

# Report of the Commission on Impairment and Leadership

## March 1, 2017

### Introduction

The work of the Commission on Impairment and Leadership was precipitated by a crisis: the death of a bicyclist caused by a bishop of the Episcopal Church who was driving while impaired. Less than three months later, the House of Bishops passed a resolution asking the Presiding Bishop and the President of the House of Deputies to appoint a commission to “explore the canonical, environmental, behavioral and procedural dimensions of matters involving the serious impairment of individuals serving as leaders in the Church, with special attention to issues of addiction and substance abuse.”

The resolution further requested that the commission include “individuals with professional or personal experience with varieties of impairment, members of Full-Communion partner churches, and members of this Church,” and that its final report include “recommendations for both action and further review, as appropriate, in order to clarify lines of authority, to ensure mutual accountability, and to promote justice, well-being and safety within both the Church and the world.” (The full text of the resolution is in Appendix 1.)

This is not the first time that the church has sought to address alcohol, substance abuse, and impairment. Appendix 2 is a history of resolutions adopted by the General Convention between 1979 and 2009. Proposals for addressing clergy impairment were made at the 2009 General Convention and again at the 2012 General Convention, when the Standing Commission on Ministry Development brought forward a resolution on clergy impairment, proposing a Title III canonical process rather than a disciplinary Title IV process. Appendix 2 includes a link to that resolution and a statement from the Standing Commission on Constitution and Canons, explaining why the decision was made not to present it as legislation for the 2015 Convention.<sup>1</sup>

In following the directives of the resolution establishing the Commission on Impairment and Leadership, we have investigated the processes and practices of selecting, forming, and evaluating church leaders and are, with this report, making recommendations for appropriate actions, including interventions when leaders demonstrate impairment.

The commission has relied on research on the dynamics and treatment of addiction and has studied the procedures for addressing impairment within the professions of law, medicine, and aviation. The commission has also drawn on the resources of the Christian theological tradition to understand the beliefs and commitments that underlie ways to deny or to address impairment.

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<sup>1</sup> Effective January 2016, the number of the church’s Standing Commissions has been reduced, and the work of the former Standing Commission on Constitution and Canons has been folded into the new Standing Commission on Structure, Governance, Constitution, and Canons.

The tension between the right to privacy and the need for accountability to the church and the community has recurred throughout the exploration of cases of impairment. Another tension always near the surface has been the high value placed on forgiveness, on the one hand, and the importance of taking responsibility for the consequences of behaviors, on the other. The commission has observed how the isolation of leaders and the authority structures within and among dioceses can work together with the denial and codependence that are typical of addiction to prevent identification and treatment of impairment.

Unnamed and unaddressed impairment of leaders causes damage within and beyond the body of Christ. But the commission has discovered that in many instances, church polity has impeded the ability of the church to intervene, assess, and treat impaired people and care for the injured community.

## **Theological and ecclesial framework**

The theological context for the commission's work is the covenant of baptism in which Christians are baptized into the death and resurrection of Jesus Christ, turned from the old life of sin, and reborn to new life in Christ (BCP 254). In baptism, Christians are initiated into Christ's body, the church (BCP 298), and are enabled to live together in holiness and righteousness, embody the risen Christ, and exercise ministry in the world. The community formed by baptism is one whose members are mutually interdependent (1 Corinthians 12:12–13), and so the health and wholeness of individual members or leaders of the community are indissolubly bound together with the health of that community. This insight is in contrast with those ways of thinking that place the "rights" of the clergy in opposition to the "rights" of the parish or Christian body. Moreover, it reflects an important aspect of the divine economy with regard to health and wholeness — namely, that what is healing for the individual is, at the same time, healing for the body and vice versa.

The call to ordained leadership is mutually discerned by a candidate for ministry and by the church within which that candidate is formed. Bishops, priests, and deacons promise to pattern their lives in accordance with the teachings of Christ, so that they may be a wholesome example to all people (BCP 532, 544). Furthermore, the authority of the ordained leader is granted by the community of the faithful, and that leader continues to be accountable to the community who recognizes this authority and with whom the leader exercises responsibility.

This model of leadership understands authority to be characterized by mutuality and to be founded in relationship. It may be distinguished from a one-directional model in which God grants authority to a leader to govern a community once and for all, and that leader grants authority to the community. The leadership is exercised within the baptismal community and is accountable to it. Instead of an entitlement or privilege, a call to ministry is a sacred trust.

In addition to our understanding of the event of baptism and the covenant in which we express faithful Christian living, the commission suggests that the event of Pentecost serves as an example of the primacy of a communal understanding of authority. In the book of Acts, the anointing of the Holy Spirit on the followers of Jesus was a call to grow a movement, and ultimately the church, but also included an awareness of a process by which to do it.

The account of Pentecost tells a story of those gathered as individuals who could “both see and hear” (Acts 2:33). The reader may presume that the earliest disciples were being called to “see and hear” that which was prophesied about Jesus, and also to see and hear one another truly, as individuals and as a community, despite status, culture, or language. They understood that both the moment of anointing and the continued discipline of seeing and hearing one another as truly equal in Christ were how the movement was called to live.

Stemming from the disciples’ experience of “this Jesus that God raised up” and the Pentecost event, the book of Acts reflects an early Christian history of collaborative, communal, and collective decision making that embraced diversity. Even today, anointing of the Spirit of God and truly shared authority are radical notions. The responsible stewardship of power can be one of the greatest challenges for the church.

While baptism creates new birth and newness of life, the baptized remain vulnerable to illness, and the baptized community to disorder and suffering. The brokenness caused by addiction, mental illness, or physical disease is part of the ongoing brokenness of the human condition that God is working to heal and make whole. In the stories of healing in the Gospels, when Jesus “makes well” or “saves” (Mark 3:4, 5:23, 5:34, 6:56) an individual with an impediment or disease, even one who has died, the result is to restore that person to the community, the family, or the village (Mark 5:1–20, 21–43; Luke 7:11–17). Likewise, repentance does not lead to punishment, but to conversion and new life (Luke 15:1–32).

We understand our work on this commission to analyze, to understand, and to recommend how the body of the church, through its practices, norms, and teaching, might be better able to name impairment, intervene in order to promote healing and recovery for the leader, and enable the flourishing of the body of the baptized.

We are recommending actions that promote a significant cultural shift in the Episcopal Church. These recommendations address the problem of impaired leaders, but they also diagnose and suggest treatment for an impaired system that maintains denial and helplessness toward addiction, mental illness, and physical disease.

## **Framing the commission’s work**

The Commission on Impairment and Leadership was formed “to aid The Episcopal Church in assessing and improving its responsiveness to disease and human brokenness regarding issues involving impairment in The Episcopal Church.” Our charge is to promote the long-term health

and wholeness of leaders serving in the church by making recommendations for both “technical” and “adaptive” changes needed to address issues of serious impairment more effectively.

