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CONGREGATIONS, COMMUNITIES, AND CARE: A NARRATIVE REVIEW OF RELIGIOUS RESPONSES TO ADDICTION IN THE UNITED STATES

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ABSTRACT

Substance use disorders (SUDs) continue to impose profound health, social, and economic burdens across the United States, with persistent disparities in access to prevention, treatment, and long-term recovery support. In many communities, particularly rural and underserved areas, religious congregations remain trusted institutions that provide social capital, moral guidance, and informal care networks. Yet their role within the broader addiction response infrastructure remains unevenly conceptualized and insufficiently integrated into public health strategy. This narrative review examines how religious congregations and faith-based organizations engage substance use prevention, treatment, recovery support, and policy collaboration in the U.S. context. The literature reveals that congregations frequently function as informal safety-net providers, offering youth prevention initiatives, pastoral counseling, recovery ministries, referral pathways, and reintegration support. Theological interpretations of addiction, ranging from sin-based to medicalized and trauma-informed frameworks, substantially shape institutional responses and openness to harm reduction and medication-assisted treatment. While many congregations demonstrate willingness to collaborate with healthcare systems, structural limitations, training gaps, and ethical concerns regarding inclusivity and religious coercion persist. Evidence remains largely qualitative and descriptive, with limited rigorous outcome evaluation. Religious institutions represent a significant yet underutilized component of the U.S. addiction response ecosystem, requiring stronger cross-sector integration and expanded empirical assessment to maximize public health impact.

KEYWORDS: *Addiction, Congregations, Spirituality, Recovery.*

1. INTRODUCTION

The United States continues to face a persistent public health crisis related to substance use disorders (SUDs), with wide-ranging consequences for individuals, families, and communities. Despite advances in pharmacotherapy and behavioral interventions, access to care remains uneven particularly in rural regions and socioeconomically marginalized communities (Woodruff & Frakt, 2019). In many such contexts, religious congregations function as stable community anchors, often serving as first responders to personal and family crises, including addiction. National congregational data indicate that a substantial minority of U.S. congregations provide some form of substance use–related programming, though levels of engagement vary by size, leadership, and theological orientation (Anna Holleman, 2024; Luis R. Torres et al., 2018).

Religious institutions occupy a distinctive position within American civil society. With roughly 300,000 congregations nationwide, faith communities provide social capital, moral guidance, and informal care infrastructures that often operate parallel to formal health systems. Research demonstrates that spirituality and religious participation can function as protective factors and recovery resources, shaping coping strategies, identity reconstruction, and communal belonging (Byron R. Johnson, 2013; White et al., 2005). At the same time, ethnographic scholarship reveals that theological interpretations of addiction, whether framed as sin, disease, or spiritual dislocation, profoundly influence congregational responses (Helena Hansen, 2018).

The expansion of faith-based engagement has occurred alongside growing policy attention to cross-sector collaboration. Studies of church–health partnerships highlight both opportunities and friction, particularly around medication-assisted treatment and harm reduction strategies (Dennis McCarty, 2018; E. Dankwah et al., 2024; Katherine Szott, 2020). While some congregations actively collaborate with treatment providers, others encounter theological or structural barriers that limit integration (James Clements, 2022).

Existing scholarship, therefore, presents a complex landscape: congregations act as informal safety-net providers, prevention advocates, recovery communities, and referral hubs, yet engagement remains uneven and context-dependent. The literature spans public health, theology, sociology, social work, and psychology, but lacks sustained synthesis that integrates theological framing, institutional capacity,

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and collaborative dynamics into a unified analytical model. This review addresses that gap by situating congregational addiction responses within broader moral, organizational, and policy frameworks.

This narrative review synthesizes peer-reviewed U.S.-based research and specifically, it addresses five questions:

1. What theological and moral frameworks shape congregational understandings of addiction?
2. What prevention and early intervention initiatives do congregations provide?
3. What faith-based treatment and recovery models operate in the United States, and what outcomes have been documented?
4. How do congregations collaborate with healthcare systems, and what facilitates or constrains these partnerships?
5. What ethical and policy considerations arise in faith-based addiction services?

The review focuses exclusively on the U.S. context, recognizing its distinctive religious pluralism, constitutional church–state separation, and fragmented healthcare system.

