

Opioid Use Disorder Toolkit for Faith-Based Community Leaders

A TOOLKIT CREATED BY
THE OPIOID RESPONSE NETWORK



Opioid
Response
Network
STR-TA/SOR-TA

SAMHSA
Substance Abuse and Mental Health
Services Administration

Overview of ORN

The Opioid Response Network (ORN) formed in 2018 in response to the national opioid epidemic and is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) through grants awarded to the American Academy of Addiction Psychiatry (AAAP). ORN is led by AAAP in collaboration with the Addiction Technology Transfer Centers (ATTC), the Columbia University Division on Substance Use Disorders and 40 national professional organizations representing over two million constituents. The network provides education, training, mentoring and other forms of evidence-based technical assistance (TA) to all U.S. states and territories at no cost.

Technical Assistance

ORN's TA system is built upon the structure of the ATTC, which is modeled after the U.S. Department of Health and Human Services' 10 regional offices and a central office to coordinate national efforts. Each state and territory is assigned a local team of consultants led by a regional Technology Transfer Specialist (TTS). Technology Transfer Specialists are specialized in the implementation of evidence-based practices and respond to a range of basic and complex TA requests that target prevention, treatment, and recovery of opioid use disorders (OUD) and stimulant use disorders.

ORN is available to states, cities, organizations (including faith-based organizations), and individuals located within the U.S. and its territories. All are welcome to visit www.opioidresponsenetwork.org to submit a TA request and receive personalized assistance and educational resources, completely free of cost. Within 24 business hours of submitting a TA request form, a TTS will respond to the requester.

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Opioid Use Disorder Toolkit for Faith-Based Community Leaders

INTRODUCTION





Purpose

The Opioid Use Disorder (OUD) Toolkit for Faith- Based Community Leaders and Organizations is designed to assist faith-based leaders in responding to the opioid crisis. The concept of this toolkit arose from a request submitted to the Opioid Response Network (ORN) by a member of the clergy of the Episcopal church who asked for resources to better assist members and their families struggling with OUD. The OUD Toolkit provides current information, resources, and action steps to support faith-based leaders in meeting the needs of their members and communities related to the opioid crisis and OUD.

Understanding the Opioid Epidemic

Opioids are a class of drugs that include medications, such as oxycodone, hydrocodone, and methadone, which are commonly prescribed to treat pain, as well as illegal drugs, such as heroin.

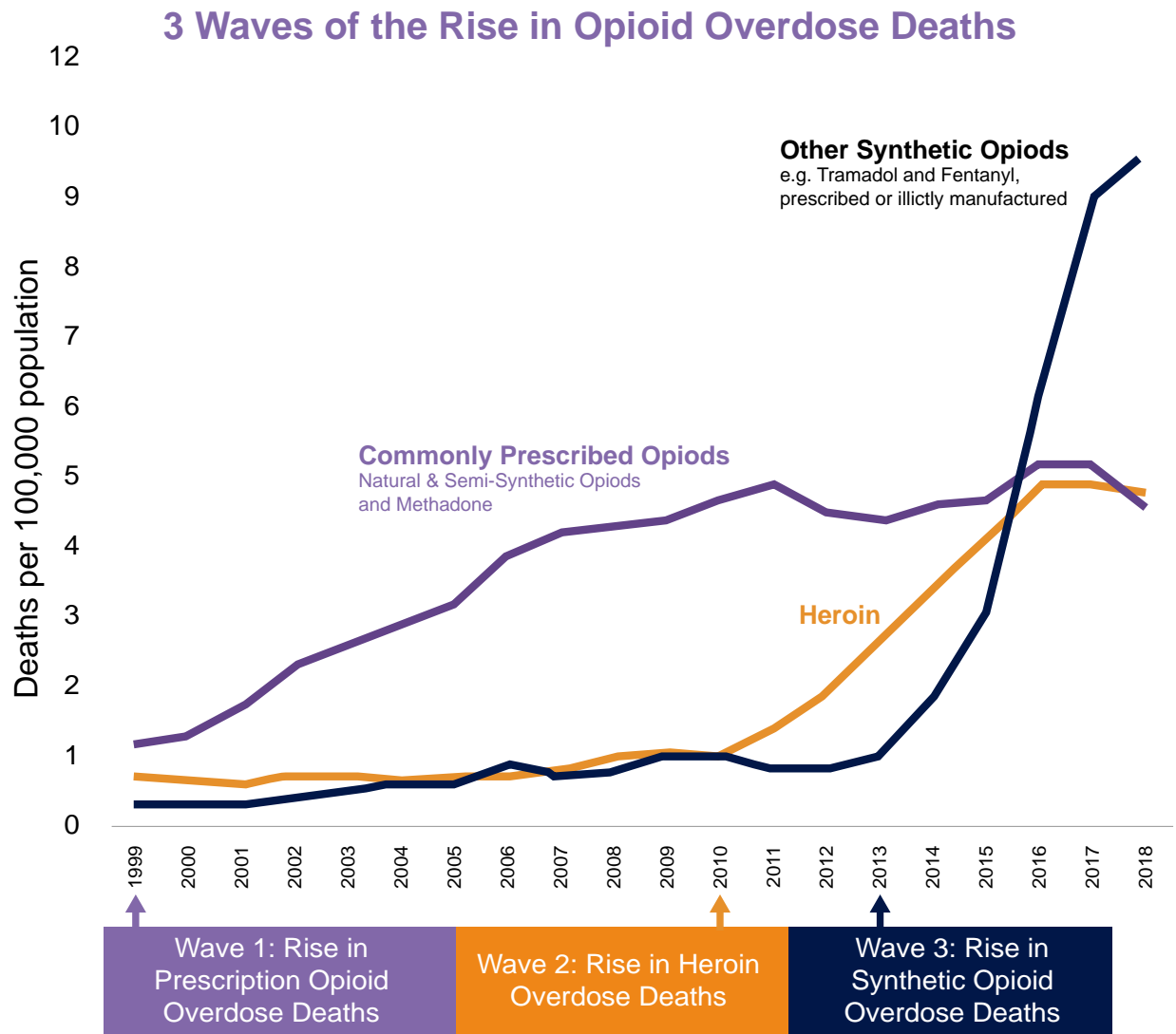
An estimated 2.1 million people in the U.S. struggle with an opioid use disorder. Rates of opioid overdose deaths are rapidly increasing. The most recent provisional data available from the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) indicate that approximately 81,230 drug overdose deaths occurred in the U.S. in the 12-months ending in May 2020. This represents a worsening of the drug overdose epidemic in the U.S. and is the largest number of drug overdoses for a 12-month period ever recorded.¹

Legally prescribed opioid pain relievers are generally safe when taken for a short time and as prescribed. Opioids produce euphoria in addition to pain relief and this can lead to them being taken in a different way or in a larger quantity than prescribed, or taken without a doctor's prescription. Regular use, even as prescribed by a doctor, can lead to dependence and, when used differently than directed, opioid pain relievers can lead to addiction, overdose incidents, and death.²

From 1999-2018, almost 450,000 people died from an overdose involving any opioid, including

prescription and illicit opioids. Many opioid-involved overdose deaths also include other drugs.³

The rise in opioid overdose death rates can be outlined in three distinct waves as illustrated in the chart below.



Wave 1 (1999): Overdose deaths involving prescription opioids increased.

Wave 2 (2010): Overdose deaths involving heroin rapidly increased.

Wave 3 (2013): Overdose deaths involving synthetic opioids (such as fentanyl) rapidly increased.

The opioid epidemic impacts all levels of society including individuals, families, schools, businesses, communities, public health, and the economy. Response to the epidemic involves all members of the community, on all levels. Faith-based community leaders are integral to that response.

The Role of Faith-based Organizations (FBOs)

Faith-based Organizations (FBOs) and communities have a long tradition of supporting individuals and families affected by substance use disorders (SUD). The following are just some examples of how FBOs contribute to SUD prevention, education, and recovery efforts:

- FBOs participate in prevention efforts by providing education and activities for youth and families.
- FBOs host or increase access to intervention and recovery support programs.
- FBOs educate staff and community members about SUD and recovery.
- FBOs create awareness and decrease stigma through open dialogue and collaborations.
- FBOs provide community outreach services, SUD resources, and individual and family guidance.
- FBOs add a sense of belonging and community that help people recover from SUDs.
- FBOs provide spiritual and faith-based leadership to their members and communities in times of need.

FBO Opportunities

FBOs can utilize their tradition, experience, and the resources in this toolkit to develop a strategic response to the opioid crisis. The table below provides examples of actions for FBOs to address OUD.

Educational Opportunities for FBO leaders, staff, volunteers, and members	Community Outreach Opportunities	Resource Opportunities	Community Partnership Opportunities
Train to increase understanding and awareness of SUD and OUD.	Host community events (e.g. education nights) on OUD, naloxone, community resources, etc.	Distribute resources (e.g., fact sheets) regarding OUD.	Connect with local SUD prevention and treatment agencies (for information and services regarding OUD).
Train to recognize the symptoms of an overdose, administering naloxone, and contacting emergency responders.	Participate in community events surrounding OUD prevention; establish organization as a community resource.	Coordinate referral resources to provide local and regional treatment locations and materials.	Connect with local SUD treatment facilities (for OUD treatment) to increase access and engagement.
Coordinate a training about Screening, Brief Intervention, and Referral to Treatment (SBIRT).	Host recovery support services and mutual aid groups.	Research evidenced-based prevention activities and programs.	Connect with law enforcement for assistance with training and emergency protocols.
Host or coordinate prevention activities for youth and families.			Connect with emergency medical services for training and guidance.

Opioid Use Disorder Toolkit for Faith-Based Community Leaders

**INTRODUCTION:
ACTION ITEMS**



Action Items

1. **Develop a Plan.** Utilize the OUD toolkit and other resources to develop a plan for your FBO to address and respond to the opioid crisis. The U.S. Department of Health and Human Services (HHS) developed The Partnership Center, Center for Faith and Opportunity Initiatives to lead its efforts to build and support partnerships with faith-based and community organizations in order to better serve individuals, families, and communities in need.⁴ Several resources exist to assist FBOs including an Opioid Crisis Practical Toolkit for Faith-based and Community Leaders.⁵
 - a. Download the toolkit to guide your planning: <https://www.hhs.gov/sites/default/files/the-opioid-crisis-practical-toolkit.pdf>.
 - b. Sign up for the Partnership Center electronic newsletter to receive updates on training, funding and research opportunities for faith-based initiatives: <https://www.hhs.gov/about/agencies/iea/partnerships/newsletter/index.html>.
 - c. Watch and share Partnership Center YouTube videos and webinars related to SUD, OUD, mental health and recovery for FBOs: <https://www.youtube.com/channel/UCQ3FfsYX5-BKD8VgGGsNOcA>.
2. **Utilize Polling Software with Your Faith Community.** Even though some people in faith communities are willing to publicly share their experience of substance use, there are others who are not. This dynamic can give the stigmatizing impression to people that while substance use exists in faith communities, it is only a reality for a select few. In order to address such a conclusion, some faith communities have used polling software such as www.polleverywhere.com or www.directpoll.com. This is software that can be used during an event or training to poll members with questions like, “Has anyone here been addicted to a substance?” or “Has anyone here had a family member with substance use disorder?” This software will then populate answer percentages for everyone to see on an overhead screen. Using this software allows for people to stay anonymous while also bringing to everyone’s attention just how common addiction is within your faith community.
3. **Start the Conversation.** Some faith leaders think that any new ministry venture must involve a program with multiple leaders and volunteers. A valuable first step a faith leader can take around addiction ministry is to start the conversation. Simply begin raising this issue with the people you are already talking with about other ministry topics. As you do this, you’ll discover that other members of the community also have a heart for this area. You’ll also likely notice what challenges might be faced in the future (e.g. stigma, indifference). So rather than getting overwhelmed by the need to start a formal addiction ministry, start the conversation with a few people in order to discover the role your faith community can play in responding to the opioid epidemic.
4. **Assess Your Community’s Assets.** In many FBOs there exist people who work in the field of addiction or mental health. Unfortunately, such people often haven’t been told their professional experience can be a resource not only to their clients, but to their FBOs as well. Seek out in-house professionals to hear their perspective on how to best minister to those in their faith community and secular community affected by OUD. These professionals possess a knowledge of both SUD and the values of their faith community. By identifying what assets exist within your particular faith community, a clearer sense will emerge of the role your faith community can play in response to the opioid epidemic.

