Occurred

08] Indicate any Disabilities of the client:

- | | | |
|--|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Epileptic | <input type="checkbox"/> YES <input type="checkbox"/> NO Deaf/Hearing Impaired | <input type="checkbox"/> YES <input type="checkbox"/> NO Speech Impaired |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Vision Impaired | <input type="checkbox"/> YES <input type="checkbox"/> NO Mental Illness | <input type="checkbox"/> YES <input type="checkbox"/> NO Other Unknown Disability |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Diabetic | <input type="checkbox"/> YES <input type="checkbox"/> NO Dyslexic / Learn Dis | <input type="checkbox"/> YES <input type="checkbox"/> NO English as Second Language |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Neuro Dysfunction | <input type="checkbox"/> YES <input type="checkbox"/> NO MR / DD | |

Legal History

Does the client have any AOD related driving charges YES NO

If YES, List All AOD related driving charges-including index / (Most recent first)

Types of Charges	Charge	Date	Penalties / Consequences / Incarceration / Fines
1. DWI			
2. DUI			
3. OMVI			
4. OVI			
5. DWI reduced to RO			
6. DUI reduced to RO			
7. OMVI reduced to RO			
8. OVI reduced to RO			
9. DWI reduced to FTC			
10. DUI reduced to FTC			
11. OMVI reduced to FTC			
12. OVI reduced to FTC			
13. RO			
14. FTC			
15. Other: (Specify)			

Does the client have any AOD related non-driving charges YES NO

If YES, List All AOD related non-driving charges / (Most recent first)

Types of Charges	Charge	Date	Penalties / Consequences / Incarceration / Fines
1. Disorderly Conduct			
2. Public Intoxication			
3. Open Container			
4. Underage Possession / Consumption			
5. Indecent Exposure			
6. Drug Possession			
7. Drug Abuse			
8. Drug Paraphernalia			
9. Drug Trafficking			
10. Shoplifting / Vandalism			
11. Forgery			
12. CCW / Other Weapons Charge			
13. Burglary / Larceny / B & E			
14. Robbery			
15. Assault			
16. Domestic Violence			
17. Arson			
18. Rape			
19. Homicide / Manslaughter			
20. Prostitution / Solicitation			
21. Probation Violation			
22. Contempt of Court			
23. Other: (Specify)			

Does the client have any non-AOD related charges YES NO

If YES, List All AOD non-related charges / (Most recent first)

Types of Charges	Charge	Date	Penalties / Consequences / Incarceration / Fines
1. Disorderly Conduct			
2. Indecent Exposure			
3. Shoplifting / Vandalism			
4. Forgery			
5. CCW / Other Weapons Charge			
6. Burglary / Larceny / B & E			
7. Robbery			
8. Assault			
9. Domestic Violence			
10. Arson			
11. Rape			
12. Homicide / Manslaughter			
13. Prostitution / Solicitation			
14. Probation Violation			
15. Contempt of Court			
16. Driving Under Suspension			
17. Other: (Specify)			

Does the client have any pending legal charges YES NO

If YES, List All pending legal charges / (Most recent first-Do not include index offense.)

Charge	Date	Charge	Date

During the past 30 Days, how many nights has the client been in jail / prison?	
Has this client attended WIP previously?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, what date(s)?	
If YES, Were they referred to treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, did they comply?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is the client currently on Probation / Parole?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, List Name of Probation / Parole Officer.	

VOCATIONAL HISTORY

Types of Work 1. Professional/ Technical 2. Managers Admin (Not Farm) 3. Sales 4. Clerical 5. Craftsman 6. Operative (Not Transport) 7. Transport Equipment Operator 8. Laborers (Not Farm) 9. Farmer and Farm Managers 10. Service Worker (Not Private Household Worker) 11. Private Household Worker 12. Migrant Worker	Is Client currently employed? <input type="checkbox"/> YES <input type="checkbox"/> NO			
	If YES: Type of Work:		Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/>	
	Place of Employment / Position:			
	Describe job duties:			
	How long has client been in this position?		Does the client have health insurance?	
	Places of Prior Employment	Type of Work	Dates of employment	Reason for Leaving

MILITARY HISTORY

Does client have any Military History? YES NO If YES:

Branch of Service		Branch	Dates	Type of Discharge	VA Eligible
1. U S Army	6. U S Navy Reserve				
2. U S Navy	7. U S Air Force Reserve				
3. U S Air Force	8. U S Marine Corps Reserve				
4. U S Marine Corps	9. U S Coast Guard				
5. U S Army Reserve	10. National Guard				
	11. Other				

Has client ever had any Vocational/Military consequences related to AOD use? (Details) _____

EDUCATIONAL HISTORY

Is client currently in school?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, Where? / GPA?			
What was the highest level of education completed by the client?			
Was the client classified as having any special education needs?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
If YES: Describe:			
Did the client receive any education past high school?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
If Yes:	Where	When	Completed? Degree/Certificate
			YES / NO
			YES / NO
			YES / NO

List any ways that the education of the client was adversely effected by AOD use: _____

SOCIAL HISTORY

Describe the favorite social activities of the client and the role that AOD plays in these activities:

Types of Activity	Social Activity	Type	Alcohol Involved
1. Sports-Participant			YES / NO
2. Sports-Spectator			
3. Social-Public			
4. Social-Private			YES / NO
5. Arts-Participant			
6. Arts-Spectator			
7. Outdoor-Passive			YES / NO
8. Outdoor-Adventure			

Describe any social consequences the client has had related to AOD use: _____

PSYCHIATRIC HISTORY

Is the client currently receiving treatment, including medication, for any Mental Health concern? YES NO
 Does the client have any history of Diagnoses, Hospitalizations, Treatments, and / or Medications, related to Mental Health Issues? (Psychiatric Medications are specified in MEDICAL section) If yes:

Diagnostic Categories	Dx Cat	Diagnosis	Treatment/ Hospitalization	Medication	Dates
1. Childhood Disorder			1. Case Management	YES / NO	
2. Cognitive Disorder			2. Outpatient		
3. Psychotic Disorder			3. Hospitalization		
4. Mood Disorder			1. Case Management	YES / NO	
5. Anxiety Disorder			2. Outpatient		
6. Somatoform Disorder			3. Hospitalization		
7. Factitious Disorder			1. Case Management	YES / NO	
8. Dissociative Disorder			2. Outpatient		
9. Sexual/Gender Identity			3. Hospitalization		
10. Eating Disorder			1. Case Management	YES / NO	
11. Sleep Disorder			2. Outpatient		
12. Impulse Control Disorder			3. Hospitalization		

Has the client ever been told that AOD use had a negative effect on a Mental Health condition or Mental Health treatment? YES NO If YES: _____

FAMILY HISTORY

With whom does the client currently live?	
How Long?	