2. THEOLOGICAL AND MORAL FRAMEWORKS

Religious responses to addiction are fundamentally shaped by theological understandings of the nature of addiction, human agency, sin, disease, and redemption. The literature reveals a complex and evolving landscape of theological frameworks, with significant implications for how congregations conceptualize their role and design their programs.

The Sin-to-Disease Transition

A central theme in the literature is the historical shift from predominantly sin-based understandings of addiction toward medicalized or disease models. Several studies document this transition within specific denominational contexts. Research examining the Southern Baptist Convention, one of the largest Protestant denominations in the United States, traces how addiction has been reframed from a moral failing requiring repentance to a disease requiring treatment, though this shift remains incomplete and contested (Okinaga, n.d.). This transition reflects broader cultural changes in how American society understands addiction, influenced by neuroscience, public health advocacy, and the medicalization of deviance. National survey data indicate that clergy views increasingly align with medical models. In a nationally representative study of U.S. congregations, researchers found that clergy are less likely than in previous decades to attribute mental illness and substance use disorders to spiritual shortcomings, instead recognizing biological, psychological, and social factors (Holleman, 2024). This shift has important implications for reducing stigma and facilitating referrals to evidence-based treatment. However, the transition from sin to disease is neither uniform nor complete. Instrument validation research in Appalachian congregations found that while 68.1% of respondents viewed addiction as a medical issue, 51.8% simultaneously believed that willpower is sufficient for recovery (Clements, Cyphers, Whittaker, & McCarty, 2021). This coexistence of disease and moral frameworks creates theological tension. Some congregants and clergy hold hybrid models that acknowledge biological and psychological dimensions while maintaining that addiction involves moral choices and spiritual dimensions.

Redemption Narratives and Identity Reconstruction

Beyond the sin-versus-disease debate, the literature highlights the centrality of redemption narratives in faith-based addiction responses. Redemption the theological concept of being saved, restored, or made whole through divine grace provides a powerful framework for identity reconstruction in recovery. Qualitative studies of Christian recovery programs document how participants describe their recovery journeys using language of transformation, rebirth, and restoration (Naegeli, 2017). These redemption narratives serve multiple functions. First, they provide meaning and purpose, reframing addiction not merely as a problem to be solved but as part of a larger spiritual journey. Second, they offer hope, particularly the eschatological hope (hope in ultimate restoration and fulfillment) that sustains individuals through the challenges of recovery. Analysis of programs like Celebrate Recovery and The Genesis Process reveals how eschatological themes the belief in God's ongoing work of restoration and the promise of ultimate healing provide motivational resources for sustained recovery (Naegeli, 2017). Third, redemption narratives facilitate social reintegration. By emphasizing that individuals are "new creations" or "restored," these narratives can counteract the stigmatized identity of "addict" and support reentry into congregational life. Research on formerly incarcerated individuals with substance use histories found that faith-based communities play a crucial role in building "recovery capital," the social, human, and spiritual resources that support sustained recovery and reintegration (Connolly & Granfield, 2017).

Shame, Stigma, and Theological Responses

Despite the potential of redemption narratives to reduce stigma, the literature consistently identifies shame and stigma as significant barriers within faith communities. Stigma operates at multiple levels: internalized shame among individuals with SUDs, interpersonal stigma in congregational interactions, and structural stigma embedded in theological teachings and institutional practices. Several studies document how moralizing language and sin-based frameworks can intensify shame and deter help-seeking. In rural communities, where religious identity is often central to social standing, the stigma of addiction can be particularly acute. Ethnographic research in rural Indiana found that religious language equating heroin uses with demonic possession ("heroin is the devil") reinforced stigma and created

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barriers to harm reduction interventions like needle exchange (Szott, 2020). However, the literature also identifies theological resources for reducing stigma. Qualitative research with Black American Christian church leaders found that many leaders expressed empathy, viewed addiction through a lens of social determinants (hopelessness and inequity), and were committed to helping people "flourish beyond staying alive" (Dankwah et al., 2024). These leaders welcomed collaborations with public health and medical systems, suggesting that theological frameworks emphasizing compassion, justice, and holistic well-being can counteract stigma (Dankwah et al., 2024). Training and education emerge as critical facilitators for reducing stigma. The Church Addiction Response Scale (CARS), validated in Appalachian congregations, found that most respondents were willing to help individuals with addiction but felt underprepared (Clements et al., 2021). Barriers to readiness included uncertainty about addiction's causes, discomfort interacting with affected individuals, and lack of knowledge about treatment options (Clements et al., 2021). Importantly, these barriers were largely addressable through training rather than reflecting fundamental value conflicts. This finding suggests that stigma reduction interventions targeting knowledge and skills rather than attempting to change core theological beliefs may be effective.