5. **Show how Addiction Ministry fits in Your Faith Community's Tradition/Mission.** Certain people in faith communities may believe that while secular service providers should give of themselves and their resources to opioid use prevention and recovery, their faith community should not. FBOs can use their practices and tradition to show how faith informs a holistic response to those impacted by OUD. Taking such a step allows people to see that faith leaders are fulfilling their mission when addressing OUD.
6. **Embrace the Communal Role of the Faith Community.** Faith communities can provide an ongoing experience of connection that is vital to a person's recovery. Involve all members of your organization- particularly include youth and families. Youth can engage in community service projects that highlight youths' ability to educate and advocate on the issue. Youth engagement itself is a powerful preventative factor for youths and youth service in prevention efforts can fit into a wider faith-based messaging on community service. Faith leaders' support of parents can reinforce prevention messaging and encourage families to open up conversations. When a faith community realizes their communal nature is a vital resource for prevention and recovery, it will be better able to embrace the unique role they can play in people's lives.
7. **Provide Your Faith Community a Spiritual Emergency Room.** While embracing the communal aspect of a faith community is important, it is also necessary to clarify what kind of community they are. The type of community that will be helpful to those impacted by OUD sees itself as a Spiritual Urgent Care Center. As Phil Yancey observes in his book, *Church: Why Bother?*, "I like to think of the [faith community] as one of those [Urgent Care Centers]: open long hours, convenient to find, willing to serve the needs of people who drop in with unexpected emergencies." A faith community that sees itself as a Spiritual Urgent Care Center views every member as capable of any struggle and therefore potentially in need of support at any time.
8. **Identify Unique Opportunities.** In addition to identifying the role of your faith community in relation to OUD, it is also valuable to identify the unique opportunities available to a community of faith. The suggestions below don't require huge paradigm shifts but instead involve paying attention to the opportunities presenting themselves to faith communities.
 - a. **Honor National Substance Abuse Prevention and National Recovery Months.** An opportunity available to any faith community is to set apart certain days of the year that are natural occasions to raise the topic of opioid addiction. Some communities have discovered that setting aside an event or gathering during National Substance Abuse Prevention Month or National Recovery Month is an easy way to bring attention to this topic. Such a day could include public prayer, testimonies (sharing of stories), or special presentations addressing the topic of addiction. The presentation could be given by a leader or by a representative of a faith-based organization specializing on the topic of addiction.
 - b. **Support Family Members.** Many leaders have received calls from people wondering how to support family members struggling with addiction. In fact, many faith leaders say they get more calls from family members than they do from people living with the addiction. At such times faith leaders should respond with spiritual guidance and information on community-based resources (e.g. Nar-Anon Family Groups, www.nar-

anon.org). It will also be helpful at times for faith leaders to assist in the reconciliation of a family member and person recovering from OUD. In all these ways faith communities are called not only to minister to those living with addiction, but also to family members affected by the pain and trauma of the opioid epidemic.

- c. **Learn from Family Members and Those with a Lived Experience.** While it is important to minister well to the family members of those living with addiction, there is a further opportunity available to communities in such contexts. Faith community leaders and members would do well to reach out to family members and individuals to get feedback on other ways they could be helpful. Instead of only being the giver of support, this puts faith based leaders in the place of learner and “receiver of feedback.” Such feedback could result in the creation of new ministries and/or a better sense of what communities must do to provide ongoing support to people and their loved ones affected by the opioid epidemic.
- d. **Utilize Peer Support.** One of the opportunities available to faith communities is to utilize peer support for the care of those struggling with opioid use disorder. Peer support can be implemented in at least two ways. First, a faith community can establish an internal support group where people with a lived experience of addiction can provide mutual sharing and support. Some communities have done this organically while others have used a standardized model such as Celebrate Recovery. Second, a faith community can get external support from people within the Substance Use Services System. These Certified Peer Specialists (CPS) are trained to use their lived experience with addiction to support others. A CPS can help your faith community see the benefits and challenges of peer support as well as what steps they can take to implement it within their FBO. In fact, this can be taken one step further if an FBO is able to identify a member of the organization who is living successfully in recovery and is interested in becoming a CPS. This would create a unique opportunity for a member of the organization to be called upon particularly in emergency situations to provide the unique perspective of the FBO combined with the peer-based “meeting people where they are” mentality.
- e. **Go Local.** Often the statistics shared about the opioid epidemic are large-scale numbers that make faith communities feel too small to make a significant impact in their society. However, the opioid epidemic is not just a national emergency but a local one as well. To testify to this, many regions provide local data with the number of deaths/overdoses as a result of opioid use. If faith community members avail themselves of such information and communicate it to the rest of their community, opportunities may reveal themselves around how to make a lasting local impact.

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SECTION 1: Opioid Use Disorder 101



Purpose

ODU 101 provides an explanation of OUD as a public health problem, key facts regarding the opioid crisis, key OUD terms and definitions, a guide to affirming language that destigmatizes the disease of addiction, and a framework for an FBO coordinated response.

Public Health Emergency

Public health protects and improves the health of people and their communities. The World Health Organization (WHO) defines a public health emergency as an occurrence or imminent threat of an illness or health condition, caused by bio terrorism, epidemic, or pandemic disease.⁶

Data from 2018 shows that every day, 128 people in the U.S. die after overdosing on opioids. The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare. The CDC estimates that the total “economic burden” of prescription opioid misuse alone in the U.S. is \$78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.^{7, 8}

The epidemic was first declared a public health emergency on October 26, 2017 and has been reviewed and renewed 8 times since. Most recently, the Secretary of HHS renewed the opioid epidemic as a public health emergency effective January 14, 2020.

Crises are designated as public health problems when they occur frequently throughout a population and can be prevented through population-based interventions designed to modify individual behaviors, reduce exposure to harmful influences, and detect and treat those who are at risk of or already suffering from the problem. Examples of public health problems include communicable diseases such as tuberculosis and polio; modern examples include HIV/AIDS, obesity, and the current opioid crisis. A public health approach uses scientific evidence to provide interventions along a continuum to include prevention, intervention, treatment access, disease management, and support for recovery. It addresses both individual and underlying social, environmental, and economic determinants of the problem and aims to improve the health, safety, and well-being of those affected by it.⁹



**die every day from
an opioid overdose**
(including Rx and illicit opioids).

Opioid Crisis Facts

According to the National Institute on Drug Abuse (NIDA):¹⁰

- Roughly 21 to 29 percent of patients prescribed opioids for chronic pain misuse them.
- Between 8 and 12 percent develop an opioid use disorder.
- An estimated 4 to 6 percent who misuse prescription opioids transition to heroin.
- About 80 percent of people who use heroin first misused prescription opioids.
- Among 38 states with prescription opioid overdose death data, 17 states saw a decline between 2017-2018; none experienced a significant increase.

Recent data gathered by the CDC shows:^{11, 12}

- The number of drug overdose deaths was four times higher in 2018 than in 1999.
- Nearly 70% of the 67,367 deaths in 2018 involved an opioid.
- Synthetic opioids are the primary driver of the increases in overdose deaths. The 12-month count of synthetic opioid deaths increased 38.4% from the 12-months ending in June 2019 compared with the 12-months ending in May 2020.
- Prior to COVID-19, the average increase in 12-month estimates of overdose deaths from synthetic opioids was 770. After COVID-19 that number increased to 2,198.

Key Terms

[Facing Addiction in America: The Surgeon General's Spotlight on Opioids](#) is an opioid-specific report aimed at providing the public and those with loved ones with an elevated risk of opioid overdose, misuse, and/or opioid use disorder with opioid-related information in one document.¹³ Defining key terms will help FBOs facilitate discussion and planning. The key terms listed below are taken from the 2018 Spotlight on Opioids Report.¹⁴

Opioid: Natural or synthetic chemicals that interact with opioid receptors on nerve cells in the body and brain, and reduce the intensity of pain signals and feelings of pain. This class of drugs includes the illegal drug heroin, synthetic opioids such as fentanyl, and pain medications available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, and many others. Opioid pain medications are generally safe when taken for a short time and as prescribed by a health care professional, but because they produce euphoria in addition to pain relief, they can be misused.

Substance Use Disorder (SUD): Occurs when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5, a diagnosis of SUD is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

Opioid Use Disorder (OUD): A disorder characterized by loss of control of opioid use, risky opioid use, impaired social functioning, tolerance, and withdrawal. OUD involves addiction to synthetic opioids, organic opiates, and/or heroin. Different factors affect an individual's experience with addiction. They include environment, genetic predisposition, experience with the substance, and/or a personal or family history of SUD. Not every person who uses opioids becomes addicted. However, an individual's continued opioid use increases the possibility of addiction. The number one risk factor for an individual to develop OUD is an initial exposure through prescription drugs.¹⁵

Dependence: A state in which an individual only functions normally in the presence of a substance, experiencing physical disturbance when the substance is removed. A person can be dependent on a substance without being addicted, but dependence sometimes leads to addiction.

Addiction: Common name for a severe substance use disorder, associated with compulsive or uncontrolled use of one or more substances. According to the American Society of Addiction Medicine, addiction is "a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences." Addiction is a serious biopsychosocial illness, meaning that biological, psychological, and social factors can all contribute to both the development of, and recovery from, this disease.¹⁶

Tolerance: Alteration of the body's responsiveness to alcohol or a drug such that higher doses are required to produce the same effect achieved during initial use.

Withdrawal: A set of symptoms and signs that are experienced when discontinuing use of a substance to which a person has become dependent or addicted, which can include negative emotions such as stress, anxiety, or depression, as well as physical effects such as nausea, vomiting, muscle aches, and cramping, among others. Withdrawal symptoms often lead a person to use the substance again.

