

The Faith Based Prevention/Health Promotion Model: A Successful Rural Program

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Abstract

The Faith Based Prevention and Health Promotion Model requires the total support of the church community. The model utilizes prevention strategies based on: a program delivery system that includes oral traditions; behavior is a function of the attitudes, values, and self-concept (Research, 1979); child-resilience concepts as influenced by the family, school, and community (Bernard, 1991); the program's likely impact on the key risk or protective factors of the target group and the extent to which the program can address those issues across life domains: individual, peers, family, school and community (Jansen, CSAP, 1997); age, gender and cultural appropriateness to the target group (Jansen, CSAP, 1997); and the extent to which the program is intense enough to achieve the desired outcomes, i.e., is a universal, selective or indicated needed (Jansen, CSAP, 1997). The model has been applied in the areas of drug and violence prevention, cardiovascular, cancer, arthritis, care-giving, tobacco, and numerous health and social service related areas within many rural churches. The prevention or health promotion program model follows four (4) phases of:

Phase 1: Community Development/Readiness/Empowerment.

The initial phase is dedicated to: learning about the organization and leaders of the community, developing relationships with local churches that may qualify for participation and determine the readiness of the community and churches to support a prevention initiative. The project staff might use the key-informant interview process to gather information about the community needs and the level of project interest. It is important to make as many contacts: (businesses, ministers/layman, social groups, politicians, funeral home directors, etc.).

Phase 2: Church Leader Training and Action Planning.

Church prevention committee members participate in a series of in-service training addressing: Alcohol and tobacco knowledge; Basic community development skills; Effective utilization of community agencies; Program planning, Implementation, and Evaluation skills; and Project assessment/reporting procedures using project related materials. Participants are identified, their needs considered, goals set and activities outlined for the balance of the year. Committee members use the information from the surveys and interviews, gather input from youth and

consider what they learned about effective prevention in their training. Activities are planned in the following areas: Large and small group instruction (Weekly drug related information, Drama, and Life Skills Training); Competitive and cooperative activities between and among churches (Quarterly Sports, Arts); Recognition for excellence programs for youth (Quarterly); Mentoring and parenting (Large Group); Keeping youth successful in school (Academic Strategies); Public relations activities (Announcements, Bulletin Boards, etc.); Intergenerational activities (Planned Activities Quarterly); Quarterly Drug Awareness Sundays; In-service activities; summer and after school enriching programs; and data collection using an action plan and budget.

Phase 3: Program Implementation.

Phase 3 is the implementation of the individual church prevention action/fiscal plan. Churches are monitored on a regular basis to ensure that their planned programs are being implemented and appropriate re-adjustments made. The training of committee members continues for the duration of the project monthly. The training agenda focuses upon program implementation, evaluation and activity documenting topics. The actual program will likely differ between churches, based on the different church or community characteristics, philosophy, target population, and project people, and other community resources.

Phase 4: Program Redesign.

Phase 4 is the ongoing adjustment in program activities, in part determined by prevention committee perceptions and ongoing data review analysis. There are three general activities that will take place in this phase of the model; process evaluation, outcome evaluation and program update and redesign. Process evaluation involves keeping a record of the activities conducted and the people participating in those activities. Appropriate forms have been developed. Collected is a description of the activity, a description of the participants, attendance, date, and start time, end time, location. Outcome evaluation is done to determine if program activities (the process) are making the desired changes, i.e., are youth choosing positive peers, achieving in school, avoiding alcohol, tobacco and other drug use and making a positive contribution to their church and community. Participants complete yearly questionnaires. The Prevention Committee uses the questionnaire information collected to monitor the project progress and determine program adjustments.

Sample Outcome

Faith Community successful church committee processes and data (N=10 churches) follows. Exercise (exercise to church music), Nutritional Practices (Cooking classes), Tobacco prevention activities, Stress Management groups, Blood Pressure and Weight Screening/Referral/Follow-up; Special Church Holidays related to Cardiovascular Health, Achievement/Recognition; Intergenerational; Community Awareness; Data Collection, pre/post surveys, monthly activity reports, vital statistics were the major activities. Significant youth 6 month changes (.0001, .01, or .05 levels) were found for: blood pressure and cholesterol checks, eating patterns (daily breakfast, salt, fat, sugar, fast foods), healthy behaviors (seatbelt, cholesterol, healthy weight, alcohol, fun activities, exercise), friends behaviors (discuss problems, respect ideas, do well at school, trust friends, say No to Drugs, fun activities, stay home at regular times). Significant adult behavioral changes (at either .001, .01, or .05 levels) included: participation in leisure time activities, exercise daily, and 30 minutes daily of moderate physical activity; consumer two daily servings of fruits and vegetables and avoid foods high in fats; maintain a normal cholesterol level and had it checked within the last five years; and friends do well at work

Introduction

President Bush in an effort to reduce disparities has established a faith-based and community organization agenda which is designed to assist in identifying and eliminating improper Federal barriers to effective faith-based and community-serving programs through legislative, regulatory, and programmatic reforms. Further, the President desires to stimulate private giving to nonprofits, faith-based programs, and community groups by expanding tax deductions and pioneer a new model of cooperation through federal initiatives that expand the involvement of faith-based and community groups. Faith based offices are now operational in the White House, The Departments of Health and Human Services, Housing and Urban Development, Justice, Education, and Labor. Some agency funding Request for Applications are including the faith community as a potential target audience and numerous faith community grant writing workshops are being held in various United States locations this current federal fiscal year.

This particular faith community prevention/health promotion model was developed in the late eighties with funding from a Department of Health and Human Services, Office of Minority Health funded cardiovascular program and later refined with funding from the American Heart Association, the Department of Health and Human Services, Centers for Substance Abuse Prevention, the Florida Department of Health and Human Services, and Florida A and M University. HPPI has utilized the same model in addressing such health areas as drug and violence prevention, cardiovascular health, cancer prevention, arthritis, care-giving, tobacco, and special events, such as Martin Luther King Day. This paper will present the faith based prevention model utilizing a drug and violence prevention approach, but will also share recent cardiovascular data and drug prevention data.

The Faith-Based Prevention Model, an African-American rural, church/community alcohol and other drug prevention strategy outcomes includes a reduction in incidence and prevalence of youth alcohol, tobacco and other drug use, youth access to alcohol, tobacco and other drugs, friend's use of drugs, peer disapproval of substance abuse, and youth 30-day cigarette and alcohol rates. There has been an increase in knowledge and positive attitudes towards non-use of abusive substances, improved self esteem, and feelings of belonging in family units. Further, found was an improvement in youth self-concept (Jackson County Partnership Final Report, 1997).

The model is not a program, but a constellation of planning and program strategies that combined have a positive impact on youth, church members, and the community. Phases include:

- Community development, readiness, and empowerment;
- Church leader training and action planning;
- Program implementation and evaluation; and
- Program redesign.

The Original Rationale for Rural African-American Church-Based Alcohol, Tobacco and Other Drug Prevention Activities

The Church Setting

Historically, churches are associated with healing. Denominations build hospitals. Churches now including health as a part of their church ministry since they are community gathering centers for spiritual, social and cultural activities, reach the complete family, have an established organizational structure, i.e., a governance structure through which mutual support for healthy behavior development or change can be facilitated (Murphy, 1991), and have permanence and prestige, which contribute to their influence and can make them effective promoters of healthy behaviors. Also churches bring order, meaning and purpose into the lives of people and communities (Foege, 1989); assist communities in developing resources to improve health and well being (Hatch, 1984) and can establish community norms and enforce community values (Wist and Flack, 1990).

