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The Role of Small and Medium-Sized African-American Churches in Promoting Healthy Life Styles

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ABSTRACT: The issues of poor health care, poverty, crime, and HIV infection make it more difficult for minority communities to combat substance abuse and other diseases that are prevalent in the African-American community. Faith communities in general, and African-American churches in particular, are a largely untapped, but potent, resource to reduce the toll of substance abuse and other health issues. Information about ministers' knowledge, attitudes, and behaviors regarding leading health indicators, the frequency with which they discuss these issues from the pulpit, and organizational readiness to develop and implement interventions can be the foundation of clergy training and health intervention efforts.

KEY WORDS: substance abuse; spirituality; community-based interventions; clergy's role.

The often co-existing and interrelated issues of poor health care, poverty, crime, and HIV infection make it more difficult for minority communities to combat substance abuse and other diseases that are prevalent in the African-American community (National Institute on Drug Abuse [NIDA], 2001; Rich-

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ardson, Williams, & Watson, 1991). Faith communities in general, and African-American churches in particular, are recognized as a largely untapped, but potent, resource to reduce the toll of substance abuse and other health issues (Center for Substance Abuse Treatment [CSAT], 1995; Farnsley, 1998). Religiosity and spirituality are defining features of African-American life that shape individual, family, and communal relationships across the developmental span (Mattis & Jagers, 2001).

Policymakers newly recognize and support the important role that faith-based programs can and should play in this struggle (Office of National Drug Control Policy [ONDCP], 2000). In creating the White House Office of Faith-Based Community Initiatives (OFBCI), President Bush strengthens and expands the role of faith-based and community organizations in addressing the nation's social problems (White House, n.d.). Specifically, the Compassion Capital Fund, a $30 million fund appropriated by Congress to the Department of Health and Human Services in January 2002, will fund a national resource center and clearinghouse for information related to technical assistance and training resources for faith- and community-based organizations and evaluate innovative practices that these organizations are using so that other organizations can benefit from their unique approaches. In addition, the scientific and research communities are becoming more aware of the necessity of integrating spirituality into treatment for substance abuse (Harris, Thorsen, McCullough, & Larson, 1999). Philanthropy, too, has focused its attention on religion. In recent years many foundations have either launched new grant-making initiatives focused on religion, increased their support for research on religion, or increased grants for technical or direct financial assistance for community-serving ministries (Larson, Johnson, & Diploid, 1998).

The link between religion and health

Research conducted by Dr. Herbert Benson at Harvard Medical School has shown a direct correlation between religious practices and health status, both physical and mental health (Benson & Dusek, 1998). Harold Koenig's compilation of scientific studies (1999) similarly reveals the impact of religious life on physical and emotional health. Duke University's Center for the Study of Religion/Spirituality and Health, under Koenig's leadership, has conducted more than 50 studies of the relationship between health and traditional religious faith and practice. In *Handbook of Religion and* Health, (Koenig, McCulloch, & Larson, 2001), the authors present a summary of the literature relating religion and health and find many associations between religious commitment and practice and health with major implications for creating healthy lifestyles and the treatment of illness. Larson's pioneering work on the development of scientific "faith factor" research on public health outcomes (physical health, mental health, and addictions) led to new training programs at Harvard University and three dozen other medical schools (1997).

Religion/spirituality and substance abuse prevention and treatment

The impact of spirituality in alcoholism and drug abuse prevention has been well documented. The National Center on Addiction and Substance Abuse at Columbia University (CASA) found that religion and spirituality have enormous potential for lowering the risk of substance abuse among teens and adults and, when combined with professional treatment, for promoting recovery (2001). Koenig et al. (2001) list nearly 175 studies that deal with the relationship between alcohol or drug abuse and religion. Of these, about 147 suggest "religion may be a deterrent to alcohol or drug abuse in children, adolescents, and adult populations." Koenig and his colleagues conclude that the mechanism for reducing substance abuse through religiosity include "reducing the likelihood of choosing friends who use or abuse substances, instilling moral values, increasing coping skills, and reducing the likelihood of turning to alcohol or other drugs during times of stress." Stanford researcher Keith Humphreys found, "Addiction treatment programs are more effective and less expensive when they link patients to spiritually-based self-help groups" (2001). The National Center for Neighborhood Enterprise (n.d.) reports that faith-based programs typically have success rates of 75–80% compared with a national rate of 21% for traditional programs. As Gary Gunderson, Director of Operations at the Interfaith Health Program at The Carter Center of Emory University, said, "Human sickness can't be accurately diagnosed or treated apart from a vision of wellness and wholeness that includes the full life of the human involved" (1993).