Describe any and all Significant Relationships in which the client has been involved:

Name of Spouse / Significant Other and Type of Relationship	Date Began	Date Ended	# of Children from Relationship	Current Status of Relationship	Current Status Types
					1. Ongoing
					2. Divorced
					3. Separated
					4. Broke-up
					5. Widowed
					6. Other

Does the Client have any Children? YES NO

Name of Child	Age	Other Parent of Child	Currently Residing Where

Does Client have any Genetic Family Members having Prior/Current Substance Use Problems? YES NO If yes,

Family Member	Age	Substance Use Problems	Family Member	Substance Use Problems
Mother		YES / NO	Maternal Grandmother	YES / NO
Father		YES / NO	Maternal Grandfather	YES / NO
Maternal Aunt	#	YES / NO	Paternal Grandmother	YES / NO
Maternal Uncle	#	YES / NO	Paternal Grandfather	YES / NO
Paternal Aunt	#	YES / NO	Sibling	# YES / NO
Paternal Uncle	#	YES / NO	Other	YES / NO

Does client have Any Genetic Family Members who have a History of AOD Treatment, 12-Step Involvement, or Recovery/Sobriety? YES NO If yes,

Family Member	AOD Treatment	12-Step Involvement	Recovery / Sobriety
	Current / Past	Current / Past	Current / Past
	Current / Past	Current / Past	Current / Past
	Current / Past	Current / Past	Current / Past
	Current / Past	Current / Past	Current / Past

List any ways that the Domestic Situation of the client has been adversely harmed by AOD use of the client. _____

Does the current Domestic Situation of the client support AOD use by the client? YES NO If yes, _____

Has the client ever been in involved in Domestic Violence? YES(Victim) Yes(Perpetrator) NO
If yes, _____

SEXUAL HISTORY

Sexual Orientation

- Heterosexual
- Homosexual
- Bisexual
- Transgender
- Questioning
- Other

What is the Sexual Orientation of the Client? _____

Has the client ever been involved in an unwanted sexual relationship as a result of AOD use? YES NO If yes, _____

Has the client ever experienced any sexual health concerns or consequences related to AOD use? YES NO If yes, _____

Has the client had any other AOD related sexual consequences? YES NO If yes, _____

RELIGION/SPIRITUAL ORIENTATION

- Catholic
- Baptist
- Methodist
- Lutheran
- Presbyterian
- Pentecostal
- Episcopalian
- Muslim
- Other (Specify)
- None
- Atheist
- Agnostic

What is the religious preference of the client? _____

How religious is the client? 1) Not at All 2) Moderately 3)Very

How important is religion in the client's life? 1) Not at All 2) Moderately 3)Very

How often does the client go to church? 1) More than one time per week 2) Weekly
3) Monthly 4) Yearly 5) Holidays 6) Does not attend

Does the client believe AOD use is contrary to spiritual beliefs? YES NO If yes, _____

Does the client identify having been involved in any AOD related behaviors contrary to spiritual values? YES NO If yes, _____

Has the client attended any religious/faith affiliated (Does not include Alcoholics Anonymous) recovery or self-help groups? YES NO If yes, _____

STRENGTHS/ ASSETS	_____ _____ _____
WEAKNESSES/ LIMITATIONS	_____ _____ _____

SYMPTOMATOLOGY

Increased Tolerance: YES NO If yes, _____

Preoccupation / Supply Anxiety: YES NO If yes, _____

Hangovers: YES NO If yes, _____

Self-Medication of Stress / Depression / etc.: YES NO If yes, _____

Blackouts: YES NO If yes, _____

Attempts to hide use: YES NO If yes, _____

Recurring guilt over use: YES NO If yes, _____

History of Physical Withdrawal: YES NO If yes, _____

Current Abstinence: YES NO If yes, _____

Uncontrollable: YES NO If yes, _____

Prior Attempts to Control Use / Abstain: YES NO If yes, _____

Other Substance Abuse Symptomatology: YES NO If yes, _____

MENTAL STATUS EXAMINATION

Appearance	1. Well-groomed 2. Disheveled 3. Bizarre/Eccentric 4. Meticulous 5. Seductive	Attitude	1. Cooperative 2. Guarded 3. Suspicious 4. Uncooperative 5. Belligerent 6. Angry	Mood	1. Euthymic 2. Depressed 3. Anxious 4. Euphoric 5. Calm 6. Unremarkable
Affect	1. Appropriate 2. Flat 3. Labile 4. Anxious 5. Expansive 6. Unremarkable	Speech	1. Normal 2. Delayed 3. Soft 4. Loud 5. Slurred 6. Excessive 7. Pressure	Motor Activity	1. Calm 2. Overactive 3. Poor Coordination 4. Tremors 5. Motor Retardation 6. Unremarkable
Thought Process	1. Intact 2. Flight of Ideas 3. Circumstantial 4. Loose Associations 5. Tangential 6. Perseveration 7. Incoherent	Intellect	1. Above Average 2. Average 3. Below Average	Hallucinations	1. None 2. Auditory 3. Visual 4. Olfactory 5. Tactile
Delusions	1. None 2. Persecutory 3. Controlled 4. Grandiose	Suicidal Thought	1. None 2. Ideation 3. Plans 4. Means	Homicidal Thought	1. None 2. Ideation 3. Plans 4. Means
Memory / Recent	1. Intact 2. Impaired	Memory / Remote	1. Intact 2. Impaired	Orientation	1. None 2. Person 3. Place 4. Time 5. Situation

Comments: _____

PLAN offered by client in final group: _____

Preliminary Recommendation(s):

- | | |
|---|--|
| <input type="checkbox"/> No formal recommendation: Isolated incident | <input type="checkbox"/> Standard Outpatient Counseling |
| <input type="checkbox"/> No formal recommendation: Judgment/maturity | <input type="checkbox"/> Intensive Outpatient Counseling |
| <input type="checkbox"/> No formal recommendation: Some additional risk | <input type="checkbox"/> Inpatient or Residential care |
| <input type="checkbox"/> Alcohol Anonymous | <input type="checkbox"/> Currently in treatment: _____ |

DIAGNOSIS / SUMMARY:

DSM-5

- Alcohol is often taken in larger amounts over a longer period than was intended. (See DSM-IV, criterion 7.)
- There is a persistent desire or unsuccessful efforts to cut down or control alcohol use. (See DSM-IV, criterion 8.)
- A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects. (See DSM-IV, criterion 9.)
- Craving, or strong desire or urge to use alcohol. ****This is new to DSM-5****
- Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home. (See DSM-IV, criterion 1.)
- Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol. (See DSM-IV, criterion 4.)
- Important social, occupational, or recreational activities are given up or reduced because of alcohol use. (See DSM-IV, criterion 10.)
- Recurrent alcohol use in situations in which it is physically hazardous. (See DSM-IV, criterion 2.)
- Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol. (See DSM-IV, criterion 11.)
- Tolerance, as defined by either of the following:
 - a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
 - b) A markedly diminished effect with continued use of the same amount of alcohol. (See DSM-IV, criterion 5.)
- Withdrawal, as manifested by either of the following:
 - a) The characteristic withdrawal syndrome for alcohol (refer to criteria A and B of the criteria set for alcohol withdrawal).
 - b) Alcohol (or a closely related substance, such as benzodiazepine) is taken to relieve or avoid withdrawal symptoms. (See DSM-IV, criterion 6.)

The presence of at least two of these symptoms indicates an **Alcohol Use Disorder (AUD)**.

The severity of the AUD is defined as:

Mild: The presence of 2 to 3 symptoms.

Moderate: The presence of 4 to 5 symptoms.

Severe: The presence of 6 or more symptoms.