Theological Diversity and Denominational Differences

The literature reveals significant theological diversity across Christian traditions, with implications for addiction responses. Conservative Protestant congregations, particularly those with charismatic practices (e.g., speaking in tongues), are more likely to provide substance use programming (Torres, Fulton, Wong, & Pitkin Derose, 2022). This association may reflect theological emphases on personal transformation, spiritual warfare, and the power of the Holy Spirit to deliver individuals from bondage. Pentecostal and charismatic traditions, in particular, often frame addiction as a spiritual battle and emphasize experiential encounters with the Holy Spirit as mechanisms of change. Longitudinal research on the Lazarus Project, a Pentecostal-based residential program, found that Spirit baptism, a distinctive Pentecostal experience, was associated with sustained recovery (Williamson & Hood, 2018). This finding highlights how tradition-specific theological practices may function as therapeutic mechanisms. In contrast, mainline Protestant and Catholic traditions may emphasize sacramental grace, communal support, and integration with professional treatment. Research examining United Methodist, Episcopal, and Jewish congregations found that readiness to engage in addiction programming varied by tradition and was influenced by congregational resources, leadership commitment, and prior experience with social service provision (Travis, Vazquez, Spence, & Brooks, 2021).

Implications of Theological Frameworks

Theological frameworks have profound implications for program design, participant experience, and collaboration with secular systems. Programs grounded in sin-based frameworks may emphasize repentance, accountability, and moral transformation, potentially intensifying shame for some participants while providing meaningful structure for others. Programs grounded in disease models may emphasize treatment, medication, and professional care, potentially reduce stigma, but risk the loss of spiritual meaning that many participants seek. Hybrid models that integrate medical and spiritual understandings appear increasingly common. For example, the Genesis Process explicitly combines "biblical principles with brain science" to promote "real and permanent change" (Naegeli, 2017). Such integration may offer the benefits of both frameworks' medical legitimacy and spiritual meaning, though it also requires careful navigation of potential tensions. The literature suggests that effective faith-based responses require theological flexibility and humility. Congregations that can hold multiple frameworks simultaneously, acknowledging addiction as both a medical condition requiring treatment and a spiritual struggle requiring grace, may be best positioned to provide compassionate, effective support. Moreover, awareness of how theological frameworks shape participant experience can inform culturally competent care and facilitate collaboration between faith-based and secular providers.

3. CONGREGATIONAL PREVENTION AND EARLY INTERVENTION

Beyond treatment and recovery, religious congregations engage in prevention and early intervention efforts, particularly targeting youth and families. The literature documents diverse approaches, from formal prevention programs to informal social support and community accountability.

Prevalence and Predictors of Prevention Programming

National survey data provides the most robust evidence on the prevalence of congregational prevention efforts. Analysis of the 2012 National Congregations Study found that approximately 38% of U.S. congregations provided substance use support programming, with roughly half of all congregational attendees belonging to a congregation offering such services (Torres et al., 2022). A subsequent analysis using 2018–19 data found that nearly half (43.6%) of congregations provided support groups for mental illness or substance use disorders, with rates increasing among Christian congregations between 2012 and 2018–19 (Holleman, 2024). Several congregational characteristics predict the provision of prevention programming. Congregations with younger members, unemployed members, conservative Protestant affiliation, charismatic practices, and resources for social services are more likely to offer substance use programming (Torres et al., 2022). External factors also matter; congregations that assess community needs and host social service

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speakers are more likely to provide programming (Torres et al., 2022). These findings suggest that both internal capacity (resources, theological orientation) and external engagement (community assessment, partnerships) facilitate prevention efforts.