In the largest survey of congregations ever conducted in the United States, Dudley and Roozen of the Hartford Institute for Religion Research (2001) found that congregations in the Historically Black denominations tend to have more participants from low-income households, are more likely to emphasize community service, and contribute greatly to the welfare of communities. Wimberley (2000) asserts that pastoral counselors have a unique role in helping church members to "formulate solutions to their crises." Anna Wanger's current ethnographic research, out of the Interfaith Health Program at Emory University, on the meaning of faith and health in African-American communities, will shed new light on the interplay of religion and health for African Americans.

The community health efforts of churches

A large number of churches are involved in community health efforts. A recent survey of The National Council of Churches of Christ found that 78 percent of the 1,800 churches surveyed were addressing at least one health concern while half are addressing three of more. These concerns included mental health, nutrition, substance abuse, immunization, and access to medical care. Seven percent were engaged in some form of treatment (Hilton, n.d.). Out-

reach activities like health clinics are often located in remote or impoverished communities where services are absent or would be more expensive than the residents can afford (Dudley & Roozen, 2001).

In February 1993, the Carter Presidential Center of Emory University initiated its Interfaith Health Resource Center which maintains a library of health education information and an annotated database on church health programs to share with churches looking for practical information on how to be involved in health ministry (Hilton, n.d.). The Faith and Health Consortium of The Interfaith Health Program was created to develop curriculum, research, and service models and to develop Whole Community Collaboratives where front-line leaders learn how to align the assets and strengths of faith and health at community scale (Interfaith Health Program, 1994). The capacity-building work of The Interfaith Health Program to form collaborative relationships with the faith community, specifically through networks such as the American Public Health Association's Caucus on Public Health and the Faith Community along with the Coalition for Healthier Cities and Communities' Faith Action Team, is supported by the Centers for Disease Control and Prevention.

The African-American church as an entry point for health

Historically, African-American churches have been seen as a prime entry point for community health interventions. Lawndale Christian Health Center on Chicago's West Side was the temporary residence of Martin Luther King, Jr. in 1966 when he called attention to the social problems that had long been ignored there. One of the first responses was a clinic to provide medical services, unavailable either geographically or financially to most of the community (Hilton, n.d.). McRae, Carey, and Anderson-Scott (1998) identified African-American churches as a supportive network that provides invaluable information to professional health workers interested in community-based efforts. Other researchers have described the pivotal roles these churches play in addressing mental illness (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000), smoking cessation (Voorhees, Stillman, Swank, Heagerty, Levine, & Becker, 1996), substance abuse (Simmons, 2001), and AIDS (James, 1999). The Center for Substance Abuse Treatment (1995) recognized the potential role of churches and their leaders in developing an educational curriculum to enhance seminary graduates' capacity to respond to problems associated with alcohol, tobacco, and other drug abuse. Reverend Joan Brown Campbell of the National Council of Churches asserts, "The church knows the health business well" (Interfaith Health Program, 1994). Through its ministry, the church regularly cares for the ill and infirm in a variety of settings and outreach efforts.