Services Supervisor Signature: _____ **Date:** _____

Recommendation(s):

- | | |
|---|--|
| <input type="checkbox"/> No formal recommendation: Isolated incident | <input type="checkbox"/> Standard Outpatient Counseling |
| <input type="checkbox"/> No formal recommendation: Judgment/maturity | <input type="checkbox"/> Intensive Outpatient Counseling |
| <input type="checkbox"/> No formal recommendation: Some additional risk | <input type="checkbox"/> Inpatient or Residential care |
| <input type="checkbox"/> Alcohol Anonymous | <input type="checkbox"/> Currently in treatment: _____ |

Clients Reaction to the Recommendation Offered: _____

LEVEL OF PARTICIPATION (Defenses noted during the weekend)

Denial Anger Changing subject Minimizing Silence Inattentive

Rationalizing Lying Observed Sleeping Compliance Humor

Did the defenses persist through the weekend? No Yes Explain: _____

Overall Participation: Minimal (ignored, refused, silent) Adequate Active

Questions/Comments: None Some Frequent and appropriate

Benefit from Program: Minimal Some Seemed to Help Great Deal

Openness to feedback from staff and other clients: Minimal Some Great Deal

Professional Financial Counselor Directory

DISCLAIMER

Persons using this resource list for help in seeking a professional financial counselor, **DO SO AT THEIR OWN RISK!** Three Oaks Center, Inc. is NOT an accrediting or licensing organization and makes no claims or guarantees as to the competency of the services provided or the professional qualifications of individuals or organizations. This resource list is simply a directory of financial counselors. Three Oaks Center, Inc. is not attempting to provide a referral service. The services mentioned on this resource list may not be suitable for you. You should use due care and your own skill and judgment in making that determination. Information included in this list is provided by professionals themselves, and Three Oaks Center, Inc. does not seek to verify and does not warrant the accuracy of the information provided by said professionals.

The financial counselors listed below have not paid Three Oaks Center, Inc. a fee in order to be included in this directory. This directory service is for informational purposes only and is entirely complimentary.

Persons who use this list for help in seeking a professional financial counselor are urged to be wise consumers and inquire directly about a particular individual's qualifications. Factors which may be important to ask about include the professional's (1) education and training, (2) licensing or certification, (3) experience, (4) area(s) of specialization, (5) Christian perspective, and (6) fees. Any legitimate professional will be happy to answer questions about such matters.

RESOURCES

James Investment Research, Inc.:

1349 Fairgrounds Road
Xenia, Ohio 45385
(937) 426-7640 or 1-800-99-JAMES
E-mail: jir@jir-inc.com
Website: <http://www.jamesfunds.com>

Barry James, President
(investment mgmt. & research company)

Budulator Corporation:

6502 Troy Pike, Ste. 102
Huber Heights, OH 45424
(937) 237-7719
Website: www.budulator.net

Ray Walker III, Founder & President
(a fee-based budget mgmt. service)

Morgan Stanley Dean Witter & Co.

1800 Lyons Road
Centerville, OH 45458
(937) 432-1150 or (937) 432-1155
Email: David.Cox@morganstanley.com
Website: <http://www.morganstanley.com>

David Cox, Certified Financial Planner &
Vice President (investment mgmt. &
research company)

Professional Resource Directory

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Persons who use this directory for help in seeking professional resources are urged to be wise consumers and inquire directly about a particular resource's qualifications. Factors which may be important to ask about include, yet are not limited to, the resource's (1) education and training, (2) licensing or certification, (3) professional experience, (4) area(s) of specialization, (5) Christian or faith-based perspective, (6) fees and eligibility for insurance payments. Any legitimate professional will be happy to answer questions about such matters.

KEY (see resource websites for more specific information)

Academic Degrees (most common)

MA = Master of Arts
Therapist

MS = Master of Science
Counselor

MSW = Master of Social Work
Worker

Ph.D. = Doctoral degree, research oriented

Psy.D. = Doctoral degree, practitioner oriented

Licensure (most common)

IMFT = Independent Marriage & Family

LCDC = Licensed Chemical Dependency

LISW = Licensed Independent Clinical Social

LP = Licensed Psychologist

LPCC = Licensed Professional Clinical
Counselor

State of Ohio Licensure Boards

- Counselor, Social Worker and Marriage and Family Therapist Board (CSWMFT Board)
Brian Carnahan, Executive Director, 614-752-5161, Brian.Carnahan@cswb.ohio.gov
50 West Broad Street, Suite 1075 ~ Columbus, Ohio 43215-5919; Web: <http://cswmft.ohio.gov>
Phone: (614) 466-0912; Fax: (614) 728-7790; Email: cswmft.info@cswb.state.oh.us
- Ohio Chemical Dependency Professionals Board (OCDP Board) ~ Amanda Ferguson, Executive Director
Vern Riffe Center, 77 S. High Street, 16th Floor ~ Columbus, OH 43215; Web: <http://ocdp.ohio.gov>
Phone: (614) 387-1110; Fax (614) 387-1109; Email: ferguson@ocdp.state.oh.us
- State Board of Psychology (PSY Board) ~ Ronald R. Ross, Ph.D., CPM, Executive Director, 614-466-1085
Vern Riffe Center, 77 S. High Street, Suite 1830 ~ Columbus, OH 43215-6108; Web:
<http://www.psychology.ohio.gov>
Phone: (614) 466-8808; Fax: (614) 728-7081; Toll Free: (877) 779-7446; Email: psy.dir@psy.ohio.gov

Addiction Intervention and Treatment Resources

Consumer Advocacy Model (CAM) Program

6 So. Patterson Blvd.
Dayton, OH 45402
Contact: Melissa Jones, Clinical Supervisor @ 937-222-2400, x. 259
Email: mzjones@premierhealth.com
Phone: Nicole Duff @ 937-222-2400, x. 246
Web: www.sbhihelp.org

- Outpatient treatment for adults experiencing alcohol, drug, and/or mental health problems with a focus on persons with physical, cognitive, and developmental disabilities.
- Our Mission: To provide mental health and addiction services that touch, teach, and heal.

Christopher House

TCN Behavioral Health Services
452 West Market Street
Xenia, OH 45385
Contact: Nate Crago, LCDC-II; Christopher House Manager; 937-376-8785
Phone: 937- 376-8700
Fax: 937- 376-8793
Web: www.tcn-bhs.org

- TCN is proud to operate Christopher House, a 16-bed facility where residents participate in a Chemical Dependency Treatment Program based upon individual need but typically runs up to 60 days. Potential clients should attend one of TCN's [AOD Walk-In Clinics](#) where eligibility will be determined. Christopher House is open to men over the age of 18 who need an intensive residential program to address their alcohol and/or chemical addiction. We specialize in clients who are dual-diagnosed (mental illness and chemical dependency).
- NOTE: If you have an urgent issue, TCN provides 24-hours Emergency Services. Please call 376-8701 for immediate response.

Darke County Recovery Services ~ Marie Dwyer Recovery Services

228 North Barron Street
Eaton, OH 45320
Phone: 937-456-7694 or 1-800-456-9909
Standard Outpatient Treatment
Payment options: sliding fee scale, self pay, insurance, Medicaid

Darlene Bishop Home for Life (Faith-based program)

703 Union Road
Lebanon, OH 45036
Phone: 513-423-5433
Email: director@dbhl.org
Web: www.dbhl.org

The mission of the Darlene Bishop Home for Life is to minister to the needs of women 18 and older that are pregnant, or dealing with abuse, or addictions and to encourage positive choices within an atmosphere of hope and healing. The Home for Life provides shelter, food, discipleship training, life skills preparation, job skills readiness, thereby, equipping each resident with the necessary tools to be set free and lead productive lives within their communities.

The Darlene Bishop Home for Life, Inc. provides a unique program, which combines important resources, training, and educational support under one roof.

In many communities there are shelters for the homeless, day care centers for children, and agencies that provide education about pregnancy, drug and/or alcohol dependency counseling. Very few communities offer a residential

facility specifically for the purpose of helping women who face consequences from life destructive choices. Some women are searching for a message of hope that will turn around personal abuse and neglect. The Home for Life provides an individualized program for them, which includes training in the practical aspects of living, such as budgeting and finance, nutrition, fitness and much more.

The Home offers compassionate care to individuals who are serious about their futures. It is our desire to be there in the "tough" times for those needing it most. There is help. There are answers!