Youth-Focused Prevention Programs

Youth represent a priority population for congregational prevention efforts, given that many substances use disorders begin in adolescence. The literature documents several models of youth-focused prevention, though rigorous outcome evaluations remain scarce. One evaluated model is the Adolescent Intervention Program (AIP), a faith-based drug and alcohol prevention program for adolescents referred by juvenile courts as an alternative to incarceration. A quality improvement evaluation of AIP found a 98% program completion rate, with only 1–2% of participants returning for a second attempt and a 5% recidivism rate (Clancy & Mechling, 2025). Stakeholders reported that the program effectively prevented substance use disorders and provided an alternative to jail (Clancy & Mechling, 2025). However, the evaluation relied on stakeholder interviews rather than controlled outcome measurement, limiting causal inference. Beyond formal programs, congregations provide informal prevention through youth groups, mentoring, and family support. Qualitative research suggests that these activities function as protective social networks, providing adult supervision, prosocial peer relationships, and value formation. However, literature lacks rigorous studies quantifying the protective effects of congregational youth programming on substance use initiation or escalation.

Community-Level Prevention and Social Capital

Congregations contribute to prevention not only through formal programs but also through community-level social capital, the networks, norms, and trust that facilitate collective action. Several studies suggest that congregational participation is associated with lower substance use, mediated by social support, accountability, and value reinforcement. Research examining the potential service population for congregational outreach found that 8.3 million Americans with substance use disorders attend religious services monthly but do not receive treatment (Heikkila, Edens, Stefanovics, Rhee, & Rosenheck, 2022). This group, disproportionately African American, had fewer socio-demographic disadvantages, behavioral problems, and illicit drug use diagnoses compared to those receiving treatment, suggesting that religious participation may function as a protective factor (Heikkila et al., 2022). However, the cross-sectional design precludes causal inference; it is equally plausible that individuals with more severe problems disengage from religious participation. Ethnographic research on faith-based responses to the opioid crisis in Massachusetts documented how a church-led memorial campaign fostered community engagement, social support, and political action (Campbell, 2022). The campaign, which displayed over 2,000 billboards and lawn signs commemorating overdose deaths, created opportunities for conversation, reduced isolation, and mobilized community resources (Campbell, 2022). This case illustrates how congregations can contribute to prevention by contesting stigma, building solidarity, and advocating for policy change.

Barriers to Prevention Programming

Despite the prevalence of prevention efforts, significant barriers exist. The most commonly cited barrier is lack of training and preparedness. Validation of the Church Addiction Response Scale found that while most respondents were willing to help, many felt underprepared, particularly regarding addiction physiology, treatment options, and how to avoid harm (Clements et al., 2021). This gap between willingness and readiness suggests that capacity-building interventions training, technical assistance, and resource provision, could substantially enhance congregational prevention efforts. Stigma also impedes prevention. Congregations where addiction is viewed primarily as moral failure may create environments where individuals and families are reluctant to disclose substance use problems or seek help. Conversely, congregations that normalize help-seeking and frame addiction as a health issue may facilitate early intervention. Resource constraints limit prevention programming, particularly in smaller congregations. Analysis of congregational predictors found that having staff dedicated to social services and financial resources for programming was associated with substance use support provision (Torres et al., 2022). Many congregations, particularly in rural and low-income communities, lack such resources.

Implications for Prevention

The literature suggests that congregations represent a substantial but underutilized resource for substance use prevention. With nearly half of U.S. congregations providing some form of programming and millions of Americans attending religious services regularly, the potential reach is considerable. However, realizing this potential requires addressing barriers related to training, resources, and stigma. Evidence-based prevention programs could be adapted for congregational settings, with attention to theological compatibility and cultural fit. For example, programs emphasizing family strengthening, youth development, and community engagement align well with congregational missions and capacities. Partnerships between public health agencies and congregations could provide training, technical assistance, and evaluation support. Moreover, congregations' contributions to prevention extend beyond formal programs to include social capital, community norms, and advocacy. Public health approaches that recognize and leverage these broader contributions rather than viewing congregations solely as program delivery sites may be most effective.

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4. FAITH-BASED TREATMENT AND RECOVERY MODELS

The literature documents a diverse array of faith-based treatment and recovery models operating in the United States, ranging from peer-led support groups to residential programs. These models vary in theological orientation, intensity, integration with professional treatment, and evidence base.