The African-American Church is an extraordinary institution. It has consistently transmitted to its people the values, culture, education, and organi-

zation to thrive against the odds. Love's paradigm for urban church education (2002) calls for a ministry that meets the spiritual and social needs of its members and restores the black church to its place as the "physical citadel of the community." Dudley and Roozen (2001) found that Black congregations are intentional about using their religious community as a resource for preserving racial/ethnic heritage and African Americans have a higher rate of church affiliation rate than does any other group. Black Americans have been described as the most religious people in America (Larson, Johnson, & Diploid, 1998). Some 82 percent of blacks (versus 67 percent of whites) are church members; 92 percent of blacks (versus 55 percent of whites) say that religion is "very important" in their life. This may be because the church has played a central role in African-American history. Recognizing this role, effective interventions must consider community values and the underlying influence of faith practices in the community (CDC, 1999).

Larger steeple churches often generate greater attention and resources than do small churches. But their sheer size can impede their ability to reach out to some of the communities' neediest members. Often small and medium-sized churches are located in the "heart of the Community." Therefore, they may be better suited to overcome their size limitations and galvanize their energy by working together. Most African Americans, like other Americans, attend churches that have less than 200 members (Los Angeles Metropolitan Churches, 2001). In *Faith Communities Today: A Report on Religion in the United States Today*, Dudley and Roozen (2001) report that half of congregations have fewer than 100 regularly participating adults, and a full quarter have fewer than 50.

A role for African-American churches in improving minority health

Healthy People 2000, a new report from the U.S. Department of Health and Human Services (HHS, 2002b) showed significant improvements in the health of racial and ethnic minorities, while indicating that important disparities in health persist among different populations. The report documents national trends in racial- and ethnic-specific rates for 17 health status indicators during the 1990's. All racial and ethnic groups experienced improvements in rates for 10 of the 17 indicators. Despite these overall improvements, the disparities for ethnic and racial minorities remained the same or even increased in some areas.

One of the goals of the HHS Healthy People Initiative is to reduce disparities in the health of different populations. Recent reports show that progress was made in reducing the gap in syphilis case rates and stroke death rates. However, for about half of the indicators, disparities in health between groups improved only slightly, and disparities actually widened substantially for work-related injury deaths, motor vehicle crashes deaths, and suicide.

"In many ways, Americans of all ages and in every racial and ethnic group

have better health today," former United States Surgeon General David Satcher said. "But our work isn't done until all infants have the same chance to thrive, all mothers have equal access to prenatal care, and all Americans are equally protected from cancer, heart disease, and stroke." Dr. Jeffrey P. Koplan, director of the Centers for Disease Control and Prevention (CDC), who prepared the report, said, "Efforts to achieve progress for all must be targeted and tailored to the needs of specific groups. For example, the drop in the syphilis rate followed an intensive campaign to eliminate syphilis community by community. Our goal is to eliminate disparities in health among all population groups by 2010." Secretary Thompson concurred, saying, "While we are making progress, this report shows how far we still have to go." David Larson of the National Institute for Healthcare Research believes that there is "ample evidence to support the important work of religious organizations in addressing secondary and tertiary clinical prevention issues" (CDC, 1999).

The report is a part of Healthy People 2000, an HHS-led effort to set health goals for each decade and then measure progress made toward achieving them. The indicators reflect various aspects of health and include infant mortality, teen births, prenatal care, and low birthweight as well as death rates for all causes, and for heart disease, stroke, lung and breast cancer, suicide, homicide, motor vehicle crashes, and work-related injuries. Infectious diseases such as tuberculosis and syphilis are also included. The percentage of children in poverty and the percentage of the population living in communities with poor air quality round out the set of measures developed to allow comparisons between local, state, and national areas on a broad set of health indicators.

HHS agencies are now working on Healthy People 2010, the nation's public health agenda for the current decade. A set of Leading Health Indicators are being tracked nationwide and in states and communities. While the goals of Healthy People 2000 aimed at reducing disparities, Healthy People 2010 (HHS, 2002c) aims at the elimination of disparities in health among all population groups. The data clearly suggest that although progress has been achieved there are still serious gaps in health care for African Americans and other ethnic minorities. Given the historical and current role of the African-American Church it would stand to reason that African-American clergy could have an impact in helping the nation to meet these goals. Attention could be focused on the following leading health indicators: Physical activity; overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, immunization, access to health care, and HIV/AIDS. NCADI (2000) recommends that prevention practitioners look for partners among faith communities at the denominational, clergy, and lay levels.