Lasate, Wells, Carelton, and Elder (1986) found that churches exist in all area of the county, have a history of volunteerism, influence entire families, have a history of helping in a wide range of programs, members are likely to live near the church they attend, and members belong to many organizations through the community and can be role models. Eng, Hatch, and Callan (1984) indicated that churches are composed of social networks (friends, families, choirs, women's or men's auxiliaries, committees, etc.) which are necessary for people to change values, behaviors, or develop new skills, set norms and enforce a community's most positive values, provide leadership development, provide a structured response to help its members through major life transitions; and serve as a unit of identity and solution. Finally, Sutherland, Barber, and Harris (1992) have pointed out that churches have organized communication networks, e.g., newsletter, bulletins, and email.

Braithwaite and Lythcott (1989) cautioned, "The health community needs to develop comprehensive and culturally sensitive approaches to address the multifaceted minority health issues. They further write, "because health behaviors are culture-bound primary prevention efforts must emerge from a knowledge or and a respect for the culture of the target community." Levin and Eng, Hatch, and Callan argue that the African-American church can provide an effective and culturally appropriate entry portal into the African-American community for primary prevention initiatives. Levin (1984) asserted, "The black church is the most important social institution in the black community and is the conservator of the black ethos . . . the service ethic inherent in the black ethos is complementary to the ethic of community medicine . . . these fundamental assertions suggest a compatibility between the therapeutic role of the black church and the mission of community medicine. Eng, Hatch, and Callan (1985) add, "The uniqueness of the black church as both a unit of identity and solution make it a potentially effective unit or practice for health professionals."

The Rural Setting

Rural communities vary and are ever changing. The term "rural" could be economic, geographic or a culture. Rural communities usually have less than 50 people per square mile and generally

have only one source for their economic base. This small economic base contributes to rural poverty --- the rural poor also do not have equal access to benefits usually available to urban low-income people since the criteria for the benefits are not the same. Further, the actual rate of rural unemployment is much higher than official estimates since a higher percentage of rural workers are self-employed or “informally” employed. In comparison to the urban settings found was that the urban income is 37% greater than rural income and growing more rapidly, the poverty rate in non-metropolitan areas is 35% higher than the rate in metropolitan area, and the school is the largest employer, claims the largest share of the local public treasury, and is the location of most community wide events (Midwest Regional Center, 1995).

The African-American Culture

Nobles, author of The Culture of Drugs in the Black Community, indicated that the emerging drug culture is antithetical to African-American culture. The cultural guiding theme of “Sense of Excellence” literally requires that behavior be governed by the necessity to be the best, to seek goodness and to achieve the highest honor. Additionally, the African-American value system that emphasizes mutual aid, importance of the family, adaptability, natural goodness, inclusivity, unconditional love, respect for elders, responsibility, reciprocity, interdependence, cooperation, and restraint make up the traditional African-American cultural orientation. Thus, the African-American culture conflicts with the drug and violence culture that is distrustful and maintains that anything is permissible. The drug culture creates people with destructive value systems. The products of the drug culture are individuals who are selfish, short-fused, extremely violent, individualistic, manipulative, paranoid, and immediate-gratification oriented. These people are materialistic and equate self-worth with quantity of possessions. They are pathological liars. Their negative value systems oppose the positive influences of the family and the community.

Theoretical Basis

In recent years, Risk and Protective Factor Theory (Hawkins, Lisher, and Catalano, 1985 and Hawkins, Catalano, and Miller, 1992) has been integrated into the model. This theory assists in understanding the underlying factors that lead to delinquency and gangs, alcohol and other drug abuse, teen pregnancy and dropping out of school. Various home, school, and community protective factors can lead to building youth resilience and choosing not to become involved in life compromising situations. Key risk and protective factors are impacted leading to a lower level relative to other similar same age youth as measured against local, state or national data. The data addresses interaction with antisocial peers (Peer Domain); social (and family) bonding (Family Domain); and academic failure (School Domain). The model can impact community laws and norms favorable toward drug use (Community Domain). Other collateral benefits of this model are philosophically based on Healthy People 2010. In that view, positive changes are also seen in the perceived social and educational status, individual and community needs/values/culture; spiritual influences; economic and business environments; perceived decision-maker priorities affecting prevention; and health levels of all children, youth, adults (including the family unit) and senior citizens.

Protective factors addressed include social competency, the personal qualities of responsiveness, flexibility, empathy and caring, communication skills, a sense of humor, and any other pro-social behavior; sense of personal responsibility: resilient children are considered more responsible, more active and more flexible (Werner and Smith, 1982); and problem solving skills include the ability to alternate solutions. Further addressed is autonomy: a strong sense of independence; internal locus of control and sense of power (Garmezy, 1974); being self-disciplined; and being able to separate from the dysfunctional family environment (Anthony, 1974) and sense of purpose and future: a belief that people can have some degree of control over their environment in the years of healthy expectations; goal-directness, success orientation, achievement motivation, educational aspiration, persistence, hopefulness, hardiness, belief in a bright future, a sense of anticipation, a sense of completing future, and a sense of coherence. Finally, Levin et. al. (1997) and Fryback and Reinert (1999) found that a number of conditions are improved as a result of religious belief and spirituality.

The Faith-Based Prevention Model also incorporates the National Institute on Drug Abuse's Preventing Drug Use among Children and Adolescents (1997) prevention program principles. These are a comprehensive program for the individual, the family, the school, the media, community organizations, and health providers that have integrated components; utilization of media and community education strategies to increase public awareness, attract community support, reinforce the school based curriculum for students and parents, and keep the public informed of the programmatic progresses; program components are coordinated with other community efforts to motivate or reinforce prevention messages; the program follows a structured organizational plan that progresses from needs assessment through planning, implementation, and review to refinement, with feedback to and from the community at all stages; and objectives and activities are specific, time-limited, feasible and integrated in an effort to evaluate program progress and outcomes. Additionally, because the family is the primary point of reference for youth to learn behavior management, the Faith-Based Prevention Model adheres to the NIDA principles (NIDA, 1997) for selecting or developing family-based program activities: reaching families at each stage of development; training parents in behavioral skills to reduce child conduct problems; improve parent-child relations, including positive reinforcement, listening and communication skills, and problem solving; provide consistent discipline and rulemaking; and monitors children's activities during adolescent; conduct a parent drug education component; and provide access to needed counseling services.

Target Population

The Faith-Based Prevention Model was originally developed to address rural, African-American needs for those living in poor rural communities that want to improve the youth physical, mental and spiritual health. Youth may reside in the local church community; committed to the value of academic achievement; recommendation by a parent, guardian, local church committee member of community member, minister or school official; and both youth and their support system must agree to follow the established program rules and regulations, per the Expectation Contract. The contract is developed by the Prevention Committee and addresses such concepts as regular attendance, parent arranged transportation for particular activities, parent participation in selected activities, willingness for the youth to work with a tutor, and signed parent consent (travel, health, access to school information, etc.) forms.

Program Description

The Faith-Based Prevention Model requires total church community support. Clergy and church members need to be committed to the program and willing to learn about effective drug prevention strategies, as well as, develop realistic action/fiscal plans that assure a quality program. The initial training identified key concepts for selecting strategies, per identified needs and assets. The model uses a program delivery system that includes oral traditions; behavior is a function of the attitudes, values, and self-concept; and child-resilience concepts as influenced by the family, school, and community (Bernard, 1991). Further considered is, the program's likely impact on the key target population risk or protective factors and the extent the program addresses the life domains: individual, peers, family, school and community (Jansen, CSAP, 1997); age, gender and cultural appropriateness to the target group (Jansen, CSAP, 1997), and whether the programs intensity is sufficient to achieve the desired outcomes.