Substance use disorder treatment: A service or set of services that may include medication, counseling, and other supportive services designed to enable an individual to reduce or eliminate alcohol and/or other drug use, address associated physical or mental health problems, and restore the patient to maximum functional ability.

Opioid Treatment Program (OTP): A SAMHSA certified program, usually comprising a facility, staff, administration, patients, and services, that engages in supervised assessment and treatment, using methadone, buprenorphine, or naltrexone, of individuals who have OUDs. An OTP can exist in a number of settings, including but not limited to intensive outpatient, residential, and hospital settings. Services may include medically supervised withdrawal and/or maintenance treatment, along with various levels of medical, psychiatric, psychosocial, and other types of supportive care.



Naloxone: Naloxone is an opioid antagonist medication approved by the U.S. Food and Drug Administration (FDA) to reverse opioid overdose. Naloxone is available in injectable and nasal spray forms. It works by displacing opioids from receptors in the brain, thereby interrupting and blocking their effects on breathing and heart rate. Typically, there is a 1- to 3-hour window of opportunity after an individual has taken the drug in which bystanders can take action to reverse the overdose and prevent death. However, the introduction of illicitly manufactured fentanyl and other highly potent synthetic opioids to the drug supply makes immediate access to naloxone (and perhaps multiple administrations) crucial to effective overdose death prevention.

Risk factors: Factors that increase the likelihood of beginning substance use, of regular and harmful use, and of other behavioral health problems associated with use.

Protective factors: Factors that directly decrease the likelihood of substance use and behavioral health problems or reduce the impact of risk factors on behavioral health problems.

Evidence-based interventions: Refers to programs and policies that are supported by research and proven to be effective.

Recovery: People can and do recover. Recovery from SUDs has had several definitions. Although specific elements of these definitions differ, all agree that recovery goes beyond the remission of symptoms to include a positive change in the whole person. In this regard, “abstinence,” though often necessary, is not always sufficient to define recovery. There are many paths to recovery. People will choose their pathway based on their cultural values, their psychological and behavioral needs, and the nature of their SUD.

Recovery Support Services (RSS): RSS, provided by both SUD treatment programs and community organizations, help to engage and support individuals in treatment and provide ongoing support after treatment. These supportive services are typically delivered by trained case managers, recovery coaches, and/or peers. Specific supports include help with navigating systems of care, removing barriers to recovery, staying engaged in the recovery process, and providing a social context for individuals to engage in community living without substance use. Individuals who participate in SUD treatment and RSS typically have better long-term recovery outcomes than individuals who receive either alone. Furthermore, active recovery and social supports, both during and following treatment, are important to maintaining recovery.

Language Matters

Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.¹⁷ Understanding addiction as an illness helps to reduce stigma when discussing it. In addition to having a common set of clearly defined terms, it is important to use language and terms that further reduce negative bias. In the table below, NIDA offers tips for terms to avoid and terms to use when talking about addiction.¹⁸

TERMS TO AVOID, TERMS TO USE, AND WHY

Consider using these recommended terms to reduce stigma and negative bias when talking about addiction.¹⁹⁻²⁸

Instead of...	Use...	Because...
<ul style="list-style-type: none"> ■ Addict ■ User ■ Substance or drug abuser ■ Junkie ■ Alcoholic ■ Drunk ■ Former addict ■ Reformed addict 	<ul style="list-style-type: none"> ■ Person with substance use disorder ■ Person with opioid use disorder (OUD) or person with opioid addiction [when substance in use is opioids] ■ Patient ■ Person with alcohol use disorder ■ Person who misuses alcohol/engages in unhealthy/hazardous alcohol use ■ Person in recovery or long-term recovery ■ Person who previously used 	<ul style="list-style-type: none"> ■ Person-first language. ■ The change shows that a person “has” a problem, rather than “is” the problem. ■ The terms avoid eliciting negative associations, punitive attitudes, and individual blame.
Instead of...	Use...	Because...
<ul style="list-style-type: none"> ■ Habit ■ Abuse 	<ul style="list-style-type: none"> ■ Substance use disorder ■ Drug addiction For illicit drugs: ■ Use For prescription medications: ■ Misuse ■ Used other than prescribed 	<ul style="list-style-type: none"> ■ Inaccurately implies that a person is choosing to use substances or can choose to stop. ■ “Habit” may undermine the seriousness of the disease. ■ The term “abuse” was found to have a high association with negative judgments and punishment. ■ Legitimate use of prescription medications is limited to their use as prescribed by the person to whom they are prescribed. Consumption outside these parameters is misuse.
<ul style="list-style-type: none"> ■ Opioid substitution replacement therapy 	<ul style="list-style-type: none"> ■ Opioid agonist therapy ■ Medication treatment for OUD ■ Pharmacotherapy 	<ul style="list-style-type: none"> ■ It is a misconception that medications merely “substitute” one drug or “one addiction” for another.

<ul style="list-style-type: none"> ■ Clean 	<p>For toxicology screen results:</p> <ul style="list-style-type: none"> ■ Testing negative <p>For non-toxicology purposes:</p> <ul style="list-style-type: none"> ■ Being in remission or recovery ■ Abstinent from drugs ■ Not drinking or taking drugs ■ Not currently or actively using drugs 	<ul style="list-style-type: none"> ■ Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions. ■ Set an example with your own language when treating patients who might use stigmatizing slang. ■ Use of such terms may evoke negative and punitive implicit cognitions.
<ul style="list-style-type: none"> ■ Dirty 	<p>For toxicology screen results:</p> <ul style="list-style-type: none"> ■ Testing positive <p>For non-toxicology purposes:</p> <ul style="list-style-type: none"> ■ Person who uses drugs 	<ul style="list-style-type: none"> ■ Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions. ■ May decrease patients' sense of hope and self-efficacy for change.
<ul style="list-style-type: none"> ■ Addicted baby 	<ul style="list-style-type: none"> ■ Baby born to mother who used drugs while pregnant ■ Baby with signs of withdrawal from prenatal drug exposure ■ Baby with neonatal opioid withdrawal/neonatal abstinence syndrome ■ Newborn exposed to substances 	<ul style="list-style-type: none"> ■ Babies cannot be born with addiction because addiction is a behavioral disorder—they are simply born manifesting a withdrawal syndrome. ■ Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions. ■ Using person-first language can reduce stigma.

The use of affirming language inspires hope and advances recovery. The Addiction Technology Transfer Center Network (ATTC) uses affirming language to promote the promises of recovery by advancing evidence-based and culturally informed practices. The ATTC Network developed a language matters downloadable tool to reduce stigma and discrimination through the use of appropriate language when talking about SUD or persons who have this disease.²⁹ This tool can be printed as a two sided card for distribution to FBO members and communities.



A Framework for Understanding OUD

The American Society of Addiction Medicine (ASAM) describes OUD as a brain disorder that can range in severity from mild to severe. Diagnosis of this disorder is based on a checklist of symptoms defined in The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, developed by the American Psychiatric Association.³⁰

DSM-5 Diagnostic Criteria for OUD

In order to confirm a diagnosis of OUD, at least two of the following should be observed within a 12-month period:³¹

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Exhibits tolerance.
11. Exhibits withdrawal.

Strategies to Prevent OUD

All people have biological and psychological characteristics that make them vulnerable to, or resilient in the face of, potential behavioral health issues. Because people have relationships within their communities and larger society, each person's biological and psychological characteristics exist in multiple contexts. A variety of risk and protective factors operate within each of these contexts.³² These risk and protective factors also influence one another.





Early initiation of substances and SUD are risk factors and are associated with a variety of negative consequences, including deteriorating relationships, poor school performance, loss of employment, diminished mental health, and increases in sickness and death (e.g., motor vehicle crashes, poisoning, violence, or accidents). Although there are exceptions, most risk and protective factors associated with substance use also predict other problems affecting youth, including delinquency, psychiatric conditions, violence, and school dropout. Therefore, programs and policies addressing those common or overlapping predictors of problems have the potential to simultaneously prevent substance use as well as other undesired outcomes.³³

Risk Factors and Protective Factors

Many factors influence a person's chance of developing a mental illness or SUD. Effective prevention focuses on reducing those risk factors, and strengthening protective factors, that are most closely related to the problem being addressed.

Risk factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes.

Protective factors are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact. Protective factors may be seen as positive countering events.

Some risk and protective factors are fixed: they don't change over time. Other risk and protective factors are considered variable and can change over time. Variable risk factors include income level, peer group, adverse childhood experiences (ACEs), and employment status.

Prevention strategies that address more than one risk factor and that exist in more than one context have greater effectiveness. Examples of possible risk and protective factors identified by the SAMHSA are outlined in the table below.³⁴ FBOs can develop programs and strategies to address multiple factors in multiple contexts for increased efficacy.

Individual-level Risk Factors may include a person’s genetic predisposition to addiction or exposure to substances prenatally.

Individual-level Protective Factors might include positive self-image, self-control, or social competence.

Relationship Risk Factors include parents who have problems related to drugs and alcohol or who suffer from mental illness, child abuse and maltreatment, and/or inadequate supervision.

Relationship Protective factors: Take away the colon and then edit so that it says “Relationship Protective Factors could include positive parental involvement.

Community Risk Factors include neighborhood poverty and violence.

Community Protective Factors could include the availability of faith-based resources and after-school activities.

Societal Risk Factors could include norms and laws favorable to substance use, as well as systemic racism and a lack of economic opportunity.

Societal Protective Factors in this context would include hate crime laws or policies limiting the availability of alcohol.

Types of Prevention

Communities and populations have different levels of risk, protection, and substance use. Well supported scientific evidence shows that communities are an important organizing force for bringing effective evidence-based interventions to scale. To build effective, sustainable prevention across age groups and populations, communities should build cross-sector community coalitions which assess and prioritize local levels of risk and protective factors as well as substance misuse problems then select and implement evidence-based interventions matched to local priorities.³⁵

Not all people or populations are at the same risk for developing SUD. Prevention interventions are most effective when they are matched to the target population’s level of risk. The Institute of Medicine (IOM), now known as the National Academy of Medicine, has described three categories of prevention interventions: universal, selective, and indicated to assist in the development and delivery of prevention programs.³⁶



Universal, Selective, and Indicated Prevention Interventions

Universal prevention interventions are aimed at all members of a given population (for instance, population-level strategies) and might target schools, whole communities, or workplaces. Examples include youth group presentations, newsletter articles, and large group education.

Selective prevention interventions target subgroups determined to be at high-risk for substance use due to biological, psychological, or social risk factors that are more prominent among high-risk groups than among the wider population (for instance, justice-involved youth). Examples include prevention education for immigrant families with young children or peer support groups for adults with a family history of substance use disorders.

Indicated Prevention interventions target individuals who show signs of being at risk for SUD. These types of interventions include referral to support services for young adults who violate drug policies or screening and consultation for families of older adults admitted to hospitals with potential alcohol-related injuries.