The role of clergy

The first step in the process of helping churches to positively impact the leading health indicators would be to develop a survey that taps: 1) ministers'

knowledge, attitudes, and behaviors regarding leading health indicators, 2) the frequency with which they discuss these issues from the pulpit, and 3) organizational readiness to develop and implement interventions. Next, focus groups could be used to clarify preliminary survey results. Areas of intervention that can be addressed from the pulpit and also at the community level would be identified. Survey results would help identify training needs for clergy (and identified church committees and/or members). Discussions with clergy would identify ways that intervention messages that are in line with scientific evidence and clergy's philosophical beliefs could be delivered. Finally, efforts could be made to identify or create community-wide interventions, with core focus areas, that churches can implement.

Examples of model faith-health programs abound. The Center for the Application of Prevention Technologies, Faith Partners, and the Johnson Institute Foundation are sponsoring a three-year demonstration project called "Congregational Teams" aimed at informing, strengthening, and mobilizing congregational leadership and religious networks to prevent substance abuse in Minneapolis-St. Paul, Minnesota and Austin, Texas. The Alameda County Health/Faith Initiative in San Francisco brings together diverse religious institutions, community resources, and larger health and social service systems to enhance the scope of public health efforts in the African-American and Latino communities. The Centers for Disease Control and Prevention has a cooperative agreement with the Congress of National Black Churches to address HIV/AIDS and immunization (Interfaith Health Program, 1994). The Balm in Gilead, a national organization, works through black churches to stop the spread of HIV/AIDS in the African-American community and to support those infected with, and affected by, HIV/AIDS. Heart Body and Soul, Inc. (HBS), a partnership in East Baltimore, Maryland comprised of Clergy United for Renewal of East Baltimore (CURE), Johns Hopkins Medical Institutions, Inc., Baltimore City Health Department, Baltimore City Public Schools, health care providers, community groups, the Mayor's Office, business community, neighborhood nonprofits, community associations and churches, has positively impacted community health for more than ten years.

The American Lung Association (ALA) supported the adaptation of the HBS program which spawned a cadre of more than 25 African-American clergy who are embracing public health through programs like HBS. The Carter Center's Interfaith Health Program supports community religious structures in improving and contributing to the health of their communities (CDC, 1999). Former U.S. Surgeon General David Satcher stressed the importance of leadership development in enhancing the skills of professionals within the public health and faith communities (Interfaith Health Program, 1994). Reverend George LaSure agreed, saying:

> The church can serve a role in bringing about a much better lifestyle, a much better health condition for all concerned. But it has to be a situation where the ministry and the key laity in churches are educated and empowered with all the

> information about particular diseases and all the things that the health community would like to impart so that they might play an ambassadorial role that [the public health community seeks]. (CDC, 1999)

The Reverend Dr. James Shopshire of Weslet Theological Seminary offers a five-step approach for involving faith communities in substance abuse efforts: 1) Cultivate regional and national partnerships between denominations and federal agencies; 2) Facilitate interfaith coalitions for drug abuse prevention among parenting, religious, and other groups; 3) Form geographic clusters that facilitate crossing denominational and racial/ethnic barriers; 4) Organize groups to participate in monitoring substance abuse policy and enforcement in the community and in society; and 5) Develop support groups among parents who are struggling and who need help with parenting (NCADI, 2000). Parents who rely on faith as a foundation for parenting skills may find support at religious functions or in church-related community functions.

Reweaving the Fabric is the inspirational story of Reverend Ron Nored (Nored & Young, 1999), an African Methodist Episcopal minister, who led the transformation of the Sandy Bottom neighborhood in Birmingham, Alabama, to Sandy Vista. It is a classic example of community-directed ministry. Reverend Nored underscores the importance of understanding the needs of the community as "church business." Churches are recognized as among the most established institutions, and church leaders are often regarded as chief supporters of the community (Freudenberg, 1997). When churches work with other organizations in the public and private sector to change communities, great things are possible.