Types of Prevention Strategies

The Prevention committee, based upon church and community needs and assets and their developed logic models (Table 1), selects from appropriate Center for Substance Abuse Prevention advocated strategies. The strategy choices include information dissemination, education, alternatives, problem identification and referral, community process, and environmental. The program model, based upon the specific community logic model, is divided into four phases (Table 1).

Phases

Phase 1. Community Development/Readiness/Empowerment (six weeks)

The initial phase is designed to gain community leadership knowledge and develop positive relationships with local ministers and church leaders. Community readiness and churches interests are also determined. A key-informant survey technique may be used to gather information about the community needs and determine church project interest. Community contacts are established with ministers and church layman; African American social organizations; African-American business owners, elected officials and politicians; fiscal institutions; and law enforcement and school system representatives. These key individuals can be identified by grass roots community members, a review of local newspapers, and requesting information from African-American community organizations. Community power players may suggest interactions with church leaders with the larger youth membership. Finally, interest breakfasts are held with ministers to determine "potential" and "real" program interest.

Church Participation Criteria.

Church participation criteria includes a church population of at least 75 active members; the minister committed to the program objectives and speaks for/about the program from the pulpit; the church governing board establishes a church prevention committee of at least 8-10 members

Table 1. Logic Model

Priority Risk & Protective Factors	Target Group	Intermediate Outcomes	Long Term Outcomes	Strategies	Theory of Change
<p>Risk Factors</p> <ul style="list-style-type: none"> • Academic failure; • Commitment to School; • Community Laws & Norms 	<p>FBPM is designed to work with 60 to 100 youth. The community generally shows evidence of at least some of the following risk factors:</p> <ul style="list-style-type: none"> • Low neighborhood attachment • Community disorganization • Laws & norms favorable to alcohol, tobacco or other drug use • High rate of poverty • Low commitment to school <p>Participating youth will be recruited and selected according to the following criteria:</p> <ul style="list-style-type: none"> • All ages • African-American ethnic heritage • Reside in the local community • Enrolled in school in good standing • Not currently using alcohol, tobacco or other drugs • Parental permission to participate • Economically deprived • Depressed school performance • Family history of involvement in delinquency or drug-treatment facility 	<p>There should be improvements in the measures for the targeted risk factors:</p> <ul style="list-style-type: none"> • Improved in academic performance • Decrease in association with anti-social peers • Stronger social & family bonds <p>As measured by the FBPM Program Evaluation Instrument.</p>	<p>Significantly lower rates than the community average as measured on the <i>Communities That Care Youth Survey</i> on the following core measures:</p> <ul style="list-style-type: none"> • Use of alcohol, tobacco or other drugs in the last 30 days • Perception of harmfulness of alcohol, tobacco or other drug use • Attitudes toward alcohol, tobacco or other drug use • Intention to use alcohol, tobacco or other drugs • Age of first use of alcohol, tobacco and other drugs <p>As measured by the FBPM Program Evaluation Instrument.</p>	<p>The following culturally sensitive strategies have been found in the scientific literature to be effective;</p> <p>Large/small group instruction</p> <p>Life Skills</p> <p>Drama/Music</p> <p>Competitive and cooperative activities</p> <p>Youth recognition</p> <p>Academic success</p> <p>Public relations</p> <p>Intergenerational activities</p> <p>Mentoring</p> <p>Parenting</p> <p>Awareness activities</p> <p>Drug Sundays</p> <p>Training</p> <p>Summer/after school programs</p> <p>Data Collection</p>	<p>Interaction with anti-social peers has been proven to change with mentoring/ tutoring activities and alternative recreational activities (Jansen).</p> <p>Three strategies have shown positive effect on academic failure -- these include early childhood education, alternatives to classroom instruction, and academic tutoring.</p> <p>Program targeted to increase parenting skills, or reduce family dysfunction and improvement in the adolescent's self-concept, self-esteem, and attitudes toward work and school can improve family bonding (Jansen).</p> <p>The church environment has certain behavioral expectations, which should positively influence behavior and participation in project activities.</p>

representative of the church organizations;, and the prevention committee members agree to participate in monthly in-service training activities and to collect necessary evaluative data.

Phase 2: Church Leader Training and Action Planning (eight weeks initially and then ongoing monthly training and assessment)

The ministers and church prevention committee members participate in in-service training activities addressing alcohol and tobacco knowledge, attitudes, and desired behaviors; basic community development skills; effective community agencies utilization; program planning, implementation, and evaluation skills; and project assessment/reporting procedures. Project staff have developed training manuals on *How to Develop a Church ATOD Prevention Program and a Drug-Free Community, The Ministers Manual, Church Governance Structure, Basic ATOD Prevention, Community Development/Training Manual, Life Skills Training, Raising Drug-Free Children: What Grandparents Can Do, and Parenting/Intergenerational Activities*. Additional training materials are available from governmental clearinghouses, state or local organizations. Finally, the Prevention Committee designs an action and fiscal plan. Youth participants are identified, needs considered, goals established and activities outlined. The plans are designed considering survey and interview results, as well as, concepts selected from the areas of:

- Large and small group instruction (Weekly drug related information, Drama, and Life Skills Training)
- Competitive and cooperative activities between and among churches (Quarterly Sports, Arts);
- Recognition for excellence programs for youth (Quarterly);
- Mentoring and parenting (Large Group);
- Keeping youth successful in school (Academic Strategies);
- Public relations activities (Announcements, Bulletin Boards, etc.);
- Intergenerational activities (Planned Activities Quarterly);
- Quarterly Drug Awareness Sundays;
- Awareness activities for other churches (Quarterly);
- Training activities for the church committees and pastors (Monthly);
- Summer and/or after school programs; and
- Data collection (Monthly, Quarterly, Yearly).

Phase 3: Program Implementation (ongoing, beginning by 15th week)

Phase 3 is the implementation of the developed prevention action/fiscal plans. Churches are monitored to ensure that their activities are implemented per action plans and if necessary make appropriate re-adjustments. Committee member training is ongoing monthly with specific topics depending upon identified, perceived, and real needs, as well as, individual church prevention action/fiscal plan. Churches are monitored on a regular basis to ensure that their planned programs are being implemented and appropriate re-adjustments made. Model developed manuals and other training materials address many of these needs

There are several effective life skills education curricula. We recommend the *Social Problem Solving and Substance Abuse Prevention* curriculum developed by Positive Youth Development. Hourly, weekly lessons focus on stress management, self-esteem, problem solving, and substance and health information, as well as social networks and peer resistance skills. The curriculum is implemented per the manuals suggestions. Drama, role-play and other active learning activities allow the youth to express their emotions and practice positive interpersonal and communication skills.

As indicated in Phase 2, each church committee identifies special activities. The precise program will vary between churches, based on differing church or community characteristics, philosophy, target population, and project people, and assets.

Phase 4: Program Redesign (formal re-design for next year begins in 10th month)

Phase 4 is the redesign of program strategies, as determined by prevention committee perceptions and outcome data. Several types of data are reviewed. Process data involves reviewing project records to determine what activities were conducted and what individuals participated in these activities. Specifically developed forms, i.e., activity description, sign-in sheets, volunteers, etc. are examined on a regular basis.

Outcome evaluation ensures that the program activities (the process) leading to changes in positive youth attitudes and behaviors. For example, are the youth achieving academically; avoiding alcohol, tobacco and other drug use; and making a positive contribution to their community. When youth enter the program, basic demographics and parental permissions are obtained and youth complete a two page jury validated knowledge, attitudes, and behavioral instrument. The instrument is administered on a yearly basis. Finally, the church committee used the collected information to monitor project progress and make appropriate programmatic adjustments on a quarterly basis. Planning activities for the next year occur during project months ten and eleven.