The term “impairment” can describe a variety of problems and behaviors affected by physical, mental, and emotional health. The commission has used the following definition of impairment for our work and this report:

*The inability to exercise ministry with reasonable skill and safety by virtue of physical or mental illness, inebriation, or excessive use of drugs, narcotics, alcohol, chemicals, or other substances — or because of other behaviors.*

Because the resolution of the House of Bishops requested a commission to devote “special attention to issues of addiction and substance abuse,” we have focused primarily on impairment related to substance abuse. We acknowledge, however, that other patterns of behavior and mental health issues may also lead to impairment.

While “substance abuse” and “drug addiction” are more familiar terms, “behavioral addiction” and its equivalent, “process addiction,” are other terms with which the church must become familiar. Behavior addiction is defined as a compulsion to engage in a rewarding non–drug-related behavior despite negative consequences to the individual’s physical, mental, social, or financial well-being. In the future, appropriate bodies in the church may wish to devote further consideration to these and additional kinds of impairment.<sup>2</sup>

## Survey of data from other professions

In conducting the case studies, the commission’s interview teams sought to uncover both the individual and systemic factors that contributed to negative outcomes. The commission used the model for in-depth forensic accident investigations originally developed by the National Transportation Safety Board (NTSB) for accidents in the airline industry.<sup>3</sup>

The function of the NTSB is to investigate every civil aviation accident and all significant highway, marine, railroad, pipeline and hazardous-materials accidents.<sup>4</sup> The board’s

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<sup>2</sup> A “Periodic Table of the Intoxicants,” available from the Institute for Addiction Study, provides a comprehensive overview of drugs and behaviors that are addictive.

<sup>3</sup> Fielding, Eric, Lo, Andrew W., and Yang, Jian Helen, “The National Transportation Safety Board: A Model for Systemic Risk Management, *Journal of Investment Management*” (2011) (available at <https://ssrn.com/abstract=1804613>).

<sup>4</sup> *Ibid.* at 2.

investigative team first identifies the causes of the accidents or incidents and then develops recommendations to improve safety and reduce systemic risk.<sup>5</sup>

The NTSB also provides guidance for addressing impairment in the airline industry and for the rehabilitation of pilots.<sup>6</sup> The Human Intervention and Motivation Study (HIMS) is the FAA-funded substance abuse treatment program for pilots, which, according to the HIMS website ([www.himsprogram.com](http://www.himsprogram.com)), “coordinates the identification, treatment, and return to the cockpit of impaired aviators.” It is an industry-wide effort in which companies, pilot unions, and the Federal Aviation Administration collaborate to preserve careers and further aviation safety.<sup>7</sup>

The NTSB model has been studied for applicability to other industries, such as financial services, health care, and energy, all of which experience incidents that arise from the failure of complex systems.<sup>8</sup>

A number of other professions have also developed assistance programs as alternatives to the professional discipline process. Licensing organizations not only have a strong interest in ensuring that its professionals provide competent services to the public, but also to ensure that these highly trained individuals can return to providing professional service.<sup>9</sup> With an emphasis on rehabilitation, help is available when addiction or other impairment leads to performance failure.

For example, in California, following an investigation of a complaint against a lawyer, the state bar can initiate charges for misconduct that may lead to discipline, including disbarment.<sup>10</sup> However, if there is evidence that the misconduct was accompanied by substance abuse or mental health problems, an alternative disciplinary program (ADP) may be available. Reduced sentences are offered to lawyers who participate in a treatment program and demonstrate compliance with the treatment plan while they are on probation.<sup>11</sup>

Members of the health care industry, particularly physicians and nurses, have developed similar rehabilitation programs. Appendix 4 is a table that summarizes by profession the reporting mechanisms, available alternative treatment options, and monitoring and reinstatement

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<sup>5</sup> Ibid. at 1.

<sup>6</sup> “HIMS: The Quiet Success Story,” *Air Line Pilot* 24-29 (November/December 2007).

<sup>7</sup> Ibid.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid. “We strive to support legal professionals in achieving their optimum level of practice, while enhancing public protection and helping to maintain the integrity of the profession.”

<sup>10</sup> <http://www.calbar.ca.gov/Attorneys/MemberServices/LawyerAssistanceProgram.aspx>

<sup>11</sup> Ibid.

requirements in several licensed professions, including nurses, physicians, social workers, lawyers and airline pilots.

The overarching theme is that following an initial investigation for impairment issues, many professions now include an opportunity for probation and a pathway to return to full practice through the regulatory process for those who opt for and commit to a treatment program.

The commission recommends that a similar process be considered for impaired clergy.

## Methodology: Case studies

An accident — the collapse of a bridge, the derailment of a train, or the crash of an airplane — is a systemic failure. Accidents are inevitably the result of a constellation of factors, both technical and human, that may extend back over many years prior to the accident. Many different individuals or groups may have contributed over time.

When the NTSB is called in to investigate an accident, the investigative team examines not only the catastrophic event itself, but also the factors that contributed to it. They consider policies and procedures, training and experience, weather and materials, fitness and judgment, structural mechanics and operating systems, and information and communications — all points in a larger operational system that contributes either to the safety or risk in the system. Their objective in an investigation is not to find fault, but to promote long-term safety by determining the underlying causes that have contributed to any given incident.

The key components of their investigations include fact-finding, formal analysis, and the proposal of safety recommendations. The recommendations coming from an accident investigation are in turn addressed to the manufacturers, companies, or agencies that have the ability, knowledge, and skill to make the appropriate fixes or corrections.

While the formation of the Commission on Impairment and Leadership was precipitated by a specific event, we recognize that this event compels us to examine carefully a constellation of incidents and issues related to the church's culture and its policies and practices. We recognize the need to address problems with impaired leadership at all levels.

We have chosen to take a "case study" approach to our work, identifying several cases involving deacons, priests, and bishops across the span of their vocational life. Some involve successful recognition, intervention, and treatment, while others do not. We have interviewed individuals and groups involved in these cases, and we have used each case not simply to uncover facts about specific incidents but, more significantly, to understand and analyze where points of weakness and failure exist in church-wide systems — points of weakness and failure that hinder our ability to recognize and respond to impairment in church leaders.

In addition to these case studies, the commission has drawn significantly on work that has already been undertaken in various professions. We have benefited also from the range of expertise represented on the commission itself — medical, psychological, legal, theological, and organizational expertise — and have endeavored to bring this collective wisdom to bear on our analysis and recommendations.

Taking a cue from the NTSB, our recommendations are addressed to the church bodies that are in a position to make appropriate corrections. Our objective has not been to find fault but to minimize risk and to promote long-term health and well-being in the church. We do this by making recommendations for both “technical” and “adaptive” changes that may improve the church’s ability to address issues of impairment.<sup>12</sup>

Recognizing the need to change and then implementing appropriate changes are imperative, demanding a significant cultural shift across the church. To change our culture will require a collective effort, and it must be the shared responsibility of those persons in leadership to whom our recommendations are addressed.

## Scope of work

The commission has identified two areas of risk management to provide a framework for recognizing and responding constructively to impairment:

**Preventive measures** include creating educational and training programs to increase knowledge about impairment, and also implementing policies, practices, and procedures to screen and evaluate the church’s leaders throughout their vocational life, promoting early detection and quality control along with confidentiality.<sup>13</sup>

**Effective responses** include cultivating knowledge, resources, and practices that support the effective recognition of impairment in leaders along with appropriate inquiry, intervention, and referral for evaluation and treatment, and also providing support for impaired leaders via re-entry, re-licensing, ongoing monitoring, and accountability.