Twelve-Step Spirituality and Christian Adaptations

Twelve-step programs, particularly Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), represent the most widespread faith-influenced recovery model in the United States. While AA and NA are not explicitly religious and emphasize "God as we understood Him," their spiritual foundations and practices have deep roots in Christian theology, particularly the Oxford Group movement. Research on the construct of "God" in twelve-step programs found that members' conceptions of a Higher Power vary widely, from traditional theistic beliefs to more abstract notions of interconnection and group support (Kelly, Greene, & Bergman, 2018). Qualitative research on AA members in Los Angeles found that many adopt a "spiritual but not religious" orientation, seeking healing truth outside traditional religious organizations while drawing on twelve-step spirituality (Davis & Jason, 2020). This perennialist orientation, emphasizing universal spiritual truths across traditions, allows AA to function as a "spiritual rather than religious organization," accommodating diverse beliefs (Davis & Jason, 2020). Christian adaptations of twelve-step programs explicitly integrate biblical teachings and Christ-centered theology. Celebrate Recovery, one of the most widely adopted Christian recovery programs, integrates the Twelve Steps with the Beatitudes, focusing on Christ as the Higher Power for "hurts, habits, and hang-ups" (Naegeli, 2017). The Genesis Process blends biblical principles with neuroscience, aiming for "real and permanent change" and restoration to a "formerly healthy state" (Naegeli, 2017). Analysis of these programs found that they emphasize eschatological hope the belief in God's ongoing work of restoration as a motivational resource (Naegeli, 2017). Research on twelve-step spirituality suggests that it can be as effective as, or more effective than, other forms of treatment for alcohol use disorders (Magill & Ray, 2009). Mechanisms of change include social support, accountability, identity transformation, and spiritual practices such as prayer and meditation. However, critics note that twelve-step approaches may not be suitable for all individuals, particularly those who are non-religious or who have experienced religious trauma.

Faith-Based Residential Programs

Faith-based residential programs provide intensive, immersive treatment in communal settings infused with spiritual practices and teachings. These programs vary widely in structure, duration, and therapeutic approach, but typically combine elements of behavioral therapy, spiritual formation, and communal accountability. One documented model is the Restoration Christian Outreach Community (RCOC) in northwest Mississippi, a holistic residential program for adults that integrates therapeutic faith community, servant leadership, and theophostic prayer (Smith, 2016). The program views addiction as both a choice and a spiritual battle, emphasizing Bible study, spiritual counseling, and behavior modification (Smith, 2016). While program descriptions highlight participant testimonies of transformation, rigorous outcome evaluations are lacking. The Lazarus Project, a Pentecostal-based residential program, has been the subject of longitudinal research. A five-year study found that Spirit baptism, a distinctive Pentecostal experience involving an encounter with the Holy Spirit, was associated with sustained recovery (Williamson & Hood, 2018). The program emphasizes personal transformation through spiritual experience, social control through communal accountability, and integration of psychological and spiritual dimensions (Williamson & Hood, 2018). This research provides rare longitudinal data on a faith-based residential program, though the lack of a comparison group limits causal inference. Faith-based residential programs often serve populations with complex needs, including individuals with co-occurring mental health disorders, histories of incarceration, and homelessness. Qualitative research on religion and recovery among individuals experiencing homelessness found that faith-based organizations provide essential recovery services and that religion offers personal and social benefits, addressing losses and crises associated with substance use and homelessness (Brekke et al., 2019). Understanding the specific benefits religion provides can guide program improvement and inform culturally competent care (Brekke et al., 2019).

Culturally Centered Faith-Based Initiatives

The literature highlights the importance of culturally centered faith-based initiatives that address the specific needs and contexts of racial and ethnic minority communities. The Imani Breakthrough project, a collaborative, culturally centered, community-driven faith-based opioid recovery initiative, targets Black and Latinx populations (Taylor et al., 2021). The project addresses barriers to treatment access through culturally tailored engagement strategies and partnerships with trusted community institutions, including churches (Taylor et al., 2021). Qualitative research with Black American Christian church leaders found that these leaders are empathetic, knowledgeable about opioid use disorder, and committed to helping people flourish (Dankwah et al., 2024). They view hopelessness and inequity as risk factors and welcome collaborations between church and state (Dankwah et al., 2024). This research underscores the potential of

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Black churches as partners in addressing the opioid crisis in African American communities, provided that interventions are culturally sensitive and community-driven.