Strategies & Dosage

Effective prevention behavior maintenance and changes demands the scientific application of specific strategies. Appropriate activities need to be of sufficient duration to provide maximum impact. Strategies and appropriate dosages are found in Table 2 on the next page.

The Program Staffing Model

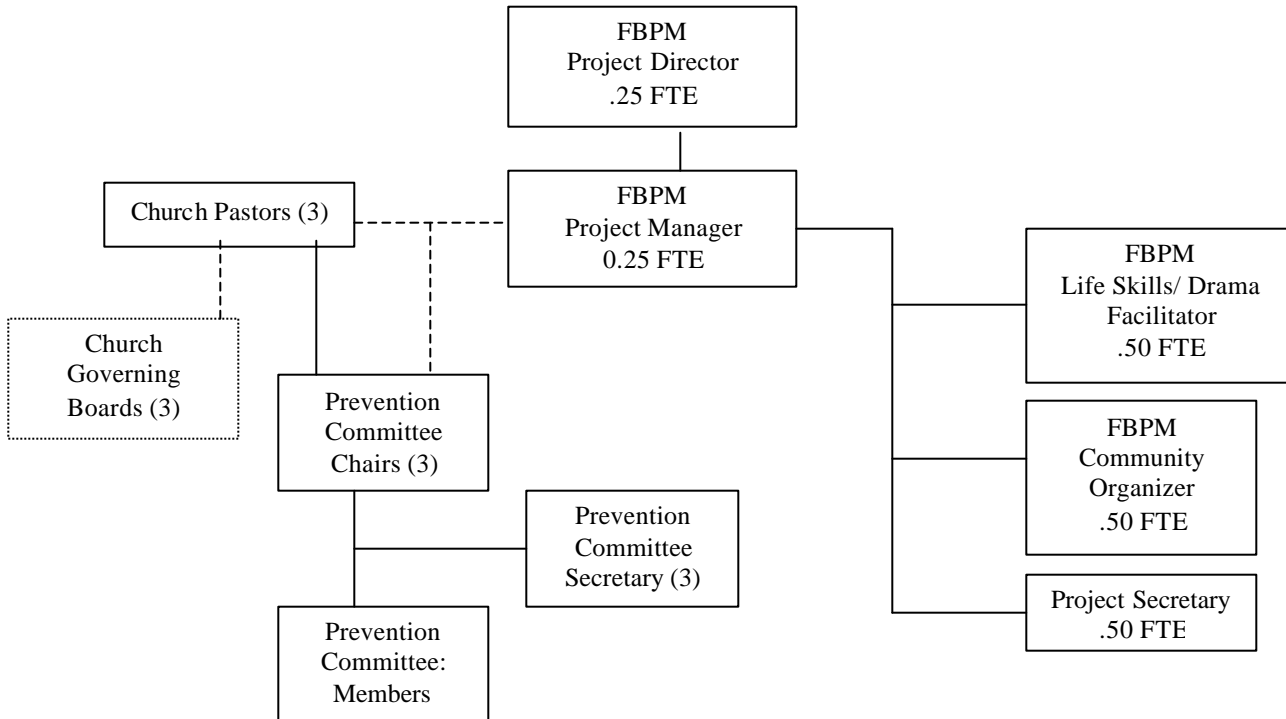
The Faith-Based Prevention Model depends on teamwork. The model is dependent upon church volunteers that are guided by project staff. The project team includes the participating church clergy, church community members serving on the Prevention Committee, and the program staff. The Principal Investigator oversees major project activities whereas the Project Manager is responsible for facilitating everyday project activities. The minister's designee, the church prevention chair, is the administrator of the prevention activities for their church. Prevention committees gather information, conduct planning activities, develop the action plan and make recommendations about which activities to conduct

Table 2. Strategies/Dosages

Program/Strategy	# of sessions	Optimum # of participants	Length of session(s)	Time range
<i>Social Problem Solving and Substance Abuse Life Skills Prevention Curriculum</i>	26 weekly sessions, varies based upon youth maturity	25	One hour unless otherwise noted in the curriculum manual	26 to 40 weeks
<i>Social Skills reinforcement - Drama</i>	40	25	1 to 2 hours	Weekly during the academic year
<i>Keeping Youth Successful in School tutoring activities</i>	Weekly during academic year; biweekly in summer	Small group instruction	Varies for youth depending upon needs, generally 1 to 2 hours	Weekly during academic year; biweekly in summer
<i>Competitive and Cooperative Activities Between Churches</i>	4-8	400	Varies per activity selected, generally 1 to 2 hours, per activity	Quarterly
<i>Youth Recognition</i>	4-8	All participating youth	One hour	Quarterly
<i>Alternatives to alcohol and tobacco</i>	Weekly	All participating youth	Two hours	Weekly
<i>Public Relations</i>	40	Church membership	Weekly	Varies
<i>Intergenerational and parenting activities</i>	Monthly	25	1 to 2 Hours	Quarterly
<i>Quarterly Drug Awareness Sundays</i>	Quarterly	Church membership	1 to 2 Hours Per Sunday	Quarterly
<i>Awareness Activities for Other Churches</i>	Quarterly	25-75	1 to 2 Hours	Quarterly
<i>Training Activities for Pastors</i>	Quarterly	5-10 Ministers	Two Hours	Quarterly
<i>Training Activities for Committees</i>	Monthly	30-50	2 to 3 Hours	Monthly
<i>Summer and/or after school program</i>	On-going	50-100	2 to 3 Hours	Several Times a Week
<i>Data collection</i>	Quarterly & Annually	Church membership	1 Hour	Quarterly & Annually

A sample staffing chart follows on the next page:

Chart 1. Base Organizational Chart



Sample Drug and Violence Prevention Outcomes

The faith based prevention model as applied in a rural, African-American setting has demonstrated positive outcomes. The initial five-year study found that males and females need separate objectives and strategies due to different drug use patterns. Further, youth entering the church prevention program prior to age 12 exhibited positive changes in knowledge, attitudes, and behaviors, but youth entering the program after age 12 exhibited changes only in knowledge and behavior. Specifically found, were improvements in friendship group quality (i.e., friends do not use drugs, friends earn good grades, etc.), school life, home life, and were less vulnerable to drug abuse (Sutherland, Hale, Harris, Stalls, Foulk, 1997). Another current study (N= 222) found that after eight months, youth made some significant changes, per Table 3. Changes were found in the areas of friends, violence, parents, and academics. Further studies are ongoing at the present time in several different sites and will be cited in the presentation.

Table 3. Results of Student T Test for Independent Samples, N=120 (unmatched) Jackson Partnership 12/2001

Item	Sig.	Significance Level
I feel safe at school	0.000	.001
During the last month, did any of your friends carry? a gun or a knife to school?	0.000	.001
My parents are proud of my school.	0.000	.001
I have failed a grade.	0.001	.001
It is easy to find drugs to use.	0.001	.001
I am going to graduate from high school.	0.000	.001

Item	Sig.	Significance Level
During the last month, did you friends set fire to? someone's property?	0.002	.01
I watch TV with my parents at night.	0.003	.01
During the last month, did you lost your temper?	0.004	.01
I am proud of the neighborhood that I live in.	0.005	.01
During the last month, did your friends get into a fist? fight?	0.005	.01
During the last month, did your friends damage school? property?	0.006	.01
I feel safe in the neighborhood that I live in.	0.011	.05
It is easy to find alcohol to drink.	0.026	.05
My grades in school are good.	0.045	.05
I can talk with my parents when I have a problem.	0.047	.05

Sample Cardiovascular Program

A nineteen month African-American, cardiovascular project was designed to decrease ethnic disparities. The community was: mobilized and resources coordinated to support effective/sustainable African-American programs addressing illness (strokes, cigarette smoking, physical inactivity, weight monitoring, and high blood pressure); learn of unhealthy lifestyles (coordinated public relations campaigns); educate/participate in screening (blood pressure, weight); community activities (awareness; alternatives; informational; educational; individual, family, and intergenerational; environmental;); increase culturally sensitive activities (community, church-based, or beauty shop) and examine data/make appropriate adjustments. Strategies included church committee implemented/evaluated church-community programs; beauty shop activities; or activities at places people gather.