Where are the critical points of accountability across the vocational life of ordained leaders in which preventive measures and/or effective responses might more effectively take place? We have identified five key phases of ministry that represent opportunities for prevention and intervention.

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<sup>12</sup> We are dependent on the work of Ronald Heifetz, especially *Leadership Without Easy Answers*, for the distinction between “technical” and “adaptive” change.

<sup>13</sup> The Rev. Dr. J. William Harkins, a member of the Commission on Impairment and Leadership, has developed a curriculum on “Addiction and Wholeness” for the Education and Wellness Department of the Church Pension Group. It includes units on “Recognizing Addiction,” “Pastoral/Spiritual Care of Addicted Persons and Families,” “Understanding Prevention Strategies,” and “The Role of Community in Recovery from Addiction.”

1. Discernment and screening
2. Training and formation
3. Transition and deployment
4. Self-care and wellness
5. Ongoing management and oversight

Recommendations appropriate to each of these five phases of ministry begin on page 16.

## Summary of learnings from case studies

The commission’s investigation of impairment and leadership focused primarily on case studies of specific individual and diocesan experiences — both those that had positive results and those that had tragic and lasting negative consequences — as well as the history of the General Convention legislation on substance abuse.

This investigation led to observations and understandings most of which we knew intuitively, but we came to realize they were common to every situation we explored. In all but one case we found a systemic disempowering of the individual and community to take responsibility and act in ways that would promote healing and wholeness of those affected by any form of impairment. Those familiar with substance abuse will recognize this dynamic of disempowerment as characteristic of the systemic consequences of addiction.

Mental health research has not been the commission’s primary focus, but issues of systemic disempowerment and concomitant challenges with accountability are often exacerbated by the comorbidity of addiction and personality disorders — that is, the simultaneous presence of two chronic diseases or conditions within an individual.<sup>14</sup> In particular, the association between substance use disorder and “cluster B” personality disorders (for example, Borderline Personality Disorder, Narcissistic Personality Disorder, Histrionic Personality Disorder, and Antisocial Personality Disorder) is noteworthy.<sup>15</sup> These comorbidities are often characterized by severe addiction problems and an unfavorable clinical course.

Leaders with dual diagnosis symptoms are often drawn to the helping professions and are among the most difficult individuals to diagnose and treat. The principle should generally be

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<sup>14</sup> Christian Guest and Mark Holland report that 75 percent of people treated for drug addiction and 86 percent of people treated for alcohol addiction also experience mental health difficulties. See “Co-existing mental health and substance use and alcohol difficulties — why do we persist with the term ‘dual diagnosis’ within mental health services?” (2011), *Advances in Dual Diagnosis* 4:4, pp. 162–172.

<sup>15</sup> Mark F. Lenzenweger *et al.* reports that the prevalence of substance use disorder in “cluster B” personality disorder is 26.7 percent. See “DSM-IV Personality Disorders in the National Comorbidity Survey Replication” (2007), *Biological Psychiatry* 62:6, pp. 553–564.



applied that the two comorbid disorders should be treated together, yet this is especially challenging because of the multilayered, systemic, and often contested narratives that destabilize and threaten the communities within which the impaired leader attempts to function.

Moreover, many scholars consider personality disorders to be a form of depressive illness, which often results in misguided attempts at self-medication through substance use or addictive behaviors. Such illness may also be punctuated by recurrent bouts of dysphoria (ubiquitous sadness and hopelessness), anhedonia (loss of the ability to feel pleasure), or clinical forms of depression (cyclothymic, dysthymic, or other). This picture is further obfuscated by the frequent presence of mood disorders.

Richard Rohr writes that addiction is “a spiritual disease, a disease of the soul, an illness resulting from longing, frustrated desire, and deep dissatisfaction,” and that ironically this dissatisfaction is itself the “beginning of any spiritual path.”<sup>16</sup> Partly because of this, addiction and its complications — especially the complications that arise from personality disorders occurring concomitantly with addiction — require further care and attention by the church.

Unfortunately, in almost every case that we examined, the ecclesial structure and polity of our church proved to contribute negatively to the situation. Clericalism, a misunderstanding of hierarchy, the canonical autonomy of parishes and dioceses, and a polity that hinders the enforcement of expectations all contributed to inactivity by responsible persons and bodies (such as bishops, chancellors, vestries, Standing Committees, search committees and consultants, Commissions on Ministry, and seminaries). Fear of exposure to liability (as individuals and as a corporate body) provided additional reason for these groups to avoid action. An often underdeveloped theology of forgiveness also contributed to the abusers being given multiple opportunities to repeat their behaviors without consequences.

In most instances of addiction and impairment among church leaders, the principal challenge is accountability — that is, how impaired persons undermine or evade personal accountability, how others in authority deflect or avoid their own responsibility and accountability to the wider community, how those who are directly or indirectly affected by impaired leaders are unwilling to call impaired leaders to accountability out of fear or shame, and how social and church systems often work to obstruct transparency and accountability. The abdication of accountability is of primary concern to the commission.

A considerable number of impairment issues might better be addressed in a way other than a disciplinary canon. The commission believes that Title III of the church’s Canons (on “Ministry”) might provide opportunities for recovery, reconciliation, and healing that are not easily realized by Title IV (on “Ecclesiastical Discipline”), in spite of the intentions articulated in Title IV, Canon 1: “The Church and each Diocese shall support their members in their life in Christ and seek to

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<sup>16</sup> Richard Rohr, *Breathing Under Water: Spirituality and the Twelve Steps* (Cincinnati: St. Anthony Messenger Press, 2011), p. 115.

resolve conflicts by promoting healing, repentance, forgiveness, restitution, justice, amendment of life and reconciliation among all involved or affected.” We believe that the addition of an impairment canon to Title III, providing guidelines for intervention, diagnosis, treatment, re-entry, and ongoing monitoring, is a way of realizing this intent without resorting to a disciplinary process.

A review of General Convention resolutions over several decades suggests that while the church continues to discuss substance abuse, its culture has not changed. The problem of addiction and substance abuse requires a stronger and more concerted effort than everyone’s good will. Indeed, the language of General Convention resolutions reflects the ambivalence and indeed conflict inherent in the church’s general attitude toward this subject. That language charges dioceses and the General Convention “if possible” to implement changes that “hopefully would work” (1979-B122). These resolutions *encourage* dioceses and *make requests* of them (emphasis added):

- “*request* dioceses to establish committees and policies related to alcoholism and other drug abuse”
- “*be encouraged* to promote the use...” (1988-C036).
- “*encourage* the efforts of...” (1991-D171).
- “*make strong efforts* to develop policies...” (2003-A123).
- “*be encouraged* to raise awareness of recovery issues...” (2009-A078).

But these resolutions do not reflect the urgency and necessity of a clear, informed, consistent, and church-wide response to impairment. Without built-in accountability, authority, strongly expressed values, and consequences for inaction, these kinds of resolutions have proven to be ineffective.