Girls/Guys Off Drugs (GOD) Program (Faith-based program)

P.O. Box 602

LICDC-S

Fairborn, OH 45324

Phone: 937- 405-1743

Location: Church Bldg Offices, 1443 Steiner Avenue, Dayton, Ohio 45417

Location: Church Bldg Offices, 107 E. Dayton-Yellow Springs Rd., Fairborn, Ohio 45324

Rev. Ronald L DeBlanc, DD, MA-Psy, ThB, BS,

- Looking for a new life. Tire of alcohol & other drugs controlling your life. Depression, worry, fear & anger. We can help!! Individual, couples, group and family therapy.
- We implement evidence based, best practice in our treatment. Moreover, we can integrate spirituality & holistic in our counseling/therapy if desired. Confidentiality as well as the comfort of meeting at a church as opposed to some big conglomerate that allows people to know your business. We also do HOME visits. Just call us.
- We apply practical guidance in counseling. My wife, Debra, is also a therapist and will be willing to address various issues with you (domestic violence, womanhood, relationship, trauma & PTSD, woman issues, etc.).
- Alternative Languages: French
- Age: Preteens / Tweens (11 to 13); Adolescents / Teenagers (14 to 19); Adults, Elders (65+)
- Treatment Orientation: Coaching, Cognitive Behavioral (CBT), Family Systems, Intervention, Limit & Lead, MET, Reality
- Therapy, Solution Focused Brief (SFBT)
- Modality: Individuals, Family, Group

His Hope Mission (Faith-based program)

Teen Challenge

P.O. Box 249

Milford, OH 45150

Contact: Rusty Toadvine @ 937-238-7385

Email: rusty.toadvine@gmail.com <mailto:rtoadvine@teenchallengecincinnati.org>

Web: www.hishopemission.org

- His Hope Mission is an Outreach / Referral mission of Teen Challenge Cincinnati founded in 2014; part of the Teen Challenge USA network. His Hope Mission offers hope to hurting people through support groups, outreach programs and their referral program.

Joshua Recovery Ministries (JRM) (Faith-based program)

70 Birch Alley, Suite 240

Beavercreek, OH 45440

Contact: Ron Will, Ex. Dir. @ 937-602-1689

Phone: 937-306-6421

Web: <http://www.joshualife.org>

- Alcohol and Drug in-house recovery program and counselling services available.
- Regardless of your type of substance addiction or sexual addiction issue, Joshua Recovery Ministries wants to be a part of the support team and help network that you need in your recovery. Our purpose and hope in working with you will be:

- Re-establishing goals for your life and future
- Rebuilding broken relationships
- Regaining interest and passion in your life
- Experiencing true joy and peace
- Becoming the person you know you were meant to be

McKinley Hall

1101 East High Street
 Springfield, OH 45505
 Contact: Mike Wallace or Sara Collinsworth
 Phone: 937- 328-5300
 TTY/Texting: (937) 328-5300, x. 127
 Web: www.mckinleyhall.org

- Standard Outpatient Treatment and Intensive Outpatient Treatment
- Payment options: sliding fee scale, self pay, insurance, Medicaid
- Serving Clark County for over 30 years, McKinley Hall is an experienced agency in providing optimal drug and alcohol treatment services and fiscal prudence. McKinley Hall is a private, nonprofit contract agency of the Mental Health and Recovery Board of Clark, Greene and Madison Counties, United Way, Housing and Urban Development, the City of Springfield, Ohio Department of Corrections, Ohio Department of Rehabilitation Services and the Ohio Department of Alcohol and Drug Addiction Services. McKinley Hall is the leader in Clark County in providing substance abuse services to the community.

Miami County Recovery Council

1059 North Market Street
 Troy, OH 45373
 Phone: 937-335-4543
 Web: <http://www.mcrcinc.org>
 Standard Outpatient Treatment

- MCRC is a non-profit agency. All services are provided on a sliding fee scale, based on ability to pay.
- Payment options: sliding fee scale, self pay, insurance, Medicaid
- Services include: Screening, evaluation, diagnosis and treatment; individual, family and group counseling; aftercare services; case management; education series for adults; services for adolescents; referral to other agencies when appropriate; employee assistance programs for business and industry; prevention and education activities; women's services; psychiatric services; and drug court programs.

New Destiny Treatment Center (Faith-based program)

6694 Taylor Rd.
 Clinton, OH 44216
 Phone: 330-825-5202
 Web: <http://www.newdestinytreatmentcenter.org>

- The center is a 65-bed facility in Clinton, Ohio. It provides 9 months of inpatient residential treatment. All of the counselors have a Chemical Dependency Counseling license from the State of Ohio.
- Our mission is to operate a chemical dependency program for the purpose of providing holistic services in a distinctly Christian environment to the chemically dependent. We aim to accomplish this mission by providing for the physical health, emotional well-being, spiritual guidance, and economic improvement of each client.
- Suboxone treatment is used to help individuals overcome addiction to opioids like heroin, methadone or prescription painkillers. Individuals who undertake this treatment are required to participate in ongoing alcohol and drug treatment to ensure the best chance of successful addiction treatment.
- For cost of Outpatient Suboxone Program and information contact Lisa Berger 330-825-5202, ext. 115.

New Hope New Life (Faith-based program)

425 N. Findlay St.
Dayton, OH 45404

Contact: David F. Adams, Director / Certified Community Service Chaplain (CCSC) @ 937-654-5130

Phone: 937-253-8850

Email: dadams@newhopewellife.com

Web: <http://newhopewellife.com>

- Provides recovery coaching services for individuals over a thirteen (13) week period, addressing thirty-five (35) assets which enhance the recovery process.

Nova Behavioral Health, Inc.

732 Beckman Street
Dayton, Ohio 45410

Contact: Jay Wainscott, Detox Services

Phone: 937-253-1680 or 1-800-750-0750

Web: novabehavioralhealth.org

- The mission of Nova Behavioral Health, Inc. is to provide individuals and families opportunities for positive change.
- Our Programs: NOVA Behavioral Health offers a continuum of comprehensive alcohol and drug treatment services and mental health residential programming. Our goal is to provide the highest level of quality care across the continuum of care.
- Programs: Out-patient, residential, and aftercare alcohol and drug treatment; Residential care for mental health treatment needs

Safe Harbor House (Faith-based program)

PO Box 124
Springfield, OH 45501

Contact: Amy Willmann, Ex. Dir.

Phone: 937-717-5908

Email: info@safeharborhouse.org

Web: <http://safeharborhouse.org>

- Safe Harbor is a 24/7 residential sober-living community, transition, and faith-based program that empowers women toward healing and equips them with life skills for quality living. Located in the heart of Springfield, Ohio, Safe Harbor currently consists of three homes – Safe Harbor House (focusing on trauma treatment), The Lighthouse (focused on transition and support), and one
- Alumni House (for women who have completed the 1-year program who would like to stay connected to the community through independent living and support).
- We desire to provide a safe place for women who find themselves at the intersection of substance abuse and various kinds of trauma, including:
 - Physical, emotional, or sexual abuse
 - Domestic Violence
 - Prostitution/Trafficking
 - Homelessness
- The complexity of the issues facing the women at Safe Harbor necessitates an approach that deals with these challenges from every possible angle.