Faith Community successful church committee processes and data (N=10 churches) follows. Exercise (exercise to church music), Nutritional Practices (Cooking classes), Tobacco prevention activities, Stress Management groups, Blood Pressure and Weight Screening/Referral/Follow-up; Special Church Holidays related to Cardiovascular Health, Achievement/Recognition; Intergenerational; Community Awareness; Data Collection, pre/post surveys, monthly activity reports, vital statistics were the major activities. Significant youth 6 month changes (.0001, .01, or .05 levels) were found for: blood pressure and cholesterol checks, eating patterns (daily breakfast, salt, fat, sugar, fast foods), healthy behaviors (seatbelt, cholesterol, healthy weight, alcohol, fun activities, exercise), friends behaviors (discuss problems, respect ideas, do well at school, trust friends, say No to Drugs, fun activities, stay home at regular times). Significant adult behavioral changes (at either .001, .01, or .05 levels) included: participation in leisure time activities, exercise daily, and 30 minutes daily of moderate physical activity; consumer two daily servings of fruits and vegetables and avoid foods high in fats; maintain a normal cholesterol level and had it checked within the last five years; and friends do well at work.

In concluding, the model has brought about significant prevention changes within an African-American community. Model fidelity needs to be maintained including having the program target all age youth and not just middle and/or high school youth. Churches are composed of families and all family members need to participate in the intervention. The model is cited by the Centers for Disease Control and Prevention as a Model of Community Engagement, by the Center for Substance Abuse Prevention and the Western CAPT as a Promising Scientific Program, received awards from the Centers for Disease Control and Prevention (Secretaries Award) and the Center for Substance Abuse Prevention (Exemplary Alcohol and Drug Prevention Program).

References

- Anthony, E.J. (1974). The Syndrome of the Psychological Invulnerable Child: In the Child in His Family. Vol.3: Children at Psychiatric Risk, New York: John Wiley and Sons, 529-544.
- Bernard, B. (1991). Fostering Resiliency in Kids: Protective Factors in the Family, School and Community. Portland, OR: Northwest Regional Laboratory (unpublished document).
- Braithwaite, R.L. and Lythcott, N. (1989). "Community Empowerment as a Strategy for Black and Other Minority Populations," JAMA, 261 (2), 282-283.
- Elder J.P.; Sallis, J. Fl.; Mayer, JH.; Hammond, N. and Peplinski, S. (1989). "Community-Based Health Promotion: A Survey of Churches, Labor Unions, Supermarkets, and Restaurants," Journal of Community Health, 14 (3), 159-168.
- Eng, E.; Hatch, J. and Callan, A. (1985). "Institutionalizing Social Support Through the Church and Into the Community," Health Education Quarterly, 12 (1), 81-92.
- Foege, W. (1989). "The Vision of the Possible: What Churches Can Do, The Church's Challenge in Health Care," Second Opinion.
- Fryback, R/ B/., Reinert, BR. (1999). Spirituality and people with potentially fatal diagnoses, Nursing Forum, 34, 13, 22.
- Garmezzy, N. (1974). "The Study on Competency in Children at Risk for Severe Psychopathology." The Child in His Family, Vol. 3, Children at Psychiatric Risk, Edited by E. J. Anthony, 1974, 77-98.
- Hale, Charles; Sutherland, Mary S.; and Harris, Gregory J. (1995). "Community Health Promotion: The Church as a Partner." Journal of Primary Prevention, 16 (2), 201-216.
- Hatch, J.W. (1984). "North Carolina Baptist Church Program," Urban Health, 10(5), 70-71.
- Hatch, J.W. and Derthick, S. (1992). "Empowering Black Churches for Health Promotion," Health Values, 6 33(5), 3-9.
- Hawkins, J.D., & Catalano, R.F. (1992). Communities That Care. San Francisco, CA: Jossey-Bass.
- Jansen, J.M., Center for Substance Abuse Prevention Unpublished Documents, 1997.
- Lasater, T.M.; Depue, J.D.; Wells, B.L.; Gans, K.M.; Bellis, J.; Carleton, R.A. (1989). The Effectiveness and Feasibility of Delivering Nutrition Education Programs Through Religious Organizations. Papers presented at the 117th Annual Meeting of the American Public Health Association, San Francisco, CA.
- Lasater, T.M.; Wells, B., Carleton, R.A., and Elder, J.P. (1986), "The Role of the Churches in Disease Prevention Studies," Public Health Reports, 101, 125-131.

- Levin, J (1984). "The Role of the Black Church in Community Medicine," Journal of the National Medical Association, 75 (5), 477 – 482.
- Levin, J.S., Larson, d. B., Pulchalski, C. M. (1997). Religion and Spirituality in Medicine: Research and Education. Journal of the American Medical Association, 278, 792-293.
- Miller, E. (1987). "Wellness Programs Through the Church: Available Alternative for Health Education," Health Values, 11(5), 3-6.
- Murphy, F. (1991). Personnel Correspondence.
- Nobles, W. (1987). The Culture of Drug in the Black Community. Oakland, CA: A Black Family Publication.
- NIDA, 1997 Preventing Drug Use Among Children and Adolescents.
- Safe and Drug Free Schools and Communities Programs, Midwest Regional Center, unpublished materials, 1995.
- Sutherland, Mary S.; Barber, Mel; and Harris, Gregory J. (1992). "Health Promotion in Southern Black Churches: A Program Model." Journal of Health Education, 23 (2), March/April 109-111.
- Sutherland, Mary S.; Hale, Charles; Harris, Gregory J.; Stalls, Phillip; and Foulk, David. (1997). "Strengthening Rural Youth Resilience Through the Church." Journal of Health Education. 28 (4), 205-215.
- Sutherland, Mary S.; Harris, Gregory J.; Barber, Mel; Lapping, Sherryl; Cowart, Marie; Warner, Victoria E.; and Lewis, John L. (1994). "Church Based Drug Prevention Programs in African-American Communities." Wellness Perspectives, 10 (2), Winter 3-22.
- Sutherland, Mary; Muire, Chris; and Bowman, Cynthia (2000). "The Faith Community as a Delivery System for Technology." The International Electronic Journal of Health Education. 3(3), 242-243.
- United Methodist Church, (1987). Health and Welfare Ministries. Health for All Program Manual. Cincinnati, OH: General Board of Global Ministries.
- US Department of Health and Human Services, HSS Fact Sheet, 2001, Trends in Racial and Ethnic-specific Rates for Health Status Indicators: United States, 1990-1998. January 2002.
- US Department of Health and Human Services (2001). Healthy People 2010. (Conference Edition, in Two volumes, Washington, D>C>: Government Printing Office.
- Werner, E.; and Smith, R. (1982). Vulnerable But Invincible: A Longitudinal Study of Resilient Children and Youth. New York: Adams, Bannister, and Cox.
- Wiist, W. and Flack, J. (1990). "A Church-Based Cholesterol Education Program," Public Health Reports, 105 (4), 381-388.