The case studies have repeatedly revealed that an inadequate theological understanding of forgiveness has often inhibited or prevented appropriate and effective intervention. The desire to forgive — to offer a second chance and to retain a leader in public ministry — has often conflicted with the responsibility given to committees, commissions, other leaders, and individuals to hold impaired leaders accountable. In many instances, devoid of expectations for substantive recovery and amendment of life, the desire to forgive has undermined the church’s collective responsibility to due diligence in the work of screening, recognizing, and diagnosing impairment in church leaders, as well as intervening and treating when appropriate. We have observed that a popular and hopeful narrative — that “great leaders have overcome great problems” — has often inhibited both individuals and committees in making critical decisions.

The case studies highlighted a need to make a distinction between loyalty — i.e., support for colleagues in need of care — and a responsibility to guard the health and well-being of the wider church community. We heard of repeated instances in which friendships between individuals undermined the ability to make objective assessments, and instances when concerns for confidentiality and privacy prevented the appropriate sharing of information with other church entities. There have been occasions when time constraints pushed committees or

individuals to make premature decisions in order to meet published schedules or deadlines, making it difficult to exercise due diligence.

Every case revealed the critical importance of mutual and systemic accountability while several critical issues contributed to negative outcomes in election processes, vocational discernment, parochial division and failures, and the handling of disciplinary problems:

- How compliance is monitored.
- How those lower in the chain of command are (or are not) empowered to speak up and be heard, especially when they have concerns about systemic practices or the behavior of others.
- How authority is defined and exercised vis-à-vis the responsibility for reviewing a leader's quality of work or fitness for service.
- How an individual or system is held accountable, and to whom each is accountable.

In spite of the efforts over the last four decades by individual dioceses and the General Convention to address the culture of substance abuse in the church, a lack of education and awareness continues regarding alcoholism and addiction. In some cases, there is a lack of access to or utilization of current scientific research and best practices regarding prevention, intervention, and treatment for both substance use and behavioral disorders. We found that people in positions of authority are often ill equipped to recognize and respond to signs of addictive behavior, and when signs are recognized, there is a tendency to avoid confrontation or questioning by the person who recognized the signs.

In each situation of impaired leadership we researched, those we interviewed described:

- *Isolation.* A sense of being alone in the midst of a situation that was out of control and wondering, "Where is the rest of the church?"
- *Disempowerment.* A sense of inadequacy and of being unauthorized and unable to speak the truth and address the problem
- *Mistrust.* An absence of confidence in individuals and the system so great that it threatened the security and safety of all, and
- *Guilt.* A sense of lasting regret with feelings that "the church wasn't being the church," and that "I should have done something."

The commission's case study research and the anecdotal experiences of its members contributed to a recognition that the church must address addiction and impaired behaviors in every aspect of its life.

With regard to clergy, this means attention to these patterns and behaviors in every evaluative, discernment, and wellness opportunity from initial application to Holy Orders until death. In addition, it requires a vocational understanding and acceptance that the souls in the clergy's care come first; if the church errs, it must not be at their expense..

With regard to lay professionals, lay leaders, and communicants, it requires the church truly to be a community unafraid to face the truth with honest and compassionate commitment to one another, in the conviction that in Christ, the healer of our souls, recovery and new life are abundant, and that every effort to achieve that end is a faithful and responsible one.

With regard to canonical structures, it means assuring that the way we organize ourselves and the processes by which we direct and live out our common life as the body of Christ — including our Constitution and Canons, diocesan canons, parish bylaws, and resolutions of the General Convention — empower every individual to speak the truth in love with the authority given in baptism.

## **Findings**

### **Background checks**

The church-wide body has no uniform set of practices and policies with regard to background checks and pre-employment investigations.

The most commonly used system for clergy background checks is the standard questionnaire and protocol used by the Oxford Document Management Company (Oxford). Even with this protocol and standard questionnaire, there is wide variation in the depth of the background check. This variation is driven by the choice of services made by dioceses and congregations. The approach uses a self-report questionnaire and an a la carte list of services such as the option of a five-, 10-, or 15-year (or more) employment history, credit reporting, a review of national criminal databases, and criminal background checks on a county-by-county basis.

There are numerous weaknesses to this widely used protocol and to alternative protocols used by other companies. The primary weakness is that it relies heavily on a self-report questionnaire and employment history with no capability for verification. Oxford sends questionnaires to bishops and past employers based upon the self-reporting of the applicant. This means that if applicants fail to report problematic periods in their ministry, or fail to list parishes or placements during which they were impaired or disciplined, then prospective employers or dioceses might never discover these issues. No one is able to cross-check an applicant's employment history or claim about church discipline because no database exists to make such a search possible. The result is a vulnerable system in which dioceses and congregations believe that they have exercised due diligence.

This gap is the result of a structural deficiency and not negligence on the part of dioceses, congregations, Oxford, or any other company that provides services similar to Oxford.

## Church-wide database

The development of a church-wide database that tracks clergy employment, discipline, issues with impairment, and other related background information should be explored. Various aspects of this data exist, but not in a single accessible place.

For example, the Church Pension Group (CPG), in its function as recorder of ordinations, tracks clergy discipline, but a bishop cannot query that database to see if a person has ever been under discipline. Further, the only disciplinary actions recorded by CPG are official Title IV sentences, while issues of impairment, or matters handled through a Pastoral Direction, are not available in a central location. Similarly, CPG has employment information, but only for those clergy who receive a stipend. Furthermore, this information is not generally available.

Before any church-wide database were implemented, significant concerns about privacy, access, and reporting must be carefully considered.

## Psychological testing

Church canons require psychological assessments for persons about to be ordained as priests and deacons and an evaluation by a licensed psychiatrist for persons about to be ordained to the episcopate. There is, however, no agreed upon testing protocol that is used church-wide. CPG has generated standardized forms for reporting by examining psychologists and psychiatrists and has invested considerable efforts in the development of self-report forms to assist examiners. Two standardized forms are available: the Life History Questionnaire (LHQ) and the Behavioral Screening Questionnaire (BSQ). The final form consists of six questions and, with the exception of two questions related to the LHQ and BSQ, has not been substantively altered for several decades.

Until 2006, only a psychiatric examination was required for ordination. Since the substantive revision of Title III at the 2006 General Convention, the canons now require a psychological assessment for those about to be ordained to the diaconate or priesthood, with further psychiatric evaluations as necessary. This marks a significant shift in the approach to the evaluation of ordinands and was the result of work completed by the Standing Commission on Ministry Development and risk management work by CPG. Canon 11, Section 3 was not revised to reflect this change and still requires a psychiatric assessment and medical examination for bishops-elect.

While a psychological assessment is required for ordinands, the assessments vary from diocese to diocese and range from significant psychological testing and in-depth clinical interviews to vocational testing. Professionals in psychological assessment should develop a standard testing protocol, providing uniformity across the church. The purpose of a standard testing protocol is not to abridge the professional judgment of individual examiners to engage in further testing for a candidate, but would have the benefit of establishing minimum and uniform standards.