Salvation Army, Adult Rehabilitation Center (Faith-based program)

913 S. Patterson Blvd.
Dayton, OH 45402

Contact: Kristen McCullar, Intake Counselor, (937) 461-2769, x.112

Web: <http://www.satruck.org/rehabilitation-program>

- The Salvation Army's Adult Rehabilitation Centers provide spiritual, social and emotional assistance for men and women who have lost the ability to cope with their problems and provide for themselves. This is a residential program, 6 months in length. There are 12 beds for females and 58 beds for males.
- Each center offers residential housing, work, and group and individual therapy, all in a clean, wholesome environment. The physical and spiritual care that program participants receive prepares them to re-enter society and return to gainful employment. Many of those who have been rehabilitated are reunited with their families and resume a normal life.
- Who Is Eligible?
 - Every potential participant undergoes a comprehensive intake interview to ensure the ARC program is the best possible match for them. If the interview process determines it's not, we'll make every effort to refer them to a program that will be.
 - A long-term commitment of at least six months is required so patterns of poor decision-making can be broken and replaced with positive life choices – changes that will help them become productive citizens of their community.
 - Applicants* with a desire to get help may be referred by families, friends, courts, clergy and community leaders or may simply call the Intake Office at 1-800-SA-TRUCK (1-800-728-7825) to make an appointment or get more information about local ARC programs.

Samaritan Behavioral Health, Inc. (SBHI)

601 Edwin C. Moses Blvd.
 Elizabeth Place - First Floor
 Crisis Care Center
 Dayton, Ohio 45417
 Phone: 937-734-8333
 Web: <http://www.sbhihelp.org>

- SERVICES: Standard Outpatient Treatment, Intensive Outpatient Treatment, Medication Assisted Treatment (Suboxone), Combined Mental Health and Substance Abuse Treatment, Naloxone Kit Distribution.
- Who Can Participate? Anyone over the age of 18 can participate in substance abuse treatment.
- Who Provides Services? SBHI provides Masters level drug counselors and alcohol counselors who are credentialed in the State of Ohio.
- Payment Options: Medicaid, Self Pay, Sliding Scale
- Vision: Where help with life's challenges is openly sought and compassionately given.
- Mission: To provide mental health and addiction services that touch, teach, and heal.
- Values: Compassion, integrity, excellence, and teamwork.

Solutions Community Counseling & Recovery Centers

975A Kingsview Dr.
 Lebanon, OH 45036
 Contact: Jane L. Groh, Director of Operations @ 513-228-7873
 Email: jgroh@solutionsccrc.org
 Phone: 513-228-7800
 Web: <http://www.solutionsccrc.org>

- Substance Abuse Treatment: Solutions CCRC provides substance abuse treatment in the Cincinnati area for those with substance abuse issues. We have certified drug abuse counselors and alcohol abuse counselors who work extensively with those who are struggling with substance abuse. Our substance abuse counselors use a wide variety of substance abuse treatment methods, including specific drug abuse treatment methods and alcohol abuse treatment methods. If you, or someone you know, struggles with substance abuse, alcohol abuse or drug abuse, please contact one of our substance abuse counselors at a Solutions CCRC location near you. We can provide substance abuse treatment geared toward your specific circumstance.
- Drug Addiction Treatment: Solutions provides evidenced based drug and alcohol assessment, individual, group, and family substance abuse treatment services. The level of service and frequency varies according to the assessed need of the individual. We offer select times at each site where individuals may walk-in and receive an assessment the same day. Solutions also offers groups in the evening to accommodate clients' work schedules.

- Who can participate? Anyone can participate in our substance abuse treatment programs.
- Who provides the service? Solutions has drug counselors and alcohol counselors who are credentialed by the State of Ohio.
- Payment: Most major insurances are accepted, non-insured, and Medicaid patients eligible. A sliding fee scale is available to all Clinton and Warren County residents. Locations: Lebanon, Mason, Springboro, and Wilmington, Ohio.

Talbert House

759 Columbus Ave.

Lebanon, OH 45036

Contact: Dan Molins

Phone: 513-221-HELP (4357). Crisis or immediate service available by calling 513-281-CARE (2273) or Text TALBERT to 839863 for help. Emergency phone lines are staffed 24 hours a day, seven days a week, offering crisis intervention, information and referral services.

Web: www.talberthouse.org

- Talbert House helps children, adults and families coping with substance abuse, mental health and/or involvement in the legal system to support positive growth and change. With a focus on quality and integrated care Talbert House services are managed in five service lines: adult behavioral health (includes mental health and substance abuse assessment and treatment services); community care; court and corrections; housing; and youth behavioral health.
- This alignment of services helps us to be more responsive to the needs of the community, provides flexibility in service delivery and fully utilize our staff expertise. We are focused on men, women and children who are entrusted in our care each and every day. Making it easier for them to access our services and take advantage of all we have to offer.
- Integrated care improves communication, opportunity and outcomes for our clients, their families and our community.

Teen Challenge: Cincinnati Men's Ranch and Women's Home (Faith-based program)

P.O. Box 249

Milford, Ohio 45150

Contact: Admissions Director at 513-248-0452, x.102; George Martin, Executive Director

Email: email@teenchallengecincinnati.org

Web: www.teenchallengecincinnati.org

Adult Center (Male) - Induction/Training

Note: Ages 18-35

Costs: \$350 Application/Intake Fee; \$900 Monthly

- Our residential (live-in) component is for men 18 to 35 years of age. Our waiting list is normally a week but has been over 15 days at times. We have a non-refundable intake fee of \$350 and a monthly assessed fee of \$900 (which is less than ½ our total costs). We are privately funded and subsidize all students (average of \$1,300/mo per student) through individual, corporate and church donations. 25% of our bed space is allocated for destitute individuals.
- Teen Challenge Cincinnati Men's Ranch and Women's Home are Honor Accredited residential facilities within the Teen Challenge USA network. A 9 to 12 month program, Teen Challenge Cincinnati is a faith based, highly disciplined educational program focusing on men and women (pregnant and not pregnant) 18 to 35 years of age.
- Our purpose is Restore God's Dignity and Destiny in the Hearts and Minds of Men, Women, and their Children!
- Operating at a capacity of 36 men and 9 women. Teen Challenge Cincinnati is structured to meet the spiritual, mental and physical needs in the student's lives. Our focus is less on treating symptoms and more on addressing the constraints in an individual's life. Student's go through intensive studies, receive their GED if necessary, participate in occupational therapy and receive life equipping skills along with job placement opportunities.

Teen Challenge Columbus (Faith-based program)

P.O. Box 24099

Columbus, OH 43224

Phone: (614) 476-4600

Contact: Jenny, Intake Coordinator [Mon.-Thurs., 9:am-4:pm]; Linda Hercenberg, Executive Director

Email: tccols@att.net

Web: <http://www.teenchallengecolumbus.net>

- Teen Challenge Columbus offers a Christian drug and alcohol rehabilitation program for women age 18 and over.
- Program average length of stay 14 months; financial obligation TBD by intake coordinator.
- Application, plus: copy of a photo ID; results of 3 blood tests ~ Hepatitis panel (A,B,C), HIV, and TB [these may be obtained through the Montgomery County Combined Health District].

The Good Samaritan's Inn (Faith-based program)

621 South Erie Hwy.

Hamilton, OH 45011

Phone: 513-896-5354

Contact: Anthony "Skip" Skipworth, Intake Coordinator

Email: nkeeper3@yahoo.com

Web: www.thegsi.com

Christian Drug Rehabilitation Center ~ Our Mission is Faith-based Recovery

- The mission of The Good Samaritan's Inn is to provide refuge, recovery and restoration along with Christian counseling. Our Christian residential treatment program uses the Word of God, and spirit-filled guidance, to bring those who suffer from alcohol or drug addiction to the understanding of what it means to become a new creation in Christ.
- Our Christian recovery program is family-focused, and also has its goal the restoration of family relationships that have been damaged by substance abuse and the dysfunctionality that accompanies it.
- The Good Samaritan's Inn offers effective, Christian counseling and recovery in the form of a 6-month residential program for men 18 years and older. If you're suffering from addiction, and want to restore your relationship with Christ, our faith-based recovery program will help you on this magnificent journey. If you have a family member or employee that is ready to stop the denials and acknowledge they need help, our Christian recovery program is for you as well. Our commitment is to heal the mind, body and soul, and to restore each person to their full potential as a unique creation of God.