Church Intervention Survey

Check the appropriate answer:

Sex **Male** **Female**

Age 14-19 20's 30's 40's 50's
 60's 70's 80's 90's

How Do You Describe Yourself?

African-American

Hispanic

Oriental/Asian

Caucasian or White

With Whom Do You Live?

By self

With spouse

With children

With other adults than spouse

Other

Read each statement or question, and then put a check in the column that best describes how your friends behave.

	Yes	No	Maybe	?
1. Eat a good breakfast everyday?	___	___	___	___
2. Avoid stressful situations?	___	___	___	___
3. Avoid drinking large amounts of alcohol?	___	___	___	___
4. Exercise several times a week?	___	___	___	___
5. Eat whole grains, fresh fruits, and vegetables regularly?	___	___	___	___
6. Get eight whole hours of sleep each night?	___	___	___	___
7. Maintain a healthy body weight?	___	___	___	___
8. Avoid smoking cigarettes?	___	___	___	___
9. Avoid eating foods that are high in fat?	___	___	___	___
10. Avoid riding in a car if the driver has been drinking alcohol?	___	___	___	___
11. Always wear a seat belt when in a car?	___	___	___	___
12. Avoid using prescription drugs or over-the-counter drugs except as intended?	___	___	___	___
13. Avoid eating foods that are high in sugar or salt?	___	___	___	___
14. Avoid fast food only on occasion, not as a regular part of your diet?	___	___	___	___
15. My friends accept people as they are.	___	___	___	___
16. If someone were having a serious problem, they could count on their friends or family to help.	___	___	___	___

	Yes	No	Maybe	?
17. People can trust their closest friends to listen to their problems.	___	___	___	___
18. Sometimes when people are with their families, they will do things that they would normally not do.	___	___	___	___
19. When people are with friends who are getting "high", they should get "high" too.	___	___	___	___
20. Friends can always say NO to using too much of a drug.	___	___	___	___
21. Friends generally respect a friend's ideas.	___	___	___	___
22. When Friends have a problem, they can discuss it with other friends.	___	___	___	___

	Yes	No	Maybe
23. Drug users usually have money problems	___	___	___
24. People can use large amounts of marijuana without it hurting their families.	___	___	___
25. Using drugs helps people overcome boredom.	___	___	___
26. Regular drug abusers get into trouble with the law.	___	___	___
27. Regular drug users have a hard time keeping friends.	___	___	___
28. People who use sleeping pills rarely become dependent upon them.	___	___	___
29. Smoking cigarettes ages a person more quickly.	___	___	___
30. People who use illegal drugs have difficulty carry out daily tasks.	___	___	___

	None	Some	All
Do Your Friends:			
31. Smoke cigarettes?	___	___	___
32. Chew tobacco or snuff?	___	___	___
33. Drink beer?	___	___	___
34. Drink wine coolers?	___	___	___
35. Drink liquor?	___	___	___
36. Smoke pot?	___	___	___
37. Use other drugs?	___	___	___

	Yes	No	Maybe
Do Your Friends:			
38. Do well at school or work?	___	___	___
39. Attend church regularly?	___	___	___
40. Talk to someone else when they have problems?	___	___	___
41. Stay home at regular times?	___	___	___
42. Follow the rules of their home?	___	___	___

	Yes	No	Maybe
43. Participate in fun activities?	___	___	___
44. Liked by others?	___	___	___
45. Are lonely?	___	___	___

Responses are as follows:

- 1= Older Student
- 2= Friends
- 3= Brothers or Sisters
- 4= Strangers
- 5= Parents
- 6= Someone Else
- 7= Store

	1	2	3	4	5	6	7
46. Friends get cigarettes from:	___	___	___	___	___	___	___
47. Friends get chewing tobacco and snuff from:	___	___	___	___	___	___	___
48. Friends get marijuana from:	___	___	___	___	___	___	___
49. Friends get other drugs from:	___	___	___	___	___	___	___
50. Friends get beer from:	___	___	___	___	___	___	___
51. Friends get wine coolers from:	___	___	___	___	___	___	___
52. Friends get liquor from:	___	___	___	___	___	___	___

53. Today's date is: _____

Madison Youth Instrument

Please circle the correct response:

- Yes No 1. I am a boy
- Yes No 2. I am an African-American
- Yes No 3. I live with my parents or stepparents
- Yes No 4. I feel that I do well in school.
- Yes No 5. I have failed a grade.
- Yes No 6. I can get extra help with schoolwork at my school.
- Yes No 7. I am proud of my school
- Yes No 8. I am going to graduate from high school.
- Yes No 9. I eat dinner most nights with one or both of my parents.
- Yes No 10. I watch TV with one or both of my parents at night.
- Yes No 11. I attend church one of two times a week.
- Yes No 12. When I have a problem, I can talk to one of my parents.
- Yes No 13. When I have a problem, I can talk to one of my teachers.
- Yes No 14. I like doing things that are a little dangerous.
- Yes No 15. Sometimes I think I am no good at all.
- Yes No 16. I am able to do things as well as most people.
- Yes No 17. If a friend wants me to do something that I don't want to do, I tell my friend,
I don't want to.
- Yes No 18. If a friend wants me to smoke a cigarette, I will say no.
- Yes No 19. If a friend wants me to have a sip of alcohol, I will say no.
- Yes No 20. During the last month, did your friends smoke cigarettes?
- Yes No 21. During the last month, did your friends drink alcohol?
- Yes No 22. During the last month, did your friends steal something?

- Yes No 23. During the last month, did your friends set fire to someone's property?
- Yes No 24. During the last month, did any of your friends damage school property?
- Yes No 25. My grades in school are good.
- Yes No 26. Teachers expect me to do my best.
- Yes No 27. Most of my friends make good grades.
- Yes No 28. My parents are proud of my school.
- Yes No 29. I am proud of the neighborhood I live in.
- Yes No 30. I feel safe in the neighborhood I live in.
- Yes No 31. I am a good person.
- Yes No 32. Other people like me.
- Yes No 33. Most of my friends respect our teachers.
- Yes No 34. During the last months, did your friends use inhalants?
- Yes No 35. People should do their own thing if other people think it is strange.
- Yes No 36. During the last month, did any of your friends carry a gun or knife to School?
- Yes No 37. During the last month, did any of your friends get into a fistfight?
- Yes No 38. During the last month, did you lose your temper?
- Yes No 39. When I get angry with my teacher. I feel like hitting them.
- Yes No 40. I feel safe at school.
- Yes No 41. I think its ok to cheat at school.
- Yes No 42. It is easy to get a cigarette to smoke.
- Yes No 43. It is easy to find alcohol to drink.
- Yes No 44. It is easy to find drugs to use.

Please Fill in the Blanks– Thank You

Age_____ Last Four-Phone Numbers_____

Faith Based Prevention Model

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Awards

Lonnie Mitchell Conference, Addie Key Prevention Award for Outstanding Faith Community and Community Development Activities in North Florida.

Department of Health and Human Services, Center for Substance Abuse Prevention, Jackson Church Program is considered a Promising Science Based Program (1999/2000)

Outstanding Prevention Research Award, American School Health Association (1998)

National Model of Community Engagement, Jackson County Project – Center for Disease Control and Prevention (1998).

Secretary's Award for Health Promotion (Excellence) – Department of Health and Human Services, (1995).

Noteworthy Program and Practices Award – Southeast Regional Drug Free Schools and Communities, (1995).