Integration of Medications for Addiction Treatment

A critical question for faith-based treatment models is the integration of medications for addiction treatment (MAT), particularly medications for opioid use disorder (MOUD) such as methadone, buprenorphine, and naltrexone. Some faith-based programs have been reluctant to incorporate MAT, viewing it as substituting one drug for another or as incompatible with abstinence-based recovery philosophies. However, emerging research suggests growing openness to MAT integration. Qualitative research with Black church leaders found that many welcomed harm reduction approaches, including MAT, as part of a comprehensive response to opioid use disorder (Dankwah et al., 2024). Analysis of faith-affiliated treatment centers found variability in MOUD provision, with some centers offering integrated services and others maintaining abstinence-only approaches (Anderson & Smith, 2020). Implementation partnerships between faith-based providers and clinical systems are discussed as pathways to bridge faith-based services and evidence-based pharmacotherapy. The question of MAT integration highlights broader tensions between abstinence-based and harm reduction philosophies. Abstinence-based approaches, common in faith-based settings, emphasize complete cessation of substance use as the goal of recovery. Harm reduction approaches prioritize reducing the negative consequences of substance use, even if use continues. These philosophical differences have practical implications for program design, participant eligibility, and collaboration with medical providers.

Outcomes and Effectiveness

Evidence on the effectiveness of faith-based treatment and recovery models is mixed and methodologically limited. The literature includes program descriptions, qualitative case studies, and participant testimonies, but few controlled trials or rigorous outcome evaluations. Some studies report positive outcomes. The Adolescent Intervention Program evaluation found high completion rates and low recidivism (Clancy & Mechling, 2025). Research on twelve-step facilitation clinical interventions that encourage active participation in twelve-step groups found that such approaches increase the likelihood of sustained recovery (Magill & Ray, 2009). Qualitative studies document participant narratives of transformation, identity reconstruction, and sustained abstinence. However, the lack of controlled trials and standardized outcome measurement limits causal inference. Many studies rely on self-reports, lack comparison groups, and have short follow-up periods. Moreover, publication bias may favor studies with positive findings. A comparative study of compliance among patients in rural Appalachia found no significant difference between medical treatment and faith-based services, suggesting equivalence but not superiority (Harris et al., 2018). The heterogeneity of faith-based models also complicates outcome assessment. Programs vary widely in intensity, duration, therapeutic approach, and population served, making generalization difficult. Moreover, outcomes may depend on participant characteristics, including religious commitment, theological compatibility, and social support.

Implications for Treatment and Recovery

Faith-based treatment and recovery models represent a significant component of the U.S. addiction treatment landscape. For many individuals, particularly those with strong religious identities, faith-based programs offer meaningful, culturally congruent pathways to recovery. The integration of spiritual practices, community support, and identity transformation addresses dimensions of recovery that purely medical models may neglect. However, the evidence base for faith-based treatment remains underdeveloped. Rigorous outcome evaluations, including randomized controlled trials, are needed to establish effectiveness and identify mechanisms of change. Such research should employ standardized outcome measures, adequate follow-up periods, and attention to moderators (e.g., religious commitment, theological fit) that may influence outcomes. Moreover, integration of evidence-based practices, including MAT, cognitive-behavioral therapy, and trauma-informed care into faith-based settings requires careful attention to theological compatibility and cultural fit. Partnerships between faith-based programs and clinical providers can facilitate such integration while respecting the distinctive missions and values of faith-based organizations.

5. CLINICAL COLLABORATION AND HEALTHCARE PARTNERSHIPS

The literature increasingly documents collaborations between religious congregations and healthcare systems, reflecting recognition that effective addiction responses require coordination across sectors. These partnerships take various forms, from informal referral relationships to formal integration of services.

Models of Collaboration

Several models of collaboration emerge from literature. First, congregations serve as referral sources, connecting individuals with substance use problems to professional treatment. National survey data found that congregations with external partnerships and community engagement are more likely to provide substance use programming (Torres et al., 2022), suggesting that referral relationships are common. Second, congregations host or co-locate clinical services. Some congregations provide space for support groups, counseling

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services, or even medication-assisted treatment. Research on whether churches can bring addiction treatment to rural areas explores the potential for congregations to serve as access points for MAT in underserved communities (Hogue et al., 2021). Third, faith-based organizations operate as licensed treatment providers, integrating spiritual and clinical services. Analysis of faith-affiliated treatment centers found that some offer medications for opioid use disorder and co-occurring mental health services, functioning as hybrid organizations that blend faith-based and clinical approaches (Anderson & Smith, 2020). Fourth, congregations participate in community coalitions and public health initiatives. The 2069 campaign in Massachusetts exemplifies how congregations can partner with public health agencies, medical professionals, and law enforcement to provide overdose response training, naloxone distribution, and social support (Campbell, 2022). Such collaborations leverage the complementary strengths of faith-based and secular organizations.