Further evaluations, looking more carefully at issues specific to clergy, might contribute to further research in this area.

## Standardization of processes

Even with standardized protocols for psychological testing, background checks, and the creation of a database, the question of how information is evaluated and shared remains unanswered.

There is a critical lack of consistency in the way in which episcopal elections are conducted. There is no clarity about who should see background checks or read the self-report questionnaires. Once again, people who are not qualified to analyze the data are often in a position of making process and outcome determinations. Or, those involved in those processes, assume that someone else in the system with greater experience and authority is doing so when in fact that may not be the case.

Currently, no one works with psychologists, physicians, or other evaluators to determine best practices for their evaluations. Identifying areas that can become problematic for clergy and addressing them in the initial stages of formation will be critical. Currently, there is no coordinated effort in this area.

A lack of consistent practice informed by appropriately accessible and shared information with regard to screening and discernment processes appears to be a key structural deficiency.

## Recommendations for changes

The Episcopal Church is not alone among religious and secular bodies in the need to develop and implement effective means of addressing impaired leadership. In addition to our analysis of various case studies within the church, the commission has looked also to the experience and work of other licensed professions as resources — doctors, nurses, psychologists, social workers, attorneys, and pilots. Our church lags significantly behind these other groups in our understanding, effectiveness, and consistency in addressing issues of impairment among its ordained leadership.

Our investigation and analysis has focused on the two broad categories noted on page 7 of this report:

**Preventive measures** include creating educational and training programs to increase knowledge about impairment, and also implementing policies, practices, and procedures to screen and evaluate the church's leaders throughout their vocational life, promoting early detection and quality control along with confidentiality.

**Effective responses** include cultivating knowledge, resources, and practices that support the effective recognition of impairment in leaders along with appropriate inquiry, intervention, and referral for evaluation and treatment, and also providing support for impaired leaders via re-entry, re-licensing, ongoing monitoring, and accountability.

After making one general recommendation below, our recommendations have then been grouped according to five critical points of accountability in which preventive measures and effective responses can take place throughout the lifespan of ordained leadership in the church. These include:

1. The *discernment and screening* process for ordination and episcopal elections.
2. The *training and formation* process for those preparing for ordination and for newly elected bishops.
3. The *transition and deployment* process for clergy of all orders.
4. *Self-care and wellness* practices (including CREDO) for deacons, priests, and bishops.
5. *Ongoing management and oversight* of all clergy, including bishops, particularly with regard to *evaluation and licensing*.

Our goal has been to identify points of weakness in our current practices where these opportunities are being missed — missed opportunities for education, training, early detection, or effective intervention. We have then made recommendations to the appropriate leadership bodies of the church for their consideration and implementation.

The recommendations of this report are not addressed solely to the General Convention, the Executive Council, or the House of Bishops. These bodies do have a significant leadership role in the health and well-being of our church. Some of the commission's recommendations invite the consideration of legislative action, canonical changes, and the possible implementation of new policy by these bodies. But the commission cannot state strongly enough our belief that legislation and policy alone cannot accomplish the greater cultural shift required in our church to address issues of addiction and substance abuse. We believe firmly that the health and well-being of our church invites a more concerted, broad-based, grassroots effort.

We invite all leadership bodies to whom these recommendations are directed to consider them openly, prayerfully, and seriously and to play an active part in the healing of the wider church.

We recognize that the Executive Council, the House of Bishops, and other bodies to whom these recommendations are addressed may need to create special committees or commissions, or may require particular assistance and expertise, to implement the recommendations below. The members of this commission are committed to serving as a continuing resource to the church as needed.

## Recommendations

### **Debrief**

1. We recommend that members of this commission conduct a personal debriefing with the key bodies involved in the establishment and support of our work, including but not limited to the Executive Council, the House of Bishops, and the bishop with oversight over the Office for Pastoral Development.

We believe that an opportunity to share personally some of the learnings from the research and case studies we have done, and to have conversation and reflect collectively with other leaders in the church, would be beneficial for carrying this work forward.

We recognize that ongoing conversation with key leaders within the church is necessary for the clarification and refinement of these recommendations.

### **The discernment and screening process for ordination**

2. We recommend that the Presiding Bishop and President of the House of Deputies commission a task force or other group to develop a more complete process of screening persons applying for ordination with regard to their history and experience with alcohol and substance abuse.

Current practices with regard to screening for alcohol and substance abuse vary widely across dioceses and depend significantly on the thoroughness of the candidate's psychological evaluation and on the bishop's and commission on ministry's awareness and capacity to address these issues.

For example, the standard Oxford questionnaire requests information about an individual's financial, criminal, and employment background, but it does not adequately explore an applicant's history of addiction and substance abuse.

Bishops and commissions on ministry would benefit from education and training in how best to evaluate applicants with a history of addiction who are now living in recovery (see Recommendations 4 and 5 below).

### **The training and formation process**

3. We recommend that the Executive Council and the General Convention take necessary steps to develop and implement a required alcohol and substance abuse training program for all persons in the process of formation for ordination and for those already



ordained. As in other professions, clergy should be required to repeat this training at designated intervals in order to maintain their license.

The commission believes that the investment in creating such a program, reflecting current research and best practices with regard to addiction and substance abuse, would yield a significant return in the health and wholeness of the church's leadership.

The program could be modeled in part on the Church Pension Group's "Safeguarding" curriculum. Since its implementation in 2004, the "Safeguarding" program has been demonstrably effective in creating a safer, healthier, and more informed church-wide culture with regard to sexual misconduct and abuse.

4. We recommend that the College for Bishops develop a substantive training component on addiction and substance abuse to be incorporated into the "Living Our Vows" program for new bishops that would include the following components:
  - a. An examination of a new bishop's personal relationship to alcohol and addiction along with education in the ways in which stepping into a high-stress position of responsibility can influence and change one's relationship with alcohol, other substances, and processes.
  - b. Training in all required policies and practices of the church and all canonical provisions that apply to clergy with regard to alcohol, substance, or process addictions.
  - c. Training in best practices for early detection, intervention, treatment, monitoring and ongoing support for clergy struggling with addiction.
  - d. Training in best practices for vetting and evaluating those in various stages of discernment — either before ordination or at any time of deployment — with regard to addiction and recovery.
  
5. We recommend that House of Bishops incorporate into its meetings an ongoing and continuing process of education that will, over time, address the same areas stated in Number 4 above, namely:
  - a. An examination of a new bishop's personal relationship to alcohol and addiction along with education in the ways in which stepping into a high-stress position of responsibility can influence and change one's relationship with alcohol, other substances, and processes.
  - b. Training in all required policies and practices of the church and all canonical provisions that apply to clergy with regard to alcohol, substance, or process addictions.

- c. Training in best practices for early detection, intervention, treatment, monitoring and ongoing support for clergy struggling with addiction.
- d. Training in best practices for vetting and evaluating those in various stages of discernment — either before ordination or at any time of deployment — with regard to addiction and recovery.