Exemplary Alcohol and Other Drug Prevention Program Award – Center for Substance Abuse Prevention – State Alcohol/Drug Agency, (1994).

Exceptional Rural and Program Award – National Rural Institute on alcohol and Drug Abuse and National Rural Alcohol and Drug Abuse Network, Inc., (1994).

Noteworthy Program and Practices Award – Southeast Regional Center for Drug Free Schools and Communities, (1993).

Refereed Publications (National and International Journals and Documents)

Sutherland, Mary; Muire, Chris; and Bowman, Cynthia (2000). “The Faith Community as a Delivery System for Technology.” The International Electronic Journal of Health Education. 3(3), 242-243.

Cowart, Marie E. and Sutherland, Mary. (1998). "Late-life Drinking Among Women." Geriatric Nursing, 19(4), 214-219.

Sutherland, Mary; Cowart, Marie E.; & Harris, Gregory. (1998). Jackson County Partnership: Developing an Effective Coalition." International Quarterly of Community Health Education, 17(4), 405-415.

Sutherland, Mary S.; Harris, Gregory J.; Foulk, David; & Gessner, Linda J. (1998). "Community Partnership Development in a Rural Southern County: A Case Study in African-American Leadership." American Journal of Health Studies, 14(2), 57-65.

Sutherland, Mary S.; Hale, Charles; Harris, Gregory J.; Stalls, Phillip; and Foulk, David. (1997). "Strengthening Rural Youth Resilience Through the Church." Journal of Health Education, 28 (4), 205-215.

Cowart, Marie E., and Sutherland, Mary S. (1995). "Late-On Set Alcoholism, Gaining Understanding" in Treating Alcohol and Other Drug Abuses in Rural and Frontier Areas, 1994 Award for Excellence Papers, USPHS, CSAT, 109-120.

Hale, Charles; Sutherland, Mary S.; and Harris, Gregory J. (1995). "Community Health Promotion: The Church as a Partner." Journal of Primary Prevention, 16 (2), 201-216.

Cowart, Marie; Sutherland, Mary S.; and Harris, Gregory J. (1995). "Health Promotion for Older Rural African-Americans: Implications for Social and Public Policy." Journal of Applied Gerontology, 14, (1) March 33-46.

Turner, Lori; Sutherland, Mary S.; Harris, Gregory J.; and Barber, Mel. (1995). "Cardiovascular Health Promotion in Rural North Florida African-American Churches." Journal of Health Values, 19 (2), March/April, 3-9.

Sutherland, Mary S. and Cowart, Marie. (1994) "Perceived Community Leadership: Agents Of Change, Journal of Health Education, 25 (4), July/August, 249-251.

Sutherland, Mary S.; Harris, Gregory J.; Kissinger, Millie; Barber, Mel; and Lewis, John L. (1994). "Creating Awareness of Drug Prevention: Using Beauty and Barber Shops as Informational Outlets." Journal of Health Education, 25 (3), May/June, 186-187.

Sutherland, Mary S.; Harris, Gregory J.; Barber, Mel; Lapping, Sherryl; Cowart, Marie; Warner, Victoria E.; and Lewis, John L. (1994). "Church Based Drug Prevention Programs in African-American Communities." Wellness Perspectives, 10 (2), Winter 3-22

Sutherland, Mary S.; Barber, Mel; and Harris, Gregory J. (1992). "Health Promotion in Southern Black Churches: A Program Model." Journal of Health Education, 23 (2), March/April 109-111.

Sutherland, Mary S.; Cowart, Marie; and Heck, Carol (1989). "A Rural Senior Citizen Health Promotion Demonstration Project." Health Education, 20 (6), November/December, 40-44.

Sutherland, Mary S.; Barber, Mel; Harris, Gregory J.; Warner, Victoria E.; Cowart, Marie; and Menard, Anne (1989). "Planning Preventive Health Programming for Rural Blacks: Developmental Processes of a Model P.A.T.C.H. Program." Wellness Perspective: Research, Theory, and Practice, 6 (1), fall, 57-67.

Sutherland, Mary S.; Cowart, Marie; and Heck, Carol (1987). "A Community Organization – Peer Facilitated Senior Citizen Health Promotion Program." International Quarterly of Community Health Education, 8 (2), Spring, 181-187.

Sutherland, Mary S, Sisco, Carol; Lacher, Thomas; and Watkins, Nancy (1987). "The Application of a Health Planning Model to a School Based risk Reduction Project." Health Education, 18 (3), June/July, 47-51.

Sutherland, Mary S.; and Cowart, Marie (1986). "A Southern Rural Senior Citizens Health Promotion Program." Eta Sigma Gamma, 18 (2), Fall, 8-9.

Presentations: Invited

Sutherland, Mary (1999). The Faith Community, A Change Agent. South Carolina Department of Health and Environmental Control, Holding the Life-Line Conference, Columbia.

Sutherland, Mary & Harris, Gregory J. (2001). The Faith Based Prevention Model. 5th Annual Interfaith Symposium for Faith-Based and Community Coalitions, Washington, DC.

Sutherland, Mary (1999). The Faith Community, A Change Agent. South Carolina Department of Health and Environmental Control, Holding the Life-Line Conference, Columbia.

Sutherland, Mary (1998). Rural Drug and Alcohol Prevention -- What Works. Program presented at the American School Health Association Convention, Colorado Springs.

Sutherland, Mary S. (1998) Community Coalition Building Via Outside Funding. Program presented at the Coppin State College Alcohol/Drug Conference, Baltimore.

Sutherland, Mary S. (1997). The Faith Community and Protective Factors. Program presented at the National Rural Institute on Alcohol and Drug Abuse, Eleventh Annual Conference, University of Wisconsin, Eau Claire.

Sutherland, Mary S. (1994). Church Health Promotion Activities. Program presented at the Dental Section of the American Public Association Convention, Washington, DC.

Sutherland, Mary S. (1994). Intergenerational Prevention Activities. Program presented at the Center for Substance Abuse Intergenerational Conference, Bethesda, MD.

Sutherland, Mary S. (1994). Intergenerational Prevention Activities. Program presented at the Center for Substance Abuse Faith Communities Conference, Bethesda, MD.

Sutherland, Mary S. and Harris, Gregory J. (1994). Faith Communities. Program presented at the Center for Substance Abuse Prevention's (CSAP) Community Partnership Grantees 1994 Eastern Regional Workshop, Baltimore, MD.

Sutherland, Mary S. and Harris, Gregory J. (1993). A Southern, Rural Church Drug Prevention Program: A Summer Youth Activities Program. Program presented at the National Rural Institute on Alcohol and Drug Abuse Eighth Annual Conference, University of Wisconsin, Eau Claire, WI.

Sutherland, Mary S.; Harris, Gregory J.; and Edwards, Karen (1993). Faith Community: The "Spirit" of Prevention. Program presented at the New Dimensions in Prevention: Shaping Today, Shaping Tomorrow, convened by the Department of Health and Human Services, Center for Substance Abuse Prevention, Washington, DC.

Harris, Gregory J. and Sutherland, Mary S.; Cowart, Marie; Barber, Mel; and Warner, Victoria E. (1992). Health Promotion Programs for Citizens of Jackson County. Program presented at the Department of Health and Human Services Fourth National Forum on Cardiovascular Health Pulmonary Disorders and Blood Resources, Minority Health Issues for An Emerging Majority Conference, Washington, DC.

Harris, Gregory J. and Sutherland, Mary S. (1992). Community Partnership Models: A Church Based Approach. Program presented at the Department of Health and Human Services Secretary Conference on Alcohol Related Injuries, Washington, DC.