For more information, please visit SAMHSA at www.samhsa.gov and SAMHSA's Evidence Based Practices Resource Center: www.samhsa.gov/ebp-resource-center

Overdose Prevention

In addition to preventing SUD, an urgent need related to OUD is the prevention of overdose and overdose deaths.

SAMHSA's Opioid Overdose Prevention Toolkit describes who may be at risk for opioid overdose and three strategies to prevent overdose deaths.³⁷

Who is at Risk?

- Anyone who uses opioids for long-term management of chronic pain is at risk for opioid overdose, as are individuals who use heroin or who use prescription pain relievers other than as directed.
- Those who are receiving rotating opioid medication regimens (and thus are at risk for incomplete cross tolerance).
- Those who have been discharged from emergency medical care following opioid overdose.
- Those who need opioid pain relievers, coupled with a suspected or confirmed SUD or history of non-medical use of prescription opioids or use of illicit opioids.
- Those who have completed opioid detoxification or are abstinent for a period of time (and presumably have reduced opioid tolerance and high risk of return to opioid use).
- Those who have been recently released from incarceration and have a history of opioid use disorder or opioid misuse (and presumably have reduced opioid tolerance and high risk of return to opioid use).

SAMHSA Strategies to Prevent Overdose Deaths

Strategy 1: Learn about Preventing Opioid Overdose. Encourage providers, persons at high risk, family members, and others to learn how to prevent and manage opioid overdose. Helpful information for laypersons on how to prevent and manage overdose is available from Prevent & Protect at <http://prevent-protect.org/>.

Strategy 2: Ensure Access to Treatment. Ensure access to treatment for individuals who are misusing opioids or who have a SUD. Effective treatment of SUDs can reduce the risk of overdose and help overdose survivors attain a healthier life. Medications for OUD as well as counseling and other supportive services can be obtained at SAMHSA-certified and Drug Enforcement Administration-registered opioid treatment programs and in specialty substance use disorder treatment programs as well as from physicians and other practitioners including nurse practitioners and physician assistants who are trained to provide care in office-based settings with buprenorphine and naltrexone. Information on treatment services available in or near your community can be obtained from your state health department, your state alcohol and drug agency, or the SAMHSA Behavioral Health Treatment Services Locator at <https://www.findtreatment.samhsa.gov>.

Strategy 3: Expand Access to Naloxone. Ensure ready access to naloxone. Opioid overdose-related deaths can be prevented when naloxone is administered in a timely manner. For instructions on how to use naloxone go to <http://prescribetoprevent.org>.

Opioid Use Disorder Toolkit for Faith-Based Community Leaders

SECTION 1: OUD 101 Action Items



Section 1: OUD 101 Action Items

1. **Obtain and Distribute Prevention Materials.** Here are some examples:
 - a. Opioid Overdose Prevention Handbook <https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA18-474>
 - b. Creating a Healthier Life, a Step-by-Step Guide to Wellness <https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4958.pdf>
 - c. Facing Addiction in America: The Surgeon General's Spotlight on Opioids https://addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf
 - d. Opioid Basics from the CDC <https://www.cdc.gov/drugoverdose/opioids/index.html>
 - e. Publications and Digital Products from SAMHSA <https://store.samhsa.gov/>
 - f. Commonly Used Drug Charts <https://www.drugabuse.gov/drug-topics/commonly-used-drugs-charts>
2. **Arrange for Speakers and Training for Staff, Volunteers, and Members.** Training can be provided by national and local experts and can be accessed through the resources listed below.
 - a. Opioid Response Network: www.opioidresponsenetwork.org
 - b. National Helpline: 1-800-662-HELP (4357) or 1-800-487-4889 (TDD, for hearing impaired)
 - c. Behavioral Health Treatment Services Locator (search by address, city, or ZIP code): <https://findtreatment.samhsa.gov/>
 - d. Buprenorphine Treatment Practitioner Locator (search by address, city, or ZIP code): <https://samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physicianlocator>
 - e. Single State Agencies for Substance Abuse Services: <https://www.samhsa.gov/sites/default/files/ssadirectory.pdf>
 - f. State Opioid Treatment Authorities: <https://dpt2.samhsa.gov/regulations/smalist.aspx>
 - g. SAMHSA Publications Ordering (all SAMHSA Store products are available at no charge): <https://store.samhsa.gov/>; 1-877-SAMHSA-7 (1-877-726-4727)
 - h. Centers for Disease Control and Prevention (CDC):
 - i. Understanding the Epidemic: <https://www.cdc.gov/drugoverdose/epidemic>
 - ii. Poisoning: <https://www.cdc.gov/homeandcreationalrecreationalsafety/poisoning>
 - iii. CDC Guideline for Prescribing Opioids for Chronic Pain: <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>
 - i. Faces & Voices of Recovery: <https://facesandvoicesofrecovery.org/>
 - j. Project Lazarus: <https://www.projectlazarus.org>
 - k. Harm Reduction Coalition: <https://www.harmreduction.org>

- l. Prevent and Protect (tools for conducting overdose prevention and naloxone advocacy, outreach, and communication campaigns): <https://prevent-protect.org/community-resources-1/>
 - m. Prescribe to Prevent: <https://prescribetoprevent.org>
 - n. Grief Recovery After a Substance Passing (for those who have lost a loved one): <http://grasphelp.org>
 - o. Learn 2 Cope (for families with loved ones who have a substance use disorder): <https://www.learn2cope.org/>
 - p. International Overdose Awareness Day (the website has a list of worldwide events): <https://www.overdoseday.com>
3. **Create Events to Prevent OUD and Support Recovery.** Research indicates that stigma is a primary deterrent to individuals living with OUD seeking treatment and support.³⁸ Faith-based organizations can encourage individuals to seek treatment and support by adapting specific measures geared towards prevention:
- a. Distribute naloxone to populations impacted by OUD.
 - b. Provide space for recovery groups to meet to support individuals living with OUD.
 - c. Coordinate with your local health department to distribute resources.
 - d. Coordinate with your local fire department to host prescription medication disposal events.
4. **Develop or Participate in a Faith-Based Prevention Coalition.** Leading an ongoing faith-based prevention coalition is an approach some have found helpful in highlighting substance use prevention. Such a coalition consists of representatives from local prevention organizations, county officials from Substance Use Services, concerned faith community leaders, and members across a particular county or region. The purpose of the coalition is to be a catalyst for substance use prevention in and through faith communities. Prevention resources and techniques can be streamlined and spread as professionals provide them to participating members. Faith leaders can then disseminate the information throughout faith communities.
5. **Offer your Building as a Space for Monthly Community Workshops.** Some faith communities will find themselves passionate not only about opioid use prevention but also about other pressing societal issues like grief, human trafficking, domestic abuse, mental health, and suicide. For faith communities desiring to take this broader approach to needs engagement an option could be to host monthly workshops for their local community. This would allow the faith community to address addiction for 1-2 months without having to focus on this area every month. One easy way to start such a series is to identify those with expertise within your faith community who can speak at the first workshop. Subsequent workshops can then be led by local experts who are invited in to speak.

6. **Request Information on your County's Assessment Process for Treatment.** If a faith leader is going to help a member get the substance use treatment they need, priority should be given to referring the person to get assessed/evaluated for such treatment. Each county identifies certain organizations as responsible for the process of treatment evaluation. Counties are also becoming increasingly creative by utilizing video-assessment and/or police stations as assessment venues in order to reduce the time it takes for an evaluation. Whatever the assessment process for your county, it's important to know it before reaching a time of crisis where such information is immediately needed. To learn about the process of treatment evaluation in your region, contact the County's Office of Substance Use Services.
7. **Provide Connection to Education and Resources.** Faith communities can play a unique role in mediating between the lives of individual citizens and larger institutions like government. This is what Peter Berger and John Neuhaus referred to as a "mediating institution." One of the opportunities a faith community has as a mediating institution is to be "Connectors." Connectors can bring the resources and approaches of professional services to the larger community while also representing the needs and desires of the community back to the system of care. Below are steps faith communities can take to as Connectors related to the issues of substance use prevention.



8. **Participate in a Countywide Prescription Drug Take Back Day.** Some counties have established days where people can drop off unneeded drugs at different collection sites. Disposing of these medications properly can keep children and others safe and keep them out of a community's water supply, which can be contaminated by improperly disposed-of pharmaceutical drugs. To support such an initiative, faith communities can offer their building or property as a collection site. To learn how to participate in such a Take Back Day, you can contact your local police department or their county's District Attorney's office. Even if your faith community isn't interested in being a collection site, it can still provide members with information on the Take Back Day's date, times, and locations.
9. **Provide Funding for Local Organizations Doing Prevention Work.** Several communities have local organizations committed to substance use prevention work. These organizations may be focused on serving the entire community or may be centered on a specific population, such as high school students. These organizations are often grant-funded and will need further funds if they are to remain serving their community after the grant is completed. One way a faith community can assist with prevention work is to provide ongoing financial support of such organizations. As a way of raising interest within your faith community for this work, leaders can invite an organizational representative to speak and set up a resource table.
10. **Initiate a Month-Long County-Wide Campaign.** Some faith leaders have seen the benefits of running a county-wide campaign consisting of a series of trainings over the course of a month. This approach allows for a variety of experts to speak on a range of perspectives from prescription disposal to overdose death prevention to faith-based resources for addiction. One such campaign took the slogan, "We Can't Do It Alone." Campaigns like these show that when civic leaders, faith communities, and human service professionals partner together, people have a better chance at recovery and families have more opportunities to get needed resources and support.
11. **Host a Town Hall Meeting with Diverse Speakers.** Certain faith communities have found it beneficial to use their space for a regional Town Hall event to highlight substance use prevention methods. Faith communities have then invited speakers such as their County District Attorney (to address opioid safety), officials from the County Drug and Alcohol Commission (to speak about the services available to the community), and a representative from a local addictions ministry (to speak about what the faith community can uniquely bring). These Town Hall meetings not only help those within the hosting faith community, but act as a service to the broader community.
12. **Get Trained to Distribute Narcan to your Faith Community.** Narcan (Naloxone) is an opioid reversal medication that can be given to someone who has overdosed in order to save their life. In certain states there are laws that make it possible for third party organizations to distribute the medication without a prescription. If a faith community would like to be a distributor of Narcan they can reach out to their local Office of Substance Abuse Services to see if they are eligible according to their state law. Even if a faith community does not become a distributor, its faith leaders and faith community members can get training on how to recognize an overdose and use Narcan to save a person's life.



Opioid Use Disorder Toolkit for Faith-Based Community Leaders

SECTION 2: Intervention and Treatment



Purpose

Despite the fact that effective treatments for OUD exist, only about one in four people (28.6 percent) with this disorder received specialty treatment for illicit drug use in the past year. This “treatment gap” is not unique to OUD. Only about 12.2 percent of adults who need treatment for a SUD receive any type of specialty treatment. Additionally, 45.5 percent of people with a SUD also have a mental health disorder yet only about half (51.0 percent) receive treatment for either disorder and only a small minority receive treatment for both.³⁹

This section provides an overview of screening, OUD treatment options, and resources.