### **Transition and deployment**

- 6. We recommend that the Church Pension Group (CPG), in its function as recorder of ordinations, establish a central personnel database to track clergy employment, discipline, issues with impairment, and other related background information for all clergy in the church that can be accessed during search and transition processes. Such a database may require the establishment of appropriate limitations to access and protocols for safeguarding confidentiality and protecting the church's liability.

Other licensed professions make use of similar databases to maintain and insure licensing standards. In the commission's case studies, one of the single greatest impediments to appropriate recognition of and response to impairment was a lack of information about an individual's personal history. Reference checks, bishop-to-bishop conversations, and background checks provide some limited information, but the case studies found the accuracy and the access to that information to be highly inconsistent.

- 7. We recommend that the bishop with oversight over the Office for Pastoral Development, drawing on the research from this commission, establish a standardized process for conducting episcopal elections.

The commission recognizes the diversity and unique context of every diocese, and we are not recommending that the church adopt a one-size-fits-all approach to episcopal elections. Nor do we wish to diminish in any way the independence needed in any given diocese to effectively discern what might be needed in a new bishop for that diocese.

We do believe, however, that establishing a standardized process based on best practices can be tailored to meet the particular characteristics of a given diocese and that doing so can insure that the key components to effective screening and discernment will not be lost in the process.

Such a standardized process for episcopal elections may include:

- a. Extensive and substantial orientation with all diocesan leadership with regard to best practices for episcopal elections, including education and training in recognizing and addressing issues of impairment.

- b. Trained consultants to provide informed and consistent guidance, based on best practices, to bishops, standing committees, search committees, and all other parties in the episcopal election process, including checklists and competent counsel for recognizing and addressing any issues with addiction or impairment that may emerge during the course of their work.

### **Wellness practices**

8. We recommend that CREDO develop a program component to help participants explore their relationship to alcohol, drugs, and other addictive substances and behaviors.

Recognizing the reach and effectiveness of CREDO across the church, its programs are a prime opportunity to educate, to train, and to promote self-awareness and insight for clergy with regard to addiction.

9. We recommend that the Pastoral Development Committee of the House of Bishops, working with a knowledgeable and skilled advisor, evaluate the policies and practices of meetings of the House of Bishops and recommend changes that may contribute to a healthy environment with regard to alcohol and addiction.
10. We recommend that the Executive Council, working with a knowledgeable and skilled advisor, evaluate the policies and practices of its meetings and the meetings of its commissions, committees, and boards make necessary changes that may contribute to a healthy environment with regard to alcohol and addiction.

### **Management and oversight**

11. We recommend that the Presiding Bishop, drawing on the research of this commission, establish a team of advisors or consultants to serve as a resource on alcoholism and other forms of addiction in order to provide a rapid response to issues of questionable impairment, to provide clergy or other concerned individuals with confidential advice, and to assist with monitoring, recovery and re-entry into ministry.
12. We recommend that the Presiding Bishop and the President of the House of Deputies appoint a working group to conduct a review of the canons of the church and to identify canonical impediments to the effective pastoral response, intervention, and treatment of addiction and substance abuse. This working group should include individuals who are familiar with the research and analysis of this Commission, individuals who serve on the Standing Commission on Structure, Governance, Constitution and Canons, and those who are familiar with the policies and practices of other professions with regard to substance abuse and addiction.

In our research, many have commented that neither the current Title III canons nor the Title IV disciplinary canons make adequate provision for intervention and treatment of

impaired leaders. Other professions not only have clearer standards and policies than does the church, but they also have formal processes of accountability that are more oriented toward healing and recovery than punishment.

13. We recommend specifically that this working group report its findings and recommendations to the Standing Commission on Structure, Governance, Constitution and Canons, which in turn shall:
  - a. Review current canons in light of any changes that might be advisable in response to the recommendations listed above.
  - b. Review current Title III and Title IV canons alongside governing or regulatory practices of other denominations and professions to identify canonical impediments to effective pastoral response to addiction and substance abuse.
  - c. Develop canons to empower intervention and effective treatment of impaired leaders and also to provide incentives to impaired leaders to self-report and to cooperate with intervention and treatment.
  - d. Recommend changes to the licensing requirements for all ordained leaders for whom intervention, treatment, and reinstatement may be needed.
  - e. Consider creating policies and canonical supports for the intervention and treatment of impaired bishops based on the policies and practices of the Evangelical Lutheran Church in America.<sup>17</sup>

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<sup>17</sup> These policies are outlined in Chapter 20 of the Constitutions, Bylaws, and Continuing Resolutions of the Evangelical Lutheran Church in America. See [http://download.elca.org/ELCA%20Resource%20Repository/Constitutions\\_Bylaws\\_and\\_Continuing\\_Resolutions\\_of\\_the\\_ELCA.pdf](http://download.elca.org/ELCA%20Resource%20Repository/Constitutions_Bylaws_and_Continuing_Resolutions_of_the_ELCA.pdf).

# Appendices

## Appendix 1

### 2015 Executive Council and House of Bishops Resolutions Establishing the Commission on Impairment and Leadership

#### **FFM 081 Commission on Impairment and Leadership**

The following is a true copy of a Resolution adopted by the Executive Council at its meeting from March 19-21, 2015 at which a quorum was present and voting.

*Resolved*, That the Executive Council of The Episcopal Church, meeting at Salt Lake City on March 21, 2015, affirms the March 17, 2015 resolution of the House of Bishops (explained below); and be it further

*Resolved*, That the 2015 budget revision include \$150,000 to fund the work of this commission.

#### **EXPLANATION**

House of Bishops March 17, 2015 resolution:

*Be it resolved*, that the House of Bishops requests the Presiding Bishop appoint, in consultation with the President of the House of Deputies, an independent commission to explore the canonical, environmental, behavioral and procedural dimensions of matters involving the serious impairment of individuals serving as leaders in the Church, with special attention to issues of addiction and substance abuse. We request that appointments to this commission include individuals with professional or personal experience with varieties of impairment, members of Full-Communion partner churches, and members of this Church. We further request that a report of the commission's work include recommendations for both action and further review, as appropriate, in order to clarify lines of authority, to ensure mutual accountability, and to promote justice, well-being and safety within both the Church and the world; and

*Be it further resolved*, that the House of Bishops request the Executive Council Joint Standing Committee on Finances for Mission allocate sufficient funding from the 2015 budget for the work of the commission.