Summary

Future research should focus on what Amy Sherman (2000) calls "the church as community asset." Public health and faith partnerships present great opportunities for disease prevention and health promotion (Interfaith Health Program, 1994). Long recognized as "the most independent, stable, and dominant institution in black communities," the Black church has a unique role in advancing the physical, emotional and spiritual well being of its members (Lincoln & Mamiya, 1990). Gayle Weaver of the University of Texas Medical Branch maintains, "The relationship between religiosity and health is an important one, particularly for African Americans, because historically religion and the church have played an important role in the survival of this country. Recent research shows that the church continues to be a very important institution within the African-American community" (CDC, 1999). In the words of William Penn, "To help mend this world is true religion."

References

Ascribed Newswire. (2001, May 21). *Faith-based self-help groups and cost-effective, efficient in treating substance abuse, say Stanford researchers.* PsycPort News Story [Online] Available: www.psycport.com/news/2001/ 05/17/ eng-ascribe__012033__233__10095

Benson, H., & Dusek, J. (1998). Self-reported health, illness, and the use of conventional and unconventional medicine and mind/body healing by Christian Scientists and others. *The Journal of Nervous and Mental Disease,186*,539–548.

CASA. (2001, November). *So help me God: Substance abuse, religion, and spirituality.* New York: Author.

Center for Substance Abuse Treatment. (1995). *Alcohol, Tobacco and Other Drug Abuse: Challenges and Responses for Faith Leaders* (National Clearinghouse for Alcohol and Drug Information Publication No. RP0898). Washington, DC: U.S. Government Printing Office.

Centers for Disease Control and Prevention. (1999). *Engaging faith communities as partners in improving community health.* Highlights from a CDC/ATSDR Forum addressing Separation of Church and State: The Science Supporting Work with Faith Communities, and Exemplary Partnerships. [Online] Available: www.phppo.cdc.gov/publications.asp

Dudley, C. S., & Roozen, D. A. (2001, March). *Faith Communities Today: A Report on Religion in the United States Today*. Hartford Institute for Religion Research, Hartford Seminary. [Online] Available: www.hirr.hartsem.edu/research

Farnsley, A. E. (1998, Fall). Thinking of congregations as community assets. *The Polis Center Research Note, 1*(7). [Online] Available: www.polis.iupui.edu/ RUC/ Newsletters/Researchvol1no7.htm

Freudenberg, N. (1997). *Health promotion in the city: A review of current practice and recommendations for directions to improve the health of urban populations in the United States.* Prepared for the CDC by the Center for AIDS, Drugs, and Community Health, Hunter College, City University of New York, 27.

Gunderson, G. (1993). *Bringing spirituality down to earth: The role of congregational nursing in the life of the local congregation.* Interfaith Health Program, The Carter Center at Emory University. [Online] Available: www.ihpnet.org/wanursetxt.htm

Harris, A. H., Thorsen, C. E., McCullough, M. E., & Larson, D. B. (1999). Spiritually and Health Oriented Interventions. *Journal of Health Psychology, 4*(3), 413–433.

Hilton, D. (n.d.). *Some models of church health ministry in the USA.* The Carter Center Interfaith Health Program, Emory University. [Online] Available November 18, 2002: www.ihpnet.org/hilton2txt.htm

Interfaith Health Program. (1994). *The Interfaith Health Program*. [Online] Available: www.ihpnet.org/4about.htm

James, J. S. (1999). Model AIDS Program Housed in African American Church. *AIDS Treatment News, 7*(318), 6–7.

Koenig, H. G. (1999). *The healing power of faith: Science explores medicine's last great frontier.* New York: Simon & Schuster.

Koenig, H. G., McCulloch, M. E., & Larson, D. B. (2001). *Handbook of religion and health.* New York: Oxford University Press.

Larson, D. B. (1997). *Scientific research on spirituality and health.* Radnor, PA: The John M. Templeton Foundation.