Facilitators of Collaboration

Several factors facilitate collaboration between congregations and healthcare systems. First, shared goals and mutual respect create a foundation for partnership. Qualitative research with Black church leaders found that many welcomed collaborations with medical and public health systems, viewing such partnerships as consistent with their mission to promote community well-being (Dankwah et al., 2024). Second, training and capacity building enable congregations to serve as effective partners. Research on congregational readiness found that awareness of resources for substance use problems was a primary predictor of readiness to engage in recovery support programming (Travis et al., 2021). Training that enhances congregational knowledge of treatment options, referral pathways, and harm reduction principles can facilitate collaboration. Third, cultural competence and sensitivity to religious values are essential. Healthcare providers who understand and respect the theological frameworks and spiritual practices of faith communities are better positioned to build trust and collaborate effectively. Conversely, approaches that dismiss or pathologize religious beliefs may alienate potential partners. Fourth, structural supports, including funding, technical assistance, and formal partnership agreements, can sustain collaboration. Public health agencies that provide grants, training, and consultation to faith-based organizations can enhance their capacity to serve as partners in addiction response.

Barriers to Collaboration

Despite the potential benefits, significant barriers impede collaboration. First, theological tensions around harm reduction and MAT create friction. Some faith-based organizations view harm reduction as incompatible with their values, preferring abstinence-based approaches. Ethnographic research in rural Indiana documented how religious opposition to needle exchange, framed in terms of moral objection to drug use, impeded public health efforts (Szott, 2020). Second, concerns about religious coercion and church-state separation create legal and ethical complexities. Healthcare providers and policymakers may be reluctant to partner with faith-based organizations if such partnerships risk imposing religious beliefs on participants or violating constitutional boundaries. These concerns are particularly acute when public funding is involved. Third, resource and capacity constraints limit congregational ability to serve as effective partners. Many congregations lack staff with clinical training, infrastructure for data collection and reporting, and financial resources for sustained programming. Partnerships that place unrealistic expectations on congregations may fail. Fourth, stigma and mistrust can impede collaboration. Some individuals with substance use disorders may have experienced judgment or rejection in religious settings and may be reluctant to engage with faith-based services. Conversely, some congregations may be wary of secular systems perceived as hostile to religious values.

Case Examples of Successful Collaboration

The literature provides several examples of successful collaboration. The Imani Breakthrough project exemplifies a collaborative, culturally centered, community-driven initiative that partners faith-based organizations with clinical providers to address opioid use disorder in Black and Latinx communities (Taylor et al., 2021). The project employs culturally tailored engagement strategies and addresses barriers to treatment access through trusted community institutions. The 2069 campaign in Massachusetts demonstrates how congregations can partner with public health agencies to provide overdose response training, naloxone distribution, and social support (Campbell, 2022). The campaign fostered community engagement, reduced stigma, and facilitated access to treatment through initiatives like the "Massachusetts Daily Detox Bed List" (Campbell, 2022). Research on congregational readiness found that interventions targeting organizational capacity including training, resource provision, and leadership development can enhance congregations' ability to engage in recovery support programming (Travis et al., 2021). Such capacity-building interventions represent a form of collaboration in which public health agencies support congregational efforts.

Implications for Collaboration

Effective collaboration between congregations and healthcare systems requires mutual respect, shared goals, and attention to both facilitators and barriers. Public health agencies and healthcare providers should view congregations as partners with distinctive strengths, including community trust, cultural competence, and spiritual resources, rather than merely as program delivery sites. Training and technical assistance can enhance congregational capacity to serve effective partners. Such support should address both practical skills

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(e.g., referral procedures, harm reduction principles) and theological concerns (e.g., integrating MAT with spiritual care). Moreover, collaboration should be bidirectional, with healthcare providers learning from congregational leaders about community needs, cultural values, and spiritual dimensions of recovery. Policy frameworks that support collaboration while respecting church-state boundaries are needed. Public funding mechanisms should ensure that faith-based organizations receiving public funds do not engage in religious coercion, discriminate based on religion, or impose religious practices on participants. At the same time, policies should not exclude faith-based organizations from partnerships solely because of their religious identity.