Presentations: Peer Reviewed

Sutherland, Mary and Harris, Gregory J. (2000). The African-American Church as a Community Development Agent. Program presented at the American Public Health Association, Boston, MA.

Sutherland, Mary and Harris, Gregory J. (2000). The Church as a Prevention Change Agent. Program presented at the American Public Health Association, Boston, MA.

Sutherland, Mary. (1999) The Role of the Church in Prevention. Program accepted at the American Association for Health Education Convention, Boston, MA.

Sutherland, M.; Hale, C.; Harris, G.; Stalls, P.; & Foulk, D. (1998). Strengthening Rural Youth Resilience Through the Church. Program presented at the National Prevention Network Conference, San Antonio, TX

Sutherland, Mary S. (1997). A School Community Needs Assessment for At-Risk Youth Academically. Program presented at the American Public Health Association Convention, Indianapolis, IN.

Sutherland, Mary S. (1997). Southern, Rural African-American Churches Can Bring About Organized Community Change. Program presented at the American Public Health Association Convention, Indianapolis, IN.

Sutherland, Mary S. and Harris, Gregory J. (1997). The Rural African-American Church Can Be An Effective Prevention Minister in Their Church Communities. Program presented at the American Public Health Association Convention, Indianapolis, IN.

Harris, Gregory J. and Sutherland, Mary S. (1996). The Jackson County Alcohol and Other Drug Prevention Partnership. Program presented at the 9th Annual National Prevention Network Conference, Phoenix, AZ.

Sutherland, Mary S. and Harris, Gregory J. (1995). Beauty Shops as Prevention Centers. Program presented at the American Public Health Association Convention, San Diego, CA.

Sutherland, Mary S. and Harris, Gregory J. (1995). Raising Drug Free Children: What Grandparents Can Do. Program presented at the American Public Health Association Convention, San Diego, CA.

Sutherland, Mary S. and Harris, Gregory J. (1995). Parenting. Program presented at the American Public Health Association Convention, San Diego, CA.

Sutherland, Mary S. and Harris, Gregory J. (1995). Growing Old Drug Free. Program presented at the American Public Health Association Convention, San Diego, CA.

Sutherland, Mary S. and Harris, Gregory J. (1994). Church Prevention Programs. Program presented at the CDC National Conference on Health Education and Health Promotion, Tampa, FL.

Sutherland, Mary S. (1994). Rural, Church Based Drug Prevention Programs. Program presented to the Association for the Advancement of Health Education, Denver, Co.

Harris, Gregory J. and Sutherland, Mary S. (1994). The African-American Church – a Delivery System for Health promotion and Disease Prevention Among Older Adults: An Old Model for New Challenges. Program presented for the Association for Gerontology and Human Development in Historically Black Colleges and Universities' 12th Annual Meeting and Conference, "Black Aging: Meeting the Challenge", Atlanta, GA.

Sutherland, Mary S. (1993). Southern Rural Drug Prevention: African-American Lead Coalitions Can Make a Difference. Program presented at the American Public Health Association's 121st Annual Meeting, San Francisco, CA.

Sutherland, Mary S. and Harris, Gregory J. (1992). Drug Use Among Rural Black Youth – A Church Program. Program presented at the American Public Health Association Convention, Washington, DC.

Sutherland, Mary S.; Barber, Mel; and Harris, Gregory J. (1992). Church Based Health Promotion Activities. Program presented at the American Public Health Association Convention, Washington, DC.

Sutherland, Mary S.; Harris, Gregory J.; Cooper, Sylvia; Barber, Mel; Kissinger, Millie; Warner, Victoria E.; Cowart, Marie; and Drake, Jim (1992). Church Based Cardiovascular Health Promotion Programs. Program presented at the American Public Health Association Convention Washington, DC.

Sutherland, Mary S.; Barber, Mel; and Harris, Gregory J. (1991). The Black Church: An Effective Health Promotion Delivery System. Program presented at the Association for the Advancement of Health Education Convention, San Francisco, CA.

Warner, Victoria E.; Harris, Gregory J.; Barber, Mel; Sutherland, Mary S.; and Cowart, Marie (1990). The Church: A Culturally Effective Delivery System for Southern, rural Blacks. Program presented at the American Public Health association Convention, New York City, NY.

Sutherland, Mary S.; Cowart, Marie; Harris, Gregory J.; Barber, Mel; and Warner, Victoria E. (1990). Black, Rural, Coalitions Can Be Successful. Program presented at the American Public Health Association Convention, New York City, NY.

Sutherland, Mary S.; Barber, Mel; and Harris, Gregory J. (1990). Health Promotion in Rural Black Churches. Program presented at Prevention 90, Atlanta, GA.

Sutherland, Mary S.; Barber, Mel; and Harris, Gregory J. (1990) PATCH: The Rural Black Viewpoint. Program presented at the Association for the Advancement of Health Education Convention, New Orleans, LA.

Harris, Gregory J.; Barber, Mel; Warner, Victoria E.; Cowart, Marie; and Sutherland, Mary S. (1990). Health Promotion: Coalitions Can Make a Difference. Program presented at the Association for Gerontology in Higher Education, Kansas City, KS.

Sutherland, Mary S.; Cowart, Marie; Barber, Mel; Harris, Gregory J.; Warner, Victoria E. and Griffin, Robert (1990). Churches: An Effective Health Promotion Delivery Service. Program presented at the Association for Gerontology in Higher Education, Kansas City, KS.

Refereed Manuals

Hale, Charles; Sutherland, Mary S.; and Harris, Gregory J. (1993). “Evaluation The Church Health Program: The Church Health Committee’s Manual.” Tallahassee: Department of Health and Human Services, Center for Substance Abuse Prevention/Area Agency On Aging for North Florida, Inc.

Hale, Charles; Sutherland, Mary S.; and Harris, Gregory J. (1993). “The Church Health Promotion Program: The Minister Manual.” Tallahassee: Department of Health and Human Services, Center for Substance Abuse Prevention/Area Agency On Aging for North Florida, Inc.

Sutherland, Mary S.; Harris, Gregory J.; Robinson, Beverly; and Washington, Steward (1993). “How To Develop A Church-Based Program for the Prevention of Drug and Alcohol Abuse: A Work Manual.” Tallahassee: Department of Health and Human Services, Center for Substance Abuse Prevention/Area Agency On Aging for North Florida, Inc.,

Sutherland, Mary S.; and Harris, Gregory J. (1991). “How To Develop a Church Health Committee: A Work Manual.” Tallahassee: Florida Department of Elder Affairs/Area Agency On Aging for North Florida, Inc.

Sutherland, Mary S.; and Harris, Gregory J. (2001). “Program Implementation Manual” Tallahassee: Area Agency on Aging for North Florida, Inc.

Other Available Manuals:

[Partnership Development/Community Development](#)

Family Life/Intergenerational Activities

Growing Old Drug Free With My Grandchildren

Consumer Health

Manuals cost \$25.00 apiece and \$5.00 for shipping/postage

Other Available Materials:

Implementation Materials and Forms Packets

Evaluative Instruments Packets

All packets cost \$25.00 apiece and \$5.00 for shipping/postage

Ordering Information:

If interested in ordering materials, please contact Dr. Sutherland or Mr. Harris via letter, on your letterhead. Please list the desired items and include a check (to cover materials or manuals costs and postage). The check must be made out to HPPI and mailed to HPPI at 2639 N. Monroe Street, Suite 118B, Tallahassee, FL 32303.

Manuals or materials will be mailed via US Postal Service, after the check is received by HPPI. If Federal Express service is desired, please include an extra \$20.00 per item.

We look forward to assisting faith communities develop, implement, and evaluate prevention programs.