The Jeremiah Tree (Faith-based program)

118 West Second Street

Xenia, OH 45385

Phone: 937-562-3121; Greg Delaney, Ex. Director

Addiction counseling by appointment. Christ-centered. Practical assistance through agency partnerships.

The Refuge (Faith-based program)

Refuge Ministries

PO Box 919

Grove City, Ohio 43123

Phone: 614-991-0131

Email: info@mensliveschanged.org

Web: <https://mensliveschanged.org>

- A Christian community service organization based in Columbus, OH area, committed to serving men of all socio-economic backgrounds and the communities in which they live. As a Christian ministry, The Refuge is dedicated to rebuilding the lives of men, 18 years and older, who have struggled with drugs, alcohol, other addictions, or just feel hopeless and lost.

The Ridge

50 West Technecenter Dr., Suite B-5
Milford, OH 45150
Intake Line: 513-732-1324
Web: www.theridgeohio.com

- The Midwest's premier residential treatment center for adults, male & female. Highly focused drug and alcohol recovery. Upscale accommodations on a private 51-acre estate. Unparalleled tranquility, clinical care and comfort. Joint Commission accredited.

Three Oaks Center, Inc. (Faith-based program)

6077 Far Hills Ave., #157
Centerville, OH 45459
Phone: 937-520-8496
Contact: Kevin R. Hoffman, D.Min. cand., LICSW (retired), LCDC-II, ICADC, Certified Pastoral Counselor & Fellow (AAPC)
Email: Kevin@ThreeOaksCenter.com
Web: ThreeOaksCenter.com

- Early Intervention Program (EIP): A Faith-based Early Intervention Program for Individuals with Alcohol & Drug Issues
- When an individual gets arrested for any alcohol or drug related offenses, a crisis of faith ensues. *"How did this happen? What will my family and friends think about me? How will my life have meaning? Is this going to wreck my future? What is the purpose of my life?"*
- Our Faith-based Early Intervention Program (EIP) can help people sort through confusing questions and empower them to make self-enhancing choices that can change the course of one's life!
- Addiction is a "bio-psycho-social-spiritual phenomenon" (Katherine van Wormer, MSSW, PhD, Professor of Social Work, University of Northern Iowa and Diane Rae Davis, MSW, PhD, Professor of Social Work, Eastern Washington University, authors of *Addiction Treatment: A Strengths Perspective*).
- Recovery from alcohol and drug related issues (including addiction) is defined as, "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (The Substance Abuse and Mental Health Services Administration-SAMHSA).
- Therefore, our program addresses the seven dimensions of whole-person growth: physical, mental, spiritual, relational/social, vocational/educational, recreational, and interpersonal-institutional/natural environments. (Howard Clinebell, PhD, founder of the Institute of Religion and Wholeness at Claremont School of Theology, author of *Understanding and Counseling Persons with Alcohol, Drug, and Behavioral Addictions*).
- Our methodology includes the use of scientifically-validated screening/triage tools; and evidenced-based programs and practices such as motivational interviewing, solution-focused group therapy, and Twelve Step facilitation therapy (SAMHSA's National Registry of Evidenced-based Programs and Practices-NREPP).
- Our primary initial goal is to help people to mobilize and use their latent psychological, relational, and spiritual resources to handle their immediate crisis constructively.

Turning Point Behavioral Services

Miami Valley Hospital
725 South Ludlow Street
Dayton OH 45409
Phone: 937- 208-4673
Hotline: 937-224-4646
Web: miamivalleyhospital.org

- Recovery in a Caring Environment ...
- Our gender-specific services are designed to meet the unique needs of women, value the female perspective, celebrate and honor the female experience, respect female development and empower women to recognize their full potential.

Woodhaven

1 Elizabeth Place
Dayton, Ohio 45417
Phone: 937- 813-1737 or 1-800-788-0440
Web: <http://www.woodhavenohio.com>

- Our Pledge: We pledge to treat you, our clients, with respect and individual attention.
- Our Mission: To provide healing for those suffering from addiction.
- Some of the Services we provide: Detox and detoxification services, assessments, inpatient/residential treatment, urinalysis, crisis intervention, case management, family counseling, individual counseling, relapse prevention, aftercare.
- Our treatment plan follows the 12-step program.

Wright Patterson AFB – ADAPT & Mental Health Clinics

Medical Center B 113
Wright Patterson AFB, OH 45433
Phone: 937-257-4121

- Active duty, retired military and adult dependents only
- Standard outpatient treatment for alcohol, drug, and mental health issues.

COUNSELING RESOURCES

Agape Counseling Center: (Insurance)

175 South Main Street
 (State Route 48 to Edenhurst)
 Centerville, OH 45458
 Phone: 937-434-0540
 Website: www.agapecounselingcenter.com

Paul D. Entner, Ph.D., LP, Clinical Psychologist
 Cheryl C. Whitmore, Psy.D., LP
 Linda Bilunka, MS, LPCC
 Ruth E. Kauffold, Ph.D., LP
 Rebecca Leubbe, LPCC
 Sarah Plassman, LISW

Aletheia Counseling Center: (Insurance / Sliding Fee Scale)

2675 Medway-New Carlisle Road
 Medway, OH 45341
 Phone: 937-849-1257
 Fax: 937-849-1336
 Email: contact@goaletheia.com

Angelia K. Dussia, MA, LPCC-S; Proprietor

Barbara Farrell, MSW, LISW-S
 Kent Freeland, MA, LPCC-S, IMFT
 Vera Bowie, MS, MSW, LISW

Website: www.goaletheia.com

Gary A. Balster, MD, Inc.: (Insurance)

2218 South Patterson Boulevard
 Dayton, OH 45409
 Phone: 937- 299-1918

Gary A. Balster, MD, Adult Psychiatry

Flexman Clinic: (Insurance)

1 Elizabeth Place, West Pavilion, Suite C
 Dayton, OH 45417
 Phone: 937-256-5300
 FAX: 937-258-4162
 Website: www.theflexmanclinic.com

Jerry E. Flexman, Ph.D., LP, Clinical
 Neuropsychologist
 Marguerite T. Wallace, MS, LPCC
 Margaret H. Roy, MA, LPCC, IMFT
 Rachel D. Fortino, MSW, LISW

JMAC Counseling Center: (Insurance / Sliding Fee Scale)

810 Orchard Lane, Suite 202
 Beavercreek, OH 45432
 Phone: 937-427-9151
 Email: jerrymccluer@earthlink.net
 Website: <http://home.earthlink.net/~jerrymccluer>

Jerry McCluer, MA, LPCC, CCDC-III

Kettering Counseling Care Center: (Insurance)

Sycamore Primary Care Center
 2115 Leiter Road
 (southeast corner of SR 725 & So. Gebhart Church Rd.)
 Miamisburg, OH 45342
 Phone: 937-384-6920 or 1-866-634-0493
 Email: bob.peach@kbnetwork.org
 Website: www.ketteringhealth.org/counseling

Robert Peach, MS, D.Min., LPCC, IMFT
 Betty Hughes, MS, LPCC

Living Water Counseling: (No Insurance)

953 Orville Way
 Xenia, OH 45385
 Phone: 937-477-3895
 Website: <http://ncca.org/Directory/search.aspx>

Wayne Thor, Ph.D.