Screening and Brief Intervention

To curb the rise in opioid overdose deaths, CDC recommends screening for substance use and SUDs before and during the course of opioid prescribing for chronic pain combined with patient education.

*NIDA’s Opioid Risk Tool*⁴⁰ and the *NIDA Quick Screen*⁴¹ are available to help practitioners screen for substance use in general medical settings.⁴²

The *Brief Negotiation Interview (BNI) and Emergency Department-Initiated Buprenorphine/Naloxone for Moderate/Severe Opioid Use Disorder* is a screening and brief intervention and referral to treatment (SBIRT) model that was developed initially combined with ED-initiated buprenorphine treatment. While designed for use in hospital emergency departments (EDs) and its target population is ED patients > 18 years of age presenting for care with moderate/severe opioid use disorders, it can be used in any ambulatory healthcare setting. The intervention is designed to engage patients in treatment and expand urgently needed access to medication-assisted treatment.⁴³

The Faith & Spirituality Integrated SBIRT Network was awarded funding from SAMHSA, (<http://www.samhsa.gov/sbirt>) to develop, implement, and evaluate a SBIRT student training that focuses on training students and professionals in the allied health care disciplines of nursing, psychology, and social work. This particular SBIRT training initiative adopts a cultural competency framework that integrates faith and spirituality into the SBIRT training. SBIRT is an evidence-based practice used to identify, reduce, and prevent risky and problematic use of alcohol and illicit drugs in various allied health care settings.⁴⁴



Treatment Options: Overview

The first step in SUD treatment may be detoxification and medically managed withdrawal. This occurs in either an inpatient or outpatient setting. The next step is a treatment program tailored to an individual's needs.

According to NIDA, there are five common treatment options for substance use disorder, including OUD:⁴⁵

1. **Long Term Residential Treatment:** Provides care 24 hours a day, generally in non-hospital settings. Lengths of stay are between 6 and 12 months. They focus on the resocialization of the individual and use the program's entire community as active components of treatment. Addiction is viewed in the context of an individual's social and psychological deficits, and treatment focuses on developing personal accountability and responsibility and socially productive lives.
2. **Short Term Residential Treatment:** Provides intensive but brief treatment based on a modified 12-step approach. It is important for individuals to remain engaged in outpatient treatment programs and/or aftercare programs after a 3 to 6 week stay in the program. This reduces risk of recurrence.
3. **Outpatient Treatment Programs:** Varies in the type and intensity of services offered. Such treatment costs less than residential or inpatient treatment and often is more suitable for people with jobs or extensive social supports. Low-intensity programs offer little more than drug education. Outpatient models such as intensive day treatment are comparable to residential programs in services and effectiveness. Group counseling can be a major component of many programs. Some outpatient programs also treat patients with other medical or mental health problems in addition to their SUD. The type of program depends on the individual's treatment needs.
4. **Individualized Drug Counseling:** Focuses on reducing or stopping illicit drug or alcohol use and addresses related areas of impaired functioning like family and social relationships. Emphasis is on short-term behavioral goals. Counseling helps the individual develop coping strategies and tools to abstain from drug use and maintain abstinence. The counselor also encourages recovery-oriented programming and provides referrals for medical, psychiatric, employment, and other services.
5. **Group Counseling:** Peer discussion helps promote drug-free lifestyles. Research has shown that when group therapy either is offered in conjunction with individualized drug counseling or is formatted to reflect the principles of cognitive-behavioral therapy or contingency management, positive outcomes are achieved.

Outlined in the table below are recommendations from the Surgeon General's Spotlight on Opioids on what people should look for in a treatment program.⁴⁶

Components of Care
Personalized diagnosis, assessment, and treatment planning—one size does not fit all, and treatments should be tailored to you and your family.
Long-term disease management—addiction is a chronic disease of the brain with the potential for both recovery and recurrence. Long-term outpatient care is the key to recovery.
Access to FDA-approved medications.
Effective behavioral interventions delivered by trained professionals.
Coordinated care for other/co-occurring diseases and disorders.
Recovery support services—such as mutual aid groups, peer support specialists, and community services that can provide continuing emotional and practical support for recovery.

Medication for Opioid Use Disorder (MOUD)

MOUD (also known as Medication Assisted Treatment (MAT)) is the use of medications and behavioral therapies designed to help treat an individual with SUD. Research shows this combination helps individuals achieve and sustain recovery.⁴⁷

There are three medication options in the MOUD approach. They are FDA approved and proven effective in OUD treatment.

Buprenorphine, methadone, and naltrexone are used to treat OUDs to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. These MOUD medications are safe to use for months, years, or even a lifetime. As with any medication, consult your doctor before discontinuing use.⁴⁸

1. **Buprenorphine** - suppresses and reduces cravings for opioids. Learn more about buprenorphine at <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/buprenorphine>.
2. **Methadone** - reduces opioid cravings and withdrawal and blunts or blocks the effects of opioids. Learn more about methadone at <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/methadone>.
3. **Naltrexone** - blocks the euphoric and sedative effects of opioids and prevents feelings of euphoria. Learn more about naltrexone at <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/naltrexone>.

Requirements to Prescribe MOUD

Buprenorphine: A practitioner must obtain a waiver to prescribe buprenorphine. This is in accordance with the DATA 2000 Act. The practitioner must notify the SAMHSA Center for Substance Abuse Treatment of their intent to prescribe, meet appropriate requirements, and complete approved training based on their practitioner level. A waived practitioner can prescribe up to 100 patients in one year. After the first year, they can apply to prescribe up to 275 patients per year.

States vary on their requirements for nurse practitioners and physician assistants. You can check with your state to determine what is required for these individuals to be able to provide medication assisted treatments.

Methadone: Any individual receiving methadone requires physician supervision in an Opioid Treatment Program (OTP).

Naltrexone: Any healthcare provider who is licensed to prescribe medications can prescribe naltrexone. Special training is not required.



How MOUD Is Obtained

Individuals utilizing MOUD obtain medications through two avenues:

OTP: Opioid Treatment Programs (OTPs), are regulated providers that dispense methadone. They are the only providers permitted to do so. Independent practitioner offices cannot. OTPs also dispense buprenorphine.

OTPs must be accredited by a SAMHSA-approved accrediting body and certified by SAMHSA.⁴⁹

OBOT: Office Based Treatment Programs (OBOTs) are private practices that feature a practitioner legally allowed to prescribe buprenorphine and naltrexone, but not methadone. OBOTs are most often associated with physician offices.

Addressing MOUD Stigma

Differing public opinions regarding MOUD as a means of sustaining recovery exist. Some groups within the recovery community advocate abstinence from all substances as the only way to sustain long term recovery. Some feel that MOUD is replacing one substance for another and may come from different public views on what recovery means. SAMHSA describes MOUD as the use of medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. Medications used in MOUD are approved by the FDA and MOUD programs are clinically driven and tailored to meet each patient’s needs.

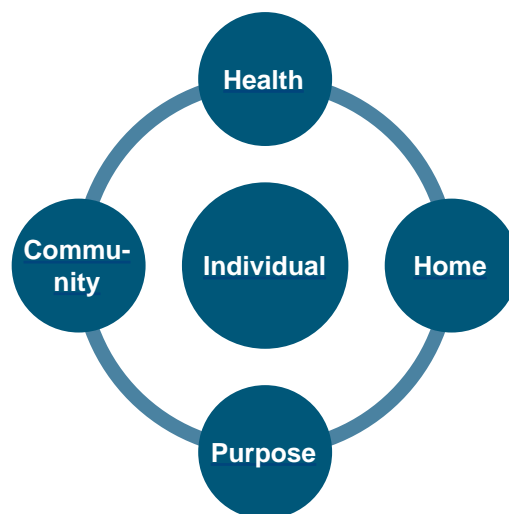
Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MOUD can help sustain recovery. MOUD is also used to prevent or reduce opioid overdose.⁵⁰

According to SAMHSA, the goal of MOUD is full recovery.⁵¹

MOUD improves patient survival, increases treatment retention, decreases illegal opiate use and other criminal activity among those with substance use disorders. It also increases patients’ quality of life and improves birth outcomes among women who have substance use disorders and are pregnant.⁵²

Stability: Four Treatment Opportunity Areas

Not every individual receives treatment in an inpatient setting. Individuals may choose MOUD and outpatient therapies as a means of treatment, leaving space for them to add in other opportunities to reach their treatment goals. SAMHSA addresses four stability areas for an individual to experience successful recovery: health, home, purpose, and community. These four areas also address unrealized opportunities for an individual’s successful treatment:



Faith-based organizations play a large role in an individual's treatment opportunities, as they provide a sense of community and purpose for the individual.

Recovery is covered more in-depth in the next section of the toolkit. The following are ideas exploring possibilities for an individual in treatment beyond traditional methods.

Treatment Opportunities: Home

The sense of home to an individual receiving treatment is where they defined their treatment path. Home is where they decided to contribute to their community because it was healthy, supportive, and gave them purpose. Safe and stable housing also creates a sense of home. One unrealized opportunity for treatment can be safe housing, like a recovery residence. A recovery residence is a broad term describing a sober, safe, and healthy living environment that promotes recovery from alcohol and other drug use and associated problems.⁵³

Treatment Opportunities: Health

Holistic therapies in conjunction with traditional therapies such as inpatient treatment, MOUD, and counseling are employed to treat the whole individual. They include:

- Acupuncture (alternative treatment for chronic pain)
- Massage (alternative treatment for chronic pain)
- Meditation (mindfulness and reflection on treatment goals)
- Yoga (mindfulness and reflection on treatment goals)



Treatment Opportunities: Purpose

Purpose is powerful. It connects an individual in treatment with a path to achieve their treatment goals. Opportunities for individuals to experience purpose while in treatment include:

- Having participants help run groups (inpatient, outpatient, or mutual aid groups)
- Volunteering opportunities with recovery-oriented organizations

Treatment Opportunities: Community

Community is essential to an individual in treatment. Feeling connected to a community helps provide purpose and focus towards maintaining and sustaining successful recovery. SAMHSA established recovery support systems (RSS) to promote partnering with people in recovery from mental and substance use disorders and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster health and resilience (including helping individuals with behavioral health needs be well, manage symptoms, and achieve and maintain abstinence). They can also increase housing to support recovery, reduce barriers to employment, education, and other life goals, and secure necessary social supports in their chosen community.⁵⁴

FBOs are an integral part of RSS and consistently provide a sense of community. They are essential in the life of an individual. FBOs have an opportunity to provide a sense of community to an individual in treatment and in recovery by providing an open and nonjudgmental space. Research indicates that stigma is a primary deterrent to individuals living with OUD to seek treatment and support.⁵⁵ FBOs can combat this stigma by using people first, affirming language,⁵⁶ providing education to convey the message that OUD is a medical condition and not a moral failing, distributing evidence-based fact sheets and other materials to leaders, staff, and members,⁵⁷ providing referrals to treatment resources,⁵⁸ and conveying that individuals struggling with OUD and their families are valued members of the FBO.