The members of the Commission on Impairment and Leadership included:

- The Very Rev. **Martha J. Horne**, Chair, *Dean and President, Emerita, Virginia Theological Seminary*
- The Rt. Rev. **Mark Hollingsworth Jr.**, Vice Chair, *Bishop of Ohio*
- Canon **Jill Mathis**, Secretary, *Canon for Transition Ministry, Diocese of Pennsylvania*
  
- The Rev. **Jan M. Brown**, *Founding/Executive Director, SpiritWorks Foundation Center for the Soul, Williamsburg, Virginia*
- The Rt. Rev. **Mary Gray-Reeves**, *Bishop of El Camino Real*
- The Rev. **Mark S. Hanson**, *Former Presiding Bishop, Evangelical Lutheran Church in America*
- The Rev. Dr. **J. William Harkins**, *Marriage and Family Therapist; Pastoral Theology and Counseling/Th.D. Program Co-Director, Columbia Theological Seminary*
- The Very Rev. **Cynthia Kittredge**, *Dean and President, Seminary of the Southwest*
- The Rt. Rev. **Robert O'Neill**, *Bishop of Colorado*
- The Rt. Rev. **Sean Rowe**, *Bishop of Northwestern Pennsylvania and Bishop Provisional of Bethlehem*
- The Very Rev. Dr. **Steven L. Thomason**, *Physician; Dean, St. Mark's Cathedral, Seattle*

Legal counsel:

- Canon **William A. Powel III**, *Chancellor and Canon to the Ordinary, Diocese of Ohio*

Members *ex officio*:

- The Most Rev. **Michael Bruce Curry**, *Presiding Bishop*
- The Rev. **Gay Clark Jennings**, *President, House of Deputies*

Mr. **Jay Blossom** of the Diocese of Pennsylvania served as editor of this report.

Between November 21, 2015, and December 8, 2016, the commission met nine times (including four times in person and five times by conference call).

## Appendix 2

### A history of canonical recommendations

The General Convention took up matters related to alcohol as early as 1979. The first resolution, *1979-B122, Request Dioceses to Establish Committees on Alcoholism*, included the request that each diocese of the church form a Committee on Alcoholism under the guidance of the bishop. It further resolved that the committees would work in conjunction with local and regional organizations to offer educational materials and training on the subject of alcoholism and its effects of quality of life. Each diocese was also requested to develop a written policy on alcohol that included:

1. Addressing the issues of education, prevention, intervention and treatment.
2. A written procedure for treatment of clergy and diocesan employees and members of their families who suffer from alcoholism.
3. A section in the policy containing a statement covering the use of alcoholic beverages during church functions and on church property, especially as it relates to non-alcoholic choices.
4. Providing an employee policy statement that includes assurances of job security and insurance coverage completing a prescribed course of care (treatment).
5. Providing help or encouragement for clergy and lay leaders who are working with alcoholics and their families.

The final portion of the resolution stated that the Executive Council of the General Convention also comply with provisions 2, 3, 4.

In the following years, additional resolutions were passed regarding alcoholism, many addressing or referring back to, 1979-B122, the original resolution in 1979.

Two additional issues of significant importance to the church addressing matters related to alcoholism in 1979 include the Diocese of Maryland Resolution on Alcoholism Policy and Guidelines, which passed unanimously on March 12, 1979, at the 195th Maryland Diocesan Convention, and the subsequent research and report, "A Review of Alcoholism as a Factor Among Medically Disabled Clergy of The Episcopal Church," conducted by the Rev. Halsey Cook for the President and Trustees of the Church Pension Fund in May 1979. The first contributed to the General Convention resolution that passed in 1979, 1979-B122, requesting that dioceses establish committees on alcoholism. The second led to the suggestion in 1979 that the Church Pension Fund underwrite an office to provide a few basic resources on alcoholism with the recognition that the expense to do so would surely be "more than recovered by a lower incident of medical disability payments in the future."

At the 2006 General Convention, the church adopted an extensive revision of the Title III Ministry canons via Resolution 2006-A082. The initial work and drafting of this resolution was completed between 2003 and 2006 by the Standing Commission on Ministry. Though the

Commission discussed and proposed ways to address clergy impairment, none were adopted by the General Convention that year.

Proposals for addressing clergy impairment were made at the 2009 General Convention and again at the 2012 General Convention. In 2009, the Committee on Ministry received a report from the Title IV Task Force II, which met during the previous triennium, detailing the need to consider canonical revisions related to clergy impairment. In response to that report, the Committee on Ministry proposed Resolution 2009-A186, which referred the matter of “canonical amendments by which to address the needs and circumstances of Members of the Clergy who may be impaired by physical, mental or substance abuse-related causes” to the Standing Commission on Ministry Development for study and to make recommendations to the 2012 General Convention.

In 2012, the Standing Commission on Ministry Development brought forward resolution 2012-A066 on clergy impairment which proposed a Title III canonical process rather than a disciplinary Title IV process that allowed bishops to address clergy who have issues with “physical, mental or substance abuse-related causes.” The proposal passed in the House of Bishops, but was referred to the Standing Commission on Constitution and Canons by the House of Deputies. (The full text of the resolution is available at [http://episcopalarchives.org/cgi-bin/acts/acts\\_resolution-complete.pl?resolution=2012-A066](http://episcopalarchives.org/cgi-bin/acts/acts_resolution-complete.pl?resolution=2012-A066).)

The Standing Commission on Constitution and Canons reviewed the process thoroughly over the course of the triennium. The 2015 Blue Book report from the committee concluded the following with regard to 2012-A066:

*This resolution proposed adding a new Canon III.9.14 that would require and authorize Bishops to take certain actions, in some instances with the participation of the Standing Committee, with regard to a clergy person who is considered to be “severely impaired.”*

*After consideration of the proposal and consultation with its proponents, the Commission reached three conclusions. First, while it understood the grave situation that exists when an impaired clergy person continues to function as rector of a congregation, and the harm that can result, the Commission determined that the canonical change proposed by A066 contained problematic ambiguity in its terms as well as possible contradictions with other canons, raising questions about whether the proposal protected the due process of clergy persons thought to be impaired.*

*Second, costs to the diocese and to clergy persons thought to be impaired were not addressed by A066. Finally, it is the Commission’s view that current Canon IV.7 providing for Pastoral Direction to a Member of the Clergy can be used to address the situation of an impaired clergy person sufficiently. To that end, the Commission chose not to present A066 or an amended variation of it to the 78th General Convention.*



## Appendix 3

### 2015 General Convention Resolutions

#### **A158-GC2015**

#### **Task Force to Review and Revise Policy on substance abuse, addiction and recovery**

Committee:

22 - Alcohol & Other Drug Abuse

Proposer:

22 - Alcohol & Other Drug Abuse

#### **Finalized text**

*Resolved*, the House of Bishops concurring, that the 78th General Convention acknowledge The Episcopal Church's long-standing tolerance for the use of alcohol which, in some cases, has contributed to its misuse, and has undermined a climate of wholeness and holiness for all; that our Church culture too often avoids hard conversations about alcohol use, and the role of forgiveness and compassion in healing and recovery; and that The Episcopal Church now commits to create a new normal in our relationship with alcohol. We aspire to be a place in which conversations about alcohol, substance misuse, or addiction are not simply about treatment but about renewal, justice, wholeness, and healing. We affirm that Recovery Ministries of The Episcopal Church has long been and continues to be a valuable resource for this work; and be it further

*Resolved*, that the 78th Convention adopt the following policy on alcohol and other substance misuse and encourage dioceses, congregations, seminaries, schools, young adult ministries, and affiliated institutions to update their policies on the use of alcohol and other substances with the potential for misuse. These policies should consider the following:

1. The Church must provide a safe and welcoming environment for all people, including people in recovery.
2. All applicable federal, state and local laws should be obeyed, including those governing the serving of alcoholic beverages to minors.
3. Some dioceses and congregations may decide not to serve alcohol at events or gatherings. Others may decide to permit a limited use of alcoholic beverages at church-sponsored events. Both can be appropriate if approached mindfully.
4. When alcohol is served, it must be monitored and those showing signs of intoxication must not be served. Whenever alcohol is served, the rector, vicar, or priest-in-charge must appoint an adult to oversee its serving. That adult must not drink alcoholic beverages during the time of his or her execution of his or her responsibilities. If hard liquor is served, a certified server is required.