Levin, J. S., Chatters, L. M., & Taylor, R. J. (1995). Religious effects on health status and life satisfaction among black Americans. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 50,* S154–S163.

Lincoln, C. E., & Mamiya, L. H. (1990). *The Black church in the African American experience.* Durham, NC: Duke University Press.

Los Angeles Metropolitan Churches. (2001). *2001 Annual Report.* Los Angeles: Author.

Love, J. R. (2002). *The gathering place: Empowering your community through urban church education.* Grand Rapids, MI: Zondervan Publishing House.

Mattis, J. S., & Jagers, R. J. (2001, August). A relational framework for the study of religiosity and spirituality in the lives of African Americans. *Journal of Community Psychology, 29*(5), 519–539.

McRae, M. B., Carey, P. M., & Anderson-Scott R. (1998). Black Churches as Therapeutic Systems: A Group Process Perspective. *Health Education Behavior, 25*(6), 778–789.

National Center for Neighborhood Enterprise. (n.d.). *NCNE Faith-Based Substance Abuse Treatment Report.* [Online] Available: www.ncne.com/ teampublish/main/60__205__554,cfm

National Clearinghouse for Alcohol & Drug Information. (2000). Incorporating faith-based organizations in prevention strategies. *Prevention Alert, 3*(13). [Online] Available: www.health.org/govpubs/prevalert/v3i13.aspx

National Institute on Drug Abuse (2001). Director's Column: Meeting the Challenge of Reducing Health Disparities. National Institutes of Health Publication No. 01-3478). *NIDA Notes, 16*(1): 1–3. Washington, DC: U.S. Government Printing Office.

Nored, R. E., & Young, A. (1999). *Reweaving the fabric: How congregations and communities can come together to build their neighborhoods.* Montgomery, AL: Black Belt Press.

Office of National Drug Control Policy. (2000). *Drug Facts: Minorities and Drugs*. [Online] Available: http://www.whitehousedrugpolicy.gov/drugfact/ minorities/index.html

Richardson, T. M., Williams, B. A., & Watson, D.W. (1991). *Recovery for the African American Family*. Center City, MN: Hazelden.

Sherman, A. L. (2000). *The church as community asset.* Keynote address at the National Conference of the Christian Reformed World Relief Committee, March 3, 2000, Colorado Springs. [Online] Available: www.hudsonfaithincommunities.org/speeches/theChurchAsCommunityAsset.html

Simmons, R. (2001). *Understanding Christian Drug and Alcohol Recovery*. Los Angeles: FREE 'N' ONE.

Taylor, R. J., Ellison, C. G., Chatters, L. M., Levin, J. S., & Lincoln, K. D. (2000). Mental Health Services in Faith Communities: The Role of Clergy in Black Churches. *Social Work, 45*(1), 73–87.

U.S. Department of Health and Human Services. (2002a). *Healthy People 2000.* Washington, DC: Author.

U.S. Department of Health and Human Services. (2002b). *Healthy People 2010.* Washington, DC: Author.

U.S. Department of Health and Human Services. (2002c). *News Release.* Washington, DC: Author.

Voorhees, C. C., Stillman, F. A., Swank, R. T., Heagerty, P. J. Levine, D. M. & Becker, D. M. (1996). Heart, Body, and Soul: Impact of Church-Based Smoking Cessation Interventions on Readiness to Quit. *Preventive Medicine, 25*(3), 277–285.

Watson, D. W. (1992). Prevention, Intervention and Treatment of Chemical Dependency in the Black Community. In R.L. Braithwaite & S. Taylor (Eds.), *Contemporary Mental Health Issues: Perspectives on the Black Community* (pp. 64–78). San Francisco: Jossey-Bass, Inc.

The White House. (n.d.). *White House Office of Faith-Based and Community Initiatives.* [Online] Available: www.whitehouse.gov/government.fbci

Wimberley, E. P. (2000). *Relational refugees: Alienation and reincorporation in African American churches and communities.* Nashville, TN: Abingdon Press.