Opioid Use Disorder Toolkit for Faith-Based Community Leaders

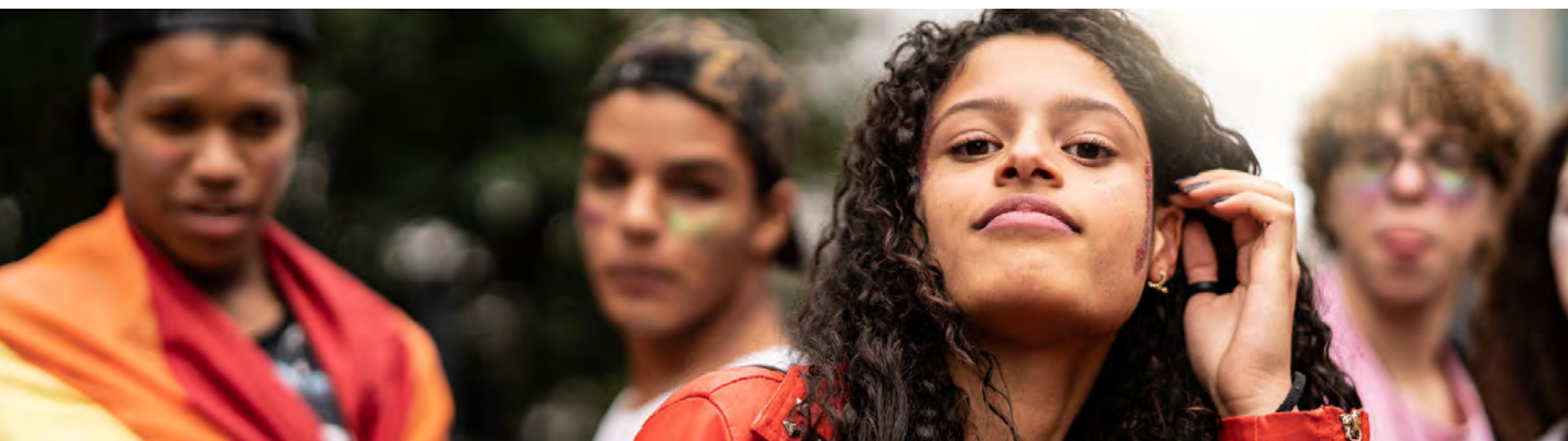
SECTION 2: Intervention and Treatment Action Items



Section 2: Intervention and Treatment Action Items

1. **Begin to Form Partnerships with Local Treatment Centers.** FBOs can find a list of local treatment resources from their county health department or at <https://findtreatment.samhsa.gov/>.
2. **Complete a Resource Map.** Support your faith community by developing a resource list to link members to services.
3. **Contact Providers.** Introduce yourself and your faith community to area providers, to learn more about each organization's services.
4. **Ask How You Can Become Part of the Continuum of Care.** Systems of care function along a continuum. Such a continuum of care typically moves people along a path from more intensive services (e.g. treatment) to more community-based services that help people experience recovery in their natural context. One challenge of any continuum of care is where to discharge people to when they're no longer eligible for services. This is where a faith community can express its desire to serve their county by becoming part of that continuum of care. Their place along such a continuum will often be to provide a supportive community to those discharged from treatment or other intensive professional services. By seeking to become part of such a continuum, faith communities are showing both their desire to help the broader system as well a willingness to stay engaged in this work over the long haul. Such an approach to partnership will build trust among treatment providers with whom you desire to collaborate.
5. **Have Mobile Crisis Services and Other Emergency Numbers Stored in Your Phone.** Many counties have a mobile crisis team with the task of stabilizing and resolving crisis situations as well as helping individuals plan for future crises. Given that anyone may experience a substance-use related crisis and require immediate support, it is worth knowing and even storing in your phone the number to your local mobile crisis team. If there is a physical emergency related to safety, the priority is always to call the police/emergency services at 9-1-1. However, if the crisis requires personal support and the potential need for treatment, it is valuable for faith leaders to have the number for Mobile Crisis Services. Such crisis services will not only be helpful around immediate care but will also know the available human services and treatment centers in your county.
6. **Embrace an Approach to Overcome Stigma Between Providers and FBOs.** Stigma is an issue addressed elsewhere in this toolkit to combat the negative bias associated with SUD. Stigma can also be a reality in the relationships between faith leaders and treatment providers. Some treatment providers think of faith leaders as those who are dismissive of the physical and medical issues related to addiction. Conversely, some faith leaders think of treatment providers as those who are dismissive of the spiritual issues and resources related to addiction. As a result, each group at times resists making referrals to the other which, ultimately, hurts people in need of holistic support. It is important to fight stigma on all fronts. Each side must look at what they can learn from the other and how collaboration can help those both in treatment and in the faith community. This mutual learning can happen when each side embraces a both/and, rather than either/or approach. Faith leaders can nurture this mutual learning and de-stigmatization by taking the crucial first step of reaching out to a local treatment provider for an introductory meeting.

7. **Attend Local Providers Meetings.** Most county systems of care hold provider meetings that bring together representatives from various human service organizations. At times these meetings are organized by region and at other times they are organized by service sector. By attending these meetings faith community representatives can network, organically start relationships with treatment centers, and let others know about their community's desire to serve the broader community. You can typically get information on such meetings by reaching out to your County's Human Services Department.
8. **Start or Join a Multi-Faith Coalition.** If your county does not already have a Multi-Faith Coalition you can join, it would be worth gathering some ministry colleagues and speaking to your local Department of Human Services about such a venture. Multi-Faith Coalitions bring together people from different sectors (e.g. faith communities, human services providers, county government) and different faiths for the purpose of resource-sharing, dialogue, and collaboration for the common good. Among the benefits of such a coalition is that it provides a natural way for faith communities and treatment centers to develop an ongoing partnership.
9. **Connect with Providers of Substance Use Treatment AND Mental Health Treatment.** Both Substance Use Treatment providers and Mental Health Treatment providers call upon their staff to be co-occurring competent. Co-Occurring competence refers to the ability to respond effectively to people who have co-occurring substance use and mental health disorders. It will be valuable for your faith community to build relationships with both local substance use treatment providers and mental health treatment providers.
10. **Get Everyone in the Room.** Regions are increasingly looking at how partnerships across systems can strengthen the community safety net. As foundations and county governments look to develop such partnerships, there is a concerted effort to get everyone in the room. If partnerships are to occur there is value in bringing together those from multiple systems of care including faith communities, substance use, children and youth, victim services, mental health, homeless services, county government, and philanthropy. Upon reaching out to your local Human Services Department it may be discovered that there aren't spaces where such gatherings are occurring. If this happens, consider using your own faith community as a gathering point for such meetings. If willing to provide the space for such a meeting, your local Human Services Department and Office of Substance Use Services may be willing to promote the event within their provider network.





SECTION 3: Recovery



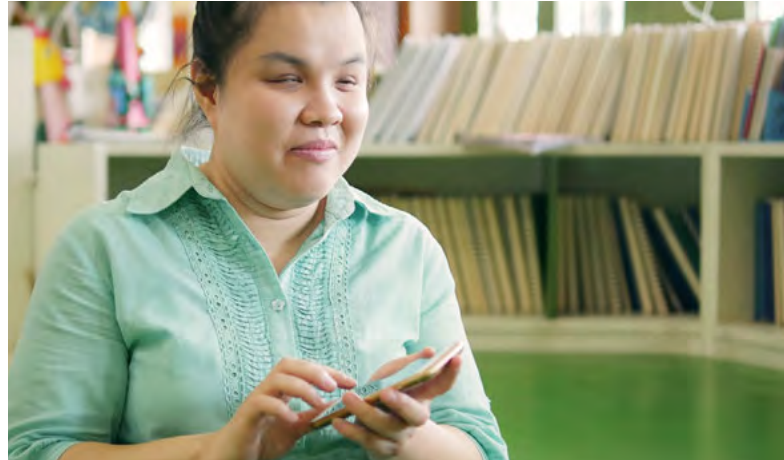
Purpose

This section provides a working definition for recovery and an overview of concepts of recovery and wellness to assist communities in developing supportive environments and services for individuals with OUD, family members, and FBOs.

Understanding Recovery

SAMHSA has developed a working definition and a set of principles for recovery. A standard, unified working definition will help advance recovery opportunities for all Americans, and help to clarify these concepts for peers, families, funders, providers, and others.

Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. There are four major dimensions that support recovery:



1. **Health** - overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being.
2. **Home** - having a stable and safe place to live.
3. **Purpose** - conducting meaningful daily activities and having the independence, income, and resources to participate in society.
4. **Community** - having relationships and social networks that provide support, friendship, love, and hope.⁵⁹

Successful recovery often involves making significant changes to one's life to create a supportive environment that avoids substance use, cues, or triggers. Recovery can involve changing jobs or housing, finding new friends who are supportive of one's recovery, and engaging in activities that do not involve substance use. Ongoing RSS in the community can be invaluable for helping individuals avoid recurrence and rebuild lives.⁶⁰ SAMHSA's recovery principles outline that recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches.

Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families.⁶¹

FBOs can develop coordinated strategies to foster resilience and support recovery. Some ideas are in the table below.

Suggestions for various key stakeholders to address OUD and support recovery adapted from <i>Facing Addiction in America: The Surgeon General's Spotlight on Opioids</i>.⁶²
Reach out, if you think you have a problem with opioid use or a substance use disorder.
Be supportive (not judgmental) if a loved one has a problem.
Carry naloxone and be trained on how to use it.
Show support toward people in recovery.
Parents, talk to your children about substance use.
Understand pain. Many scientifically proven pain management options do not involve opioids.
Talk to your health care provider about an individualized plan that is right for your pain. Be safe.
Only take opioid medications as prescribed to you.
Always store in a secure place.
Dispose of unused medication properly.
Provide treatment and recovery supports.
Teach accurate, up-to-date scientific information about substance use disorders as medical conditions.
Enhance training of leaders and staff.
Address substance use-related health issues with the same sensitivity and care as any other chronic health condition.
Support high-quality care for SUD.
Promote effective integration of prevention, treatment, and recovery support services.
Build awareness of substance use as a public health problem.
Invest in evidence-based prevention interventions and recovery supports.
Support youth substance use prevention.

Provide leadership, guidance, and vision in supporting a science-based approach to addressing substance use-related health issues.

Collect and use data to guide local response to people and places at highest risk. Improve coordination between social service systems and the health care system to address the social and environmental factors that contribute to the risk for substance use disorders.

Support criminal justice reforms to transition to a less punitive and more health-focused approach.

The 10 Principles of Recovery⁶³

FBOs can develop and provide RSS to support their members and the community. SAMHSA's Principles of Recovery can serve as a guide.

1. **Recovery Emerges from Hope.** Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.
2. **Recovery Is Person Driven.** Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals.
3. **Recovery Occurs via Many Pathways.** Recovery pathways are highly personalized. They may include professional clinical treatment, use of medications, support from families and in schools, faith-based approaches, peer support, and other approaches.
4. **Recovery Is Holistic.** Recovery encompasses an individual's whole life, including mind, body, spirit, and community.
5. **Recovery Is Supported by Peers and Allies.** Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.
6. **Recovery Is Supported through Relationship and Social Networks.** An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover, who offer hope, support, and encouragement, and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks.
7. **Recovery Is Culturally-Based and Influenced.** Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

8. **Recovery Is Supported by Addressing Trauma.** The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust as well as promote choice, empowerment, and collaboration.
9. **Recovery Involves Individual, Family, and Community Strengths and Responsibility.** Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.
10. **Recovery Is Based on Respect.** Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery.