Living Word Counseling Center

Pastoral Care & Counseling: *Renew, Reform, Redeem*
 Family Life Center
 250 N. Cassel Rd
 Vandalia, OH 45377
 Phone: 937-280-2003, x. 3009
 Email: counselingcenter@dlwc.org

Dennis Durig, D.Min., Pastoral Care Specialist
 Randy Wheeler, MAT, Bd. Cert. Pastoral Counselor
 Dick Smith, Biblical Cert. Christian Counselor

- Living Word Pastoral Care and Counseling Center involved in coming along side of individuals and couples and assisting them through their life's journey. Through the Holy Spirit, the Word of God, and professional training and life's experience, we assist people in going from hurting to being healthy fully functional followers of Christ.

Karen L. Nelson, LPCC-S, LICDC-CS, CEAP: (No Insurance / Sliding Fee Scale)

7071 Corporate Way
 Centerville, OH 45459
 3095 Dayton-Xenia Rd.
 Beavercreek, OH 45434
 Phone: 937-903-6606

Certified Imago Relationship Therapist
 Couples, Individuals & Families

Website: <http://pub.imagorelationships.org> (click on the "Find A Therapist" tab and follow prompts)

New Creation Counseling Center: (Insurance / Sliding Fee Scale)

7695 South County Road 25A; Tipp City, OH 45371
 (South Campus, Ginghamburg Church)
 637 E. Whipp Rd., Centerville, OH 45459
 (Satellite Campus @ Fairhaven Church)
 Phone: 937-667-4678
 Website:

John F. Jung, MS, LPCC-S, Director/
 Clinical Supervisor
 Kitty Kincaid, MGS, MTS, LSW,
 Associate Director
 Jared Mueller, MSW, LSW, Coordinator
 of Off-Site Facilities
 Steven White, MS, LPCC, LICDC
 Elizabeth Boblitt, MA, LPCC
 David Lauffenburger, LP
 Deborah Zunke, MS, LPCC
 Charles Roberts, MS, LPC
 Vicky Kettering, MS, LPCC
 Michelle Gearhardt, JD, LPC
 Dr. Philip Hash, MD ~ Child, Adolescent, Psychiatry

www.newcreationcounselingcenter.org

M. R. Lighthouse Counseling and Consulting Services, LLC

548 W. Alex Bell Rd.
 Centerville, OH 45459
 Phone: 937-416-1093

Michael A. McDonald, MS, M.Div., LPCC
 Rebecca A. Steele, MS, LPCC
 Email: mrlighthouse@woh.rr.com

New Reflections Counseling: (Limited Insurance / Sliding Fee Scale)

267 Regency Ridge Drive
 Centerville, OH 45459
 Phone: 937-396-7077
 Email: mpavlik@nrcounseling.com
 Website: www.nrcounseling.com

Matt Pavlik, MA, PCC-S
 Beth Bench, MS, PCC
 Sophia Sparks, MS, LSW

Doctor Ange: (No Insurance / No Sliding Fee Scale)

1255-G Lyons Road, Centerville, OH 45458
 1 W. National Rd., Vandalia, OH 45377
 Phone: 937-438-0068
 FAX: 937-438-0989
 Email: info@doctorange.com
 Website: <http://doctorange.com>

Dr. Constance E. Ange, DO
 Child, Adolescent & Adult Psychiatry

Patterson Park Church Counseling Ministry: (No Insurance)

3655 East Patterson Road
 (only Tues. & Thurs. evenings)
 Beavercreek, OH 45430
 Phone: 937-427-0130, x133
 Email: rstackhouse@pattersonpark.org
 Website: www.pattersonpark.org

T. L. Drake, MA

True Relationships, Inc.- Marriage Ministry / Reconciling Troubled Marriages: (No Insurance)

1553 Beaver Valley Road
 Beavercreek, OH 45434
 Phone: 937-510-5595
 Counselor/Administrative Assistant
 Email: info@truerelationships.org
 Website: www.truerelationships.org

Tim Buttrey, Pastoral Counselor
 Linda Buttrey, Counselor Support
 Cory Luby, Lay

Sue Buttrey, Lay Counselor
 Amy Nienaber, Lay Counselor,
 Pastoral Counselor-In-Training Sheri
 Schmitt, MSW, LISW (Columbus, OH
 Office)

APPENDIX E. COMPARISON OF AA, MAIMONIDES,
AND RABBENU YONAH OF GERONA¹

GENERIC STEPS	AA STEPS	MAIMONIDES	RABBENU YONAH
THE GREAT AWAKENING	1	A	III, V, VI, XII
BECOME A BELIEVER	2	Rabbinic Judaism assumes this step to be a given.	Rabbinic Judaism assumes this step to be a given.
TURNING TO A HIGHER POWER	3	F	VII
MORAL INVENTORY	4	A, H	XI
ADMITTING OUR WRONGS TO GOD AND OTHERS	5	A, G	XIV
PRAYING FOR GOD'S FORGIVENESS	7	A, F	VIII, XV
ACKNOWLEDGING THOSE WE HAVE HARMED AND PREPARING TO FACE THEM	8	I	XVI
REPARATIONS	9	J	X, XVI
CONTINUING THE MORAL INVENTORY	10	H, K	IV, XV, XVIII, XIX
MAINTAINING THE SPIRITUAL PATH	11	E, H, K	IV, XV, XVIII, XIX
SPREADING THE WORD	12		XX

¹ Carol Glass, "Addiction and Recovery through Jewish Eyes," in *Addiction and Spirituality: A Multidisciplinary Approach*, ed. Oliver J. Morgan and Merle Jordon (St. Louis, MO: Chalice Press, 1999), 242-245.

The Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove all our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

Maimonides

The Laws of Repentance

- A. Confession before God which includes:
 - (1) Naming the specific sin.
 - (2) Statement of regret at having sinned.
 - (3) Expression of shame felt at having sinned.
 - (4) Pledge not to repeat the same sin.
- B. Abandonment of sin.
- C. Change of thought.
- D. Change of name.
- E. Supplication to God.
- F. Public confession (is praiseworthy).
- G. Acknowledgement of your sins on this and the following *Yom Kippur*.
- H. Reparations (compensation) for sins against other people.
 - I. Apology to victims of the sin.
 - J. Self-restraint from repeating the sin when the opportunity to do so presents itself.

Rabbenu Yonah of Gerona

The Gates of Repentance

- I. Regret for having committed the sin.
- II. Forsaking the sin.
- III. Experience sorrow over the transgression.
- IV. Bodily suffering in relation to the sin.
- V. Worry over the punishment for the transgression.
- VI. Feel shame at having transgressed before God.
- VII. Behave with humility (speak in a low voice...).
- VIII. Have a humble attitude.
- IX. Break the physical desire to commit the sin.
- X. Compensation (in actions) to prevent recurrence of sin.
- XI. Moral inventory.
- XII. Consider the punishment from God and the consequences of sin.
- XIII. Minor transgressions as equivalent to major ones.
- XIV. Confession.
- XV. Pray for forgiveness.
- XVI. Reparations (monetary, apology, request forgiveness, confession).
- XVII. Pursue acts of loving-kindness and truth.
- XVIII. Keep your sin before you always.
- XIX. Fight off your evil inclination. Don't give in to sin when the desire is strong.
- XX. Turn others away from transgression.

These are two versions of the prescribed way for a Jew to do *Teshuvah* (repentance), that is, the method for Jews to change and redress unethical behavior, thereby achieving a return to acceptable conduct and spiritual wholeness.

APPENDIX F. CELEBRATE RECOVERY: TWELVE STEPS AND THEIR BIBLICAL COMPARISONS¹

1. We admitted we were powerless over our addictions and compulsive behaviors, that our lives had become unmanageable

“I know that nothing good lives in me, that is, in my sinful nature. For I have the desire to do what is good, but I cannot carry it out.” (Romans 7:18)
2. We come to believe that a power greater than ourselves could restore us to sanity.