5. Serving alcoholic beverages at congregational events where minors are present is strongly discouraged. If minors are present, alcohol must be served at a separate station that is monitored at all times to prevent underage drinking.
6. Alcoholic and non-alcoholic beverages must be clearly labeled as such. Food prepared with alcohol does not need to be labeled provided the alcohol is completely evaporated by the cooking process; however, it is recommended that even in this case the use of alcohol in cooking be noted on a label.
7. Whenever alcohol is served, appealing non-alcoholic alternatives must always be offered with equal prominence and accessibility.
8. The serving of alcoholic beverages at church events should not be publicized as an attraction of the event, e.g. "wine and cheese reception," "cocktail party," and "beer and wine tasting."
9. Ministries inside or outside of congregations will make certain that alcohol consumption is not the focus of the ministry and that drinking alcohol is not an exclusively normative activity.
9. Food must be served when alcohol is present.
10. The groups or organizations sponsoring the activity or event at which alcoholic beverages are served must have permission from the clergy or the vestry. Such groups or organizations must also assume responsibility for those persons who might become intoxicated and must provide alternative transportation for anyone whose capacity to drive may be impaired. Consulting with liability insurance carriers is advised.
11. Recognizing the effects of alcohol as a mood-altering drug, alcoholic beverages shall not be served when the business of the Church is being conducted.
12. Clergy shall consecrate an appropriate amount of wine when celebrating the Eucharist and perform ablutions in a way that does not foster or model misuse.
13. We encourage clergy to acknowledge the efficacy of receiving the sacrament in one kind and consider providing non-alcoholic wine.

And be it further

*Resolved*, that, mindful of the emerging legalization of other addictive substances and the increasing rise of addiction, the Executive Council of The Episcopal Church provide for the ready availability, implementation, and continuing development of this policy church-wide, in consultation and coordination with Recovery Ministries of The Episcopal Church.

## **A159-GC2015 The Role of the Church in the Culture of Alcohol and Other Drug Abuse**

Committee:

22 - Alcohol & Other Drug Abuse

Proposer:

22 - Alcohol & Other Drug Abuse

### **Finalized text**

*Resolved*, the House of Bishops concurring, that the 78th General Convention recognize that the field of substance use disorders and addiction has advanced substantially since 1985 when the 68th General Convention passed the current policy, acknowledging that alcohol use, addiction and recovery all involve biological, psychological, social and spiritual dimensions; and be it further

*Resolved*, that, as Holy Baptism is the entrance to the life of wholeness and holiness and addiction disrupts relationships with God, others, and ourselves, impairing body, mind, and spirit, the Church, respecting the dignity of every human being, has a moral and ethical responsibility to:

1. Confront and repent of the Episcopal Church's complicity in a culture of alcohol, denial, and enabling,
2. Speak to cultural norms that promote addiction,
3. Promote spiritual practices as a means of prevention and healing,
4. Advocate for public funding and health insurance coverage for prevention, intervention, treatment and recovery, and collaborate with qualified community resources offering these services, and to respond with pastoral care and accountability.

And be it further

*Resolved*, that The Episcopal Church affirms the need for exercising a healing ministry to all whose lives are affected by addiction and encourages all members of The Episcopal Church to pursue healing in their personal, professional, relational and vocational lives, and to seek help at the first sign of the disease of addiction; and be it further

*Resolved*, that The Episcopal Church acknowledge that the epidemic of addiction has a severely adverse social, economic, environmental, and spiritual impact on all communities, and presents particular challenges to communities of marginalized people at home and abroad; and be it further

*Resolved*, The Episcopal Church directs dioceses to work in partnership with The Episcopal Church Medical Trust, Recovery Ministries of The Episcopal Church, and community-based

organizations in order to address most effectively prevention, intervention/diversion, education, advocacy, treatment, and recovery, including developing a list of trained therapists and consultants who are available to assist clergy and laity in this education process.

#### **D014-GC2015 Question Ordinands About Addiction**

Committee:

22 - Alcohol & Other Drug Abuse

Proposer:

The Very Rev. Dr. Benjamin Shambaugh

#### **Finalized text**

*Resolved*, the House of Bishops concurring, That Sponsoring Clergy, Vestries, Commissions on Ministry, Standing Committees, and Bishops interviewing and evaluating Nominees, Postulants, and Candidates for Ordination explore directly issues regarding substance use in their lives and family systems; and be it further

*Resolved*, That Nominees, Postulants, and Candidates who may have addiction issues be offered appropriate resources and referred to qualified mental health, healthcare, and/or addiction professionals for further evaluation prior to proceeding in the ordination process.

## Appendix 4

### Licensed Professions: Impaired Practitioner Process

Profession	Official reporting	Colleague reports	Investigation	Treatment process	Suspension	Monitoring	Reinstatement
<b>Physicians</b>	State medical board	Mandatory	One-time “one bite” rule, if physician undergoes required treatment (OH)	State medical board-supervised, including inpatient or outpatient treatment	Yes, pending entering into Chemical Dependence Agreement (5 years)(AL)	Random Toxicology screening (AL)(urine, blood, sputum, hair)	Return to practice permitted during treatment and monitoring. Also, following period of sobriety/compliance with agreement — up to 5 years
<b>Attorneys</b>	Supreme court through disciplinary board & state bar assns.	Mandatory if non-privileged context; “may” report if privileged	Disciplinary board investigates	Disciplinary board can order treatment	Minimum of 30 days. Treatment agreements: 2 to 5 years (OH Lawyers Assistance Program)	Type and length depends on treatment agreement	In 2-5 years
<b>Nurses</b>	State nursing board	Mandatory. Once reported, nurse can apply for “alternative program for chemical dependency/substance use disorder” (OH)	Application reviewed/ investigated by state nursing board	Approval for alternative program, abstaining from alcohol/drugs, completion of substance abuse disorders treatment program, random drug/alcohol screens, approval to seek employment as nurse	Surrender of license required within 10 days of application for program	4 years of monitoring (OH)	Nursing board may reinstate after compliance with agreement
<b>Social workers</b>	State licensing board	Should approach colleague; report to regulatory authorities if individual does not report (Int’l Code of Ethics, 2.09)	State board of licensure	Intervention permitted for licensed professionals	License is suspended	Ongoing post-treatment monitoring (OH)	Following treatment and rehabilitation — no specific timetable
<b>Pilots</b>	NTSB and FAA	Self-report (or colleagues report)	NTSB	Employee assistance program (with Air Line Pilots Association) with treatment, monitoring	License is suspended	Yes	Within 30 days of sobriety

Note: Policies and procedures for many professions vary from state to state.