Opioid Use Disorder Toolkit for Faith-Based Community Leaders

SECTION 3: Recovery Action Items



Section 3: Recovery Action Items

1. **Use the Strategies for Stakeholders and the Principles of Recovery.** Develop a plan for your organization to provide awareness and hope about recovery and to implement recovery support services. Consider hosting recovery groups for marginalized populations represented in your membership.
2. **Form Community Partnerships with Recovery Support Services.** To form community partnerships with recovery support services, faith communities can embrace a three-stage process of Finding Partners, Beginning the Conversation, and Collaborating. Each of these stages is listed below along with practical steps for carrying them out.
3. **Find Partners in your FBO.**
 - a. **Identify who in your faith community works in the field of human services.** A related step was mentioned earlier in the Toolkit in terms of Assessing your Assets as a faith community so that you can discover your unique role in relation to the opioid epidemic. Beyond knowing your role, though, members of a faith community in the field of human services will also be able to make connections with substance use services. Having a person who works at the intersection of faith and addiction (one foot in the faith community and one foot in the system) will provide the community with someone who knows the system and can make introductions for leaders to other potential partners.
 - b. **Research potential partners in your region.** In many counties, there is an Office of Substance Abuse Services that will provide specific information on the different providers in your region. A list of providers could include Drug and Alcohol Intervention Services, Drug and Alcohol Prevention Programs, Drug and Alcohol Recovery Support Services, Drug and Alcohol Treatment Services, and Student Assistance Programs. Identifying the different resources available and learning about them will help you know which organizations should be contacted in order to learn more about them and consider a partnership.
 - c. **Explore whether there are any local faith-based substance use organizations/ministries.** Many faith leaders say they “don’t know who they can trust” when it comes to referring a member to a human services provider. There is a fear such providers won’t respect the faith of a person seeking support. Due to this challenge, finding an organization/professional with a holistic vision of support will be invaluable both for referring needs as well as receiving consultation and training. The only challenge here is that many faith-based organizations don’t have strong ties with the Public Drug and Alcohol system and, therefore, won’t be able to help you partner with serving many outside the faith community who are struggling.
 - d. **Find a conversation partner.** Some faith leaders have found it helpful to find a person they can call as a “conversation partner” when they have questions about substance use related issues or ministry situations. Such conversation partners would be people who have both professional expertise as well as a common faith commitment as the spiritual leader. One of the benefits of having such a person you can call is that there are some in-between situations that don’t yet require a referral but would benefit from some conversation with a trusted confidant. Some places to start in finding such a person include asking fellow faith leaders if they know people who fit this description as well as exploring what faith-based addiction ministries or non-profits exist in your region.

4. **Begin the Conversation.**

- a. **Ask them about them.** After determining with whom you want to partner, the next step is to set up a meeting with a provider and begin a conversation. Most providers, when contacted, will want to share about their different resources. By starting the conversation with what you want to learn about them (rather than speaking about your own faith community), you are more likely to get a responsive willingness to sit down and meet.
- b. **Offer to help with their needs.** Instead of focusing on your agenda as a faith community, find out from the organization how your community might be helpful to the provider and/or people they serve. This will show that you are coming at this partnership to give and not only receive.
- c. **Translate terms.** Speak in language that will make sense to human service professionals. For example, use words and phrases like “socialization” rather than “fellowship,” “service” rather than “ministry,” and “spirituality” rather than “religion.” The reason to do this is that it helps in meeting them where they are and demonstrating that what’s being offered isn’t just about the faith community’s mission (ex: gaining followers, evangelism, etc.) but about the provider’s mission as well (ex: prevention, recovery, community integration, integrated health, etc.).

5. **Collaborate.**

- a. **Offer to meet with participants interested in exploring a faith community.** One of the ways a faith community can be of benefit to recovery support services is by giving participants the opportunity to be part of a supportive community. Most substance-use professionals see the value in participants getting connected to a faith community but don’t know what faith communities exist in their area. By offering help in speaking with participants who are already interested in a faith community, you make the professional’s job easier while also helping people who may be interested in exploring your faith.
- b. **Be a Faith Community that is not just gathered but scattered.** There are times when a recovery support service may want to connect someone to the faith community. However, certain people being referred may not yet be ready to attend a faith-based meeting. This could be due to past trauma, concern over stigma, or fear of the unknown. In such situations, it is helpful for an FBO to see itself as not just a gathered community but a scattered community as well. Scattered communities see their role extending beyond their faith based services to how they love and serve people throughout the week. If an FBO is only a gathered community, there will be no other options for a person being referred who isn’t yet ready for a communal experience. However, if an FBO is a scattered community as well, there are all sorts of options for how members can engage with the person being referred. Such options could involve meeting with someone over coffee, for a walk in the park, or for a small group gathering. Taking this approach requires that a community be relational and flexible enough to meet people where they are in fresh and creative ways. They will be faith communities known for meeting people where they are. Engage your members in identifying out-of-the-box ideas that work for your faith community.

- c. **Offer to provide transportation for people, whether it be to your gatherings or other locations.** Many people receiving services will at times need support with transportation. This creates an obstacle for human service organizations since they often can't provide transportation support due to billing, regulatory, or scheduling barriers. By offering to help with transportation, an FBO is both meeting an individual's need for a ride while at the same time helping them explore the faith community.
- d. **Reach out for consultation and/or support for someone in your faith community.** While at times partnerships are formed through offering help, other times they are formed by asking for help. By calling a service provider around a need in the FBO, faith communities will experience the dual benefit of getting support for a member as well as beginning a potential partnership with a provider.
- e. **Request training for your Faith Community.** There are a variety of trainings that human service providers offer FBOs around support and skill-building. Among them have been QPR (Question, Persuade, Refer) for suicide intervention skills and Mental Health First Aid for mental health support skills. In addition to these, it is worthwhile for FBOs to receive basic training around supporting those experiencing addiction. While leaders could reach out to organizations specializing around faith and addiction, they could also request training from local providers in their own region or submit a request to <https://opioidresponesenetwork.org/>. Receiving this training will both better equip your community as well as help develop an ongoing partnership.
- f. **Participate in an Online Care Portal.** One collaborative model that has borne results are online care portals. Such portals provide a way for human service providers to post the needs of people they serve so that faith communities can respond to such needs with support. Posted onto the portal will be a broad range of material, physical, social, and spiritual needs. These portals are a “win-win” for collaborative partners since they assist providers who have limitations in what they can offer people as well as FBOs who desire to serve their community but don't always know where the needs are.



Opioid Use Disorder Toolkit for Faith-Based Community Leaders

SECTION 4: Destigmatization



Purpose

This section provides an overview of stigma, the negative impact stigma has on individuals and communities, and exercises for faith-based leaders to address stigma.

Understanding Stigma

Stigma is a discrimination against an identifiable group of people, a place, or a nation.⁶⁴ There are three types of stigma:

1. Public stigma involves the negative or discriminatory attitudes that others have about mental illness or substance use disorders.
2. Self-stigma refers to the negative attitudes, including internalized shame, that people with mental illness or substance use disorders have about their own condition.
3. Institutional stigma is more systemic, involving policies of government and private organizations that intentionally or unintentionally limit opportunities for people with mental illness or substance use disorders. Examples include lower funding for research or fewer services relative to other health care.

	Public	Self	Institutional
Stereotypes & Prejudices	People with mental illness or substance use disorders are dangerous, incompetent, to blame for their disorder, unpredictable	I am dangerous, incompetent, to blame	Stereotypes are embodied in laws and other institutions
Discrimination	Therefore, employers may not hire them, landlords may not rent to them, or the health care system may offer a lower standard of care	These thoughts lead to lowered self-esteem and self-efficacy: "Why try? Someone like me is not worthy of good health."	Intended and unintended loss of opportunity

Studies about stigma show that, "Mental disorders probably carry more stigma (and consequent discrimination) than any other illness- mental disorders, AIDS, venereal diseases, leprosy, and certain skin diseases."⁶⁵ In fact, "the level of stigma was higher towards individuals with substance use disorders than towards those with other psychiatric disorders."⁶⁶

Stigma is so consequential for people with an SUD that they often deny they have a substance use problem, fail to seek treatment, and as a result, fail to recover leading to poorer functioning, poorer quality of life, and disrupted relationships. In fact, only 1 in 10 receive treatment.⁶⁷

The most common reasons for not getting treatment include:

1. Not being ready to stop: 40.7%
2. Inability to afford treatment: 30.6%
3. Fear of treatment negatively impacting one's job: 16.4%
4. Fear of one's neighbors and community judging them: 8.3%
5. Not knowing where or how to get treatment: 12.6%
6. Not having access to a preferred type of treatment: 11%
7. Treatment being too inconvenient or far away: 11.8%⁶⁸

Why don't people get treatment?

There are several factors that influence why a person does not get treatment for their substance use problem. On an individual level, poor thinking as a result of one's substance use can impact decision making. "A common clinical feature associated with substance use disorders is an individual's tendency to underestimate the severity of their problem and to overestimate their ability to control it. This is likely due to substance-induced changes in the brain circuits that control impulses, motivation, and decision making."⁶⁹

Stigma is a major factor that influences a person's choice to enter treatment. Stigma occurs on different levels: individual, familial, health care providers, and institutions.