“For it is God who works in you to will and to act according to his good purpose.” (Philippians 2:13)
3. We made a decision to turn our lives and our wills over to the care of God.

“Therefore, I urge you, brothers, in view of God’s mercy, to offer your bodies as living sacrifices, holy and pleasing to God—this is your spiritual act of worship.” (Romans 12:1)
4. We made a searching and fearless moral inventory of ourselves.

“Let us examine our ways and test them, and let us return to the LORD.” (Lamentations 3:40)
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

“Therefore confess your sins to each other and pray for each other so that you may be healed.” (James 5:16)
6. We were entirely ready to have God remove all these defects of character.

“Humble yourselves before the Lord, and he will lift you up.” (James 4:10)
7. We humbly asked Him to remove all our shortcomings.

“If we confess our sins, he is faithful and will forgive us our sins and purify us from all unrighteousness.” (1 John 1:9)
8. We made a list of all persons we had harmed and became willing to make amends to them all.

“Do to others as you would have them do to you.” (Luke 6:31)

¹ John Baker, *Your First Step to Celebrate Recovery: How God Can Heal Your Life* (Grand Rapids, MI: Zondervan, 2012), 119-121.

9. We made direct amends to such people whenever possible, except when to do so would injure them or others.

“Therefore, if you are offering your gift at the altar and there remember that your brother has something against you, leave your gift there in front of the altar. First go and be reconciled to your brother; then come and offer your gift.” (Matthew 5:23-24)

10. We continue to take personal inventory and when we were wrong, promptly admitted it.

“So, if you think you are standing firm, be careful that you don't fall!” (1 Corinthians 10:12)

11. We sought through prayer and meditation to improve our conscious contact with God, praying only for knowledge of His will for us and power to carry that out.

“Let the word of Christ dwell in you richly.” (Colossians 3:16)

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

“Brothers, if someone is caught in a sin, you who are spiritual should restore him gently. But watch yourself, or you also may be tempted.” (Galatians 6:1)

APPENDIX G. CELEBRATE RECOVERY:

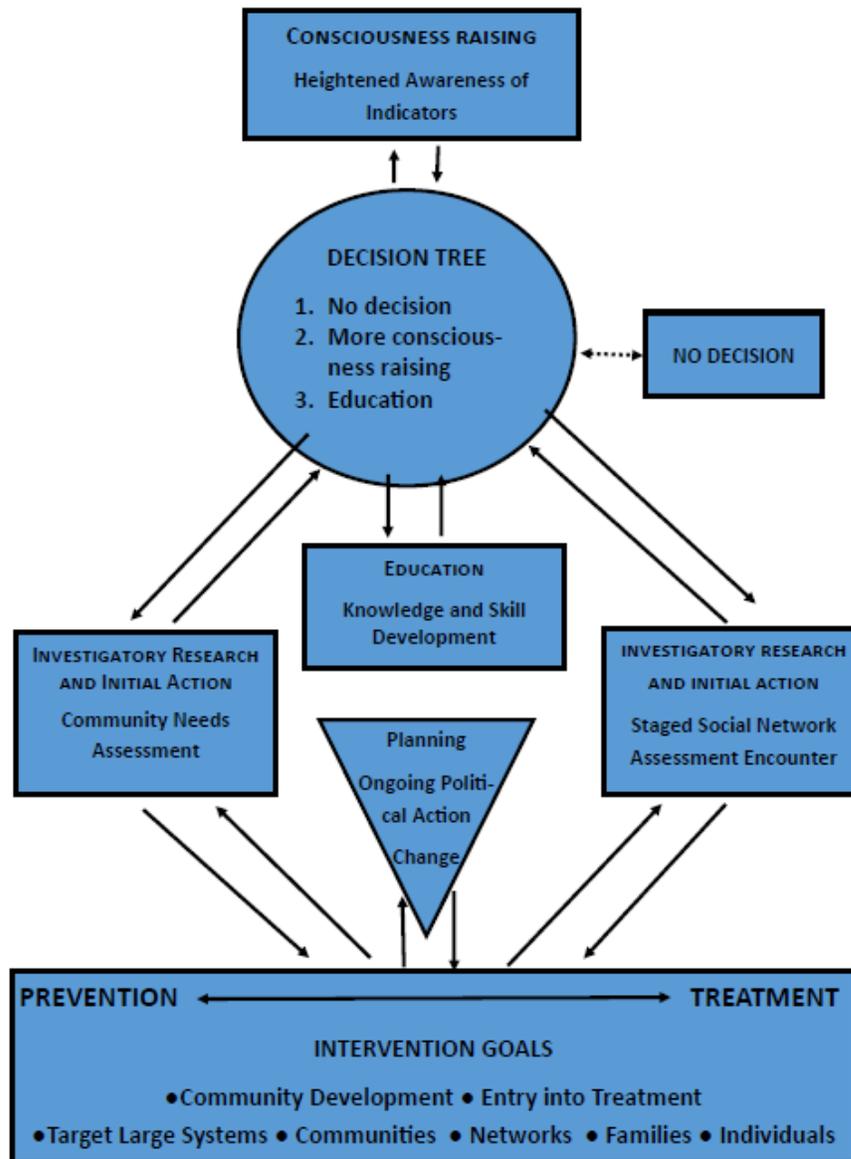
THE EIGHT PRINCIPLES OF RECOVERY¹

Principle 1	Realize I'm not God. I admit that I am powerless to control my tendency to do the wrong thing and that my life is unmanageable (Step 1). <i>"Happy are those who know they are spiritually poor" (Matthew 5:3).</i>
Principle 2	Earnestly believe that God exists, that I matter to Him, and that He has the power to help me recover (Step 2). <i>"Happy are those who mourn, for they shall be comforted." (Matthew 5:4).</i>
Principle 3	Consciously choose to commit all my life and will to Christ's care and control (Step 3). <i>"Happy are the meek" (Matthew 5:5)</i>
Principle 4	Openly examine and confess my faults to myself, to God, and to someone I trust (Steps 4 and 5). <i>"Happy are the pure in heart" (Matthew 5:8).</i>
Principle 5	Voluntarily submit to every change God wants to make in my life and humbly ask Him to remove my character defects (Steps 6 and 7). <i>"Happy are those whose greatest desire is to do what God requires (Matthew 5:6).</i>
Principle 6	Evaluate all my relationships. Offer forgiveness to those who have hurt me and make amends for harm I've done to others, except when to do so would harm them or others (Steps 8 and 9). <i>"Happy are the merciful" (Matthew 5:7). "Happy are the peacemakers (Matthew 5:9).</i>
Principle 7	Reserve a daily time with God for self-examination, Bible reading, and prayer in order to know God and His will for my life and to gain the power to follow His will (Steps 10 and 11).

¹ John Baker, *Your First Step to Celebrate Recovery: How God Can Heal Your Life* (Grand Rapids, MI: Zondervan, 2012), 29.

Principle 8	Yield myself to God to be used to bring this Good News to others, both by my example and by my words (Step 12). <i>“Happy are those who are persecuted because they do what God requires.” (Matthew 5:10).</i>
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APPENDIX H. PAULO FREIRE'S MODEL¹



¹Paulo Freire's model of "Intervention as the Foundation for Prevention and Treatment," in *Substance Abuse Intervention, Prevention, Rehabilitation, and Systems Change Strategies: Helping Individuals, Families and Groups to Empower Themselves*, Edith M. Freeman (New York, NY: Columbia University Press, 2001), 141.

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