Stigma can reduce willingness of policymakers to allocate resources, reduce willingness of providers in non-specialty settings to screen for and address substance use, and limit willingness of individuals and families to seek treatment. Public education that reduces stigma and provides information about treatment is needed.⁷⁰





Opioid Use Disorder Toolkit for Faith-Based Community Leaders

SECTION 4: Destigmatization Action Items



Section 4: Destigmatization Action Items

1. **Host a Discussion.** Use the “Real Stigma about Substance Use Disorders” study by the Recovery Research Institute as a guide to host a discussion as to ways that your organization can reduce stigma. <https://www.recoveryanswers.org/research-post/the-real-stigma-of-substance-use-disorders/>
2. **Hold a Language Matters Education Session.** View the ATTC Language Matters Slidedeck with leaders and staff in your organization. <https://attcnetwork.org/centers/mountain-plains-attc/product/slidedecks4u-language-matters>
3. **Distribute the ATTC Language Matters Card to Leaders, Staff, and Members:** <https://attcnetwork.org/centers/mid-america-attc/product/language-matters-using-affirmative-language-inspire-hope-andrs>
4. **Translate the Vocabulary of Addiction into the Vocabulary of Your Faith Tradition.** It is easy for stigma to develop in an FBO if the topic isn't brought up in a way that depicts its relevance to faith. This happens when the vocabulary of addiction is completely separated from the vocabulary of faith. People can wrongly assume that addiction is an epidemic among the “immoral outsiders” rather than a reality among “faithful insiders.” Not only does this increase stigma but it also leaves those who are struggling with the impression that either a) no one else in their community is experiencing addiction or that b) their faith doesn't provide any resources to help them in recovery. One way to overcome these assumptions and the silence that breeds them is for leaders to translate addiction language into terms that match their community's faith tradition. While each faith tradition may do this differently, the task itself remains vital. One modern-day example of such an exercise is Richard Rohr's book, “Breathing Under Water: Spirituality and the Twelve Steps.” In this work Rohr seeks to translate the Twelve Steps into terms that are accessible to faith communities.
5. **Address Addiction When Speaking About Member's Needs.** In many FBOs there are times when leaders speak about the needs of certain people within their FBO. They might speak about the needs of members who are suffering in the FBO with physical challenges like cancer. They may also speak about those outside the FBO, such as political leaders. This is also an opportunity for leaders to speak for those inside and outside their FBO who are experiencing the effects of OUD. Including OUD and addiction at these times humanizes these experiences, decreases stigma, and communicates concern for those living with addiction.
6. **Address Addiction in Faith-Based Public Speaking.** It can be difficult for leaders to decide when to address the topic of addiction within their faith based gatherings. It is equally appropriate at an event to specifically observe a faith tradition or a more social event where members of the FBO are gathered. Using illustrations and examples having to do with addiction and the opioid epidemic help normalize these experiences and decrease the stigma surrounding them. Illustrations like these also communicate that attention is being paid to societal trends and that faith is a resource for such issues.

7. **Give Opportunities for People in the FBO to Share Their Story.** There are likely people in any given FBO who are in recovery for OUD or other addictions. By asking them to share their story in a gathering of other faith community members, you are communicating that addiction isn't just an epidemic "out there" in society, but an experience "in here," within the faith community. Further, when FBOs take this step, they tend to see other people "coming out of the woodwork" who didn't know that it was safe to say such things around people of faith. When a person bravely shares something with the other members of their faith community, it provides others the gift of sharing without having to go first.
8. **Find a Place Where Faith Leaders Can Share Their Own Story.** While stigma around substance use is enough to silence anyone, it can have an especially quieting effect on faith leaders. Given the sense of responsibility faith leader's experience to "have it all together," they tend to be sensitive about sharing struggles that are stigmatized. This does not mean that such struggles among faith leaders don't exist. In fact, those in the faith community have increasingly heard stories of leaders who have wrestled with the same sorts of experiences present among their FBO. Unfortunately, members often learned about the struggle after it was too late to provide support. In recent years there have been multiple stories of faith leaders who've died by suicide. For some it was after years of dealing with mental health struggles such as anxiety and depression. Whether the issue is substance use, mental illness, or both, it is important that leaders find places where they can share their story and experiences with others. These places might be in groups with other faith leaders, faith-based recovery groups, or local support groups (e.g. Narcotics Anonymous). In certain situations, it may even be possible for leaders to share with their own FBOs. By doing so they are, in a way, "practicing what they preach" by showing the same sort of honest vulnerability they often request of their members. It is only when faith leaders share their stories that others will learn that they can share theirs as well.



9. **Reframe the Face of Addiction for Your FBO.** When FBOs think of those with SUDs, certain faces may come to mind. The same thing can happen when we think of those who are experiencing mental illness, homelessness, or hunger. We humans tend to associate certain faces or types of people with such populations. For many of us, though, the COVID-19 pandemic altered this pattern of facial recognition. As the pandemic increased isolation, depression, and anxiety across society, the faces of those with SUD looked more and more like the faces of friends and family. As the pandemic hit the economy and heightened unemployment, more and more people found themselves looking for solace in the use of substances. While these changing faces may feel unsettling, it's a reminder of how faith communities need to look for those experiencing these challenges. By helping your FBO to see that the face of addiction is a face that resembles all of us, we may diminish stigma in our faith communities and cease dehumanizing the hurting faces of those we don't know.
10. **Emphasize Person-First Language and a Faith-Based Identity.** Literature on stigma encourages the use of person-first language. This is language that puts a person before a diagnosis and emphasizes the individuality, equality, and dignity of people. For example, saying "people struggling with addiction" rather than "addicts." One reason for this shift in language is that making an addiction someone's core identity is stigmatizing and prevents people from opening up and seeking help for their experience. This change in language and identity can decrease stigma and make it more common for people to talk about their lived experience.

Conclusion

Faith-Based Community Leaders have a critical role in helping the community at large in combating the opioid crisis. You are able to offer support, service, and hope to people struggling with addiction and their friends and family. This toolkit is a great starting point to open the door on how you can better serve the people of your faith-based community and the people in your secular communities as well. To wrap up the toolkit, please find a series of exercises you can do with the members of your FBO or as thought exercises for you as a leader or with the other leaders of your FBO. It can be frightening to enter new territory but hopefully that fear will be a catalyst for growth. Step into the intersection of faith, mental health, and substance use disorders and start your organization's journey toward change!



Opioid Use Disorder Toolkit for Faith-Based Community Leaders

SECTION 5: Exercises for Faith-Based Leaders



Purpose

In addition to practical action items, it is important to have opportunities for FBOs to learn together how their organization can help support recovery and to help destigmatize and understand SUD and OUD. The following exercises give faith communities the opportunity to learn together about OUD and its impact on the community.

Exercise 1

In a small group, ask members to imagine that they are in front of the faith community and you announce to them, “I just found out I have been diagnosed with diabetes.” Ask them how they feel about your new diagnosis. Prompt the group to explore what type of changes they might make to support you with your new diagnosis (like no longer bringing sugar treats such as cakes and pies to gatherings). Ask them to explore how they can demonstrate a sense of understanding about this change. Will they be understanding when you miss an event to make a doctor’s appointment?

Following some conversation about how they can be supportive of helping you with your new diagnosis of being a person with diabetes, ask the members to imagine that they are in front of the faith community and you announce to them, “I have been diagnosed with a substance use disorder.” Ask them to explore how they feel about this? Are they afraid that you won’t be able to lead the faith community? Are they scared that something bad might happen, or angry that someone they trust is struggling?

Following some conversation, compare and contrast their responses to addressing you with a more familiar medical condition vs the less familiar medical condition that is substance use disorder. Ask the group to explore where their values and beliefs about substance use come from.





Exercise 2

Read the NIDA article “Words Matter - Terms to Use and Avoid When Talking About Addiction,” <https://www.drugabuse.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction>.

In a group format, review the information in the above link. Ask the group to explore whether they hear and use language that stigmatizes or destigmatizes substance use. Explore within the group how they feel about using less-stigmatized language and how their personal beliefs and values might be influencing their choice of language.

Exercise 3

Identify how stigma interferes with evidence-based diagnosis, prevention, and treatment in your community.

1. Is your faith community aware of local treatment providers?
2. Do your local treatment providers use the SAMHSA components of care outlined in the treatment section?
3. Are there multiple levels of care (inpatient, partial hospitalization, IOP) available in your community?
4. Does your FBO refer members to authorized treatment providers?

Exercise 4

Take a piece of paper or open a document on your computer with two columns. In column A write out the ways in which the content of this toolkit overlaps with the beliefs and values of your faith tradition. In column B write out the ways in which there is an apparent tension between the content of this toolkit and the beliefs and values of your faith tradition.

1. What are ways you use the overlaps you've identified in column A to address stigma in your faith community?
2. Who is someone within your faith tradition that can help you overcome the tensions you've identified in column B?

Exercise 5

Connect the categories of stigma listed in the toolkit with the structures that fit your particular context.

1. Public Stigma – How have you heard people in your faith community speak about people that experience substance use disorders? How does their language affect people in reaching out for help?
2. Self-Stigma – If you are someone with a lived experience, what attitudes have you held about your own journey? How do other people in your faith community with a lived experience talk about their own experiences of substance use disorders?
3. Institutional Stigma – How does your FBO and faith-based tradition address substance use disorders? Is the approach helpful to those in recovery or does it put up barriers to people getting support?



Opioid Use Disorder Toolkit for Faith-Based Community Leaders

SECTION 6: Resources



Additional Federal Resources

Surgeon General's Report on Alcohol, Drugs, and Health
<https://addiction.surgeongeneral.gov/>

CDC Guideline for Prescribing Opioids for Chronic Pain
<https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>

MMWR Opioid Reports
https://www.cdc.gov/mmwr/opioid_reports.html

SGR Appendix B: Review Process for Prevention Programs
<https://addiction.surgeongeneral.gov/sites/default/files/appendices.pdf>

NIDA Opioid Risk Tool
<https://www.drugabuse.gov/sites/default/files/OpioidRiskTool.pdf>

NIDA Quick Screen
<https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen>

CDC general resources
<https://www.cdc.gov/drugoverdose/prescribing/resources.html>

CDC resources related to People Who Inject Drugs (PWID)
<https://www.cdc.gov/pwid/index.html>

CDC's Rx Awareness Campaign
<https://www.cdc.gov/rxawareness/index.html>

CDC Adverse Childhood Experiences page
<https://www.cdc.gov/violenceprevention/aces/index.html>

Preventing the Consequences of Opioid Overdose:
Understanding the Naloxone Access Laws
<https://mnprc.org/wp-content/uploads/2019/01/naloxone-access-laws-tool.pdf>

The Surgeon General's Advisory on Naloxone and Opioid Overdose
<https://www.surgeongeneral.gov/priorities/opioid-overdose-prevention/naloxone-advisory.html>

SAMHSA Opioid Overdose Prevention Toolkit
<https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA18-4742>

SAMHSA Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants
<https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054>

END NOTES

- 1 <https://emergency.cdc.gov/han/2020/han00438.asp>
- 2 <https://www.drugabuse.gov/drug-topics/opioids>
- 3 <https://www.cdc.gov/drugoverdose/epidemic/index.html>
- 4 <https://www.hhs.gov/about/agencies/iea/partnerships/index.html>
- 5 <https://www.hhs.gov/sites/default/files/the-opioid-crisis-practical-toolkit.pdf>
- 6 <https://www.who.int/hac/about/definitions/en/>
- 7 <https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis>
- 8 <https://pubmed.ncbi.nlm.nih.gov/27623005/>
- 9 <https://drugfree.org/article/ending-the-opioid-crisis-a-practical-guide-for-state-policymakers/>
- 10 <https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis>
- 11 <https://www.cdc.gov/drugoverdose/epidemic/index.html>
- 12 <https://emergency.cdc.gov/han/2020/han00438.asp>
- 13 <https://www.drugabuse.gov/nidamed-medical-health-professionals/opioid-crisis-pain-management/facing-addiction-in-america-surgeon-generals-spotlight-opioids>
- 14 https://addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf
- 15 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6040780/>
- 16 https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2
- 17 https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2
- 18 <https://www.drugabuse.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction>
- 19 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5937046>
- 20 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5854406>
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Opioid Use Disorder Toolkit for Faith-Based Community Leaders

A TOOLKIT CREATED BY
THE OPIOID RESPONSE NETWORK



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