6. ETHICAL, LEGAL, AND POLICY CONSIDERATIONS

Faith-based responses to addiction raise important ethical, legal, and policy questions, particularly regarding religious coercion, inclusivity, public funding, and the integration of evidence-based practices. The literature addresses these issues with varying degrees of depth and empirical grounding.

Religious Coercion and Voluntariness

A central ethical concern is religious coercion the imposition of religious beliefs or practices on individuals seeking addiction services. Coercion can occur in several contexts: court-mandated participation in faith-based programs, faith-based residential programs that require religious participation as a condition of admission or continued residence, and congregational programs that conflate spiritual and clinical care. The literature provides limited empirical data on the prevalence and impact of religious coercion in addiction services. Some studies note that individuals may be referred to faith-based programs by courts or probation officers, raising questions about voluntariness. The Adolescent Intervention Program evaluation, for example, described a faith-based program serving adolescents referred by juvenile courts (Clancy & Mechling, 2025). While the program reported positive outcomes, the evaluation did not assess whether participants experienced religious coercion or how non-religious participants experienced the program.

Legal standards regarding religious coercion in publicly funded or court-mandated programs are well-established. The First Amendment's Establishment Clause prohibits government from advancing or endorsing religion, and courts have held that individuals cannot be compelled to participate in religious activities as a condition of receiving government benefits or fulfilling legal obligations. However, enforcement of these standards is uneven, and some individuals may experience pressure to participate in religious activities without formal legal recourse (Greenawalt, 2017). Ethical best practices emphasize informed consent, voluntary participation, and availability of secular alternatives. Faith-based programs should clearly communicate their religious nature, allow participants to opt out of religious activities without penalty, and ensure that clinical services are not contingent on religious participation. When public funding is involved, these protections are particularly important.

Inclusivity and Religious Diversity

A related concern is inclusivity, whether faith-based addiction services are accessible and welcoming to individuals of diverse religious backgrounds, including non-Christians, non-religious individuals, and those who have experienced religious trauma. The literature reveals that the vast majority of faith-based addiction services in the United States are Christian, with limited representation of other faith traditions. Some research addresses inclusivity within Christian contexts. Qualitative research on AA found that the organization's emphasis on "God as we understood Him" allows for diverse conceptions of a Higher Power, accommodating both traditional theistic beliefs and more abstract spiritual notions (Kelly et al., 2018; Davis & Jason, 2020). This theological flexibility may enhance inclusivity, though critics note that AA's Christian roots and language may still alienate some individuals. Research on culturally centered faith-based initiatives highlights the importance of tailoring programs to specific communities. The Imani Breakthrough project, for example, was designed to be culturally centered and community-driven, addressing the specific needs and contexts of Black and Latinx communities (Taylor et al., 2021). Such tailoring can enhance inclusivity by ensuring that programs reflect participants' cultural and religious identities. However, the literature provides limited empirical data on the experiences of non-Christian and non-religious individuals in faith-based addiction services. Research is needed to understand how individuals from diverse religious backgrounds experience faith-based programs, what barriers they encounter, and what adaptations might enhance inclusivity.

Public Funding and Church-State Separation

The use of public funds to support faith-based addiction services raises constitutional and policy questions. The First Amendment's Establishment Clause prohibits government from advancing or endorsing religion, while the Free Exercise Clause protects religious organizations' autonomy. Balancing these principles in the context of publicly funded social services has been the subject of extensive legal and policy debate (Greenawalt, 2017). Federal policy has evolved over time. The Charitable Choice provisions of the 1996 welfare reform law and subsequent faith-based initiatives under the George W. Bush and Barack Obama administrations expanded opportunities for faith-based organizations to receive public funding for social services, including addiction treatment. These policies include

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safeguards intended to prevent religious coercion, such as requirements that faith-based organizations provide secular alternatives and not discriminate based on religion in hiring or service provision.

The literature provides limited empirical evaluation of the implementation and impact of these policies in the addiction services context. Some studies note that faith-based organizations receive public funding for addiction services, but detailed analyses of how such funding affects program design, participant experience, and outcomes are scarce. Research is needed to assess whether safeguards against religious coercion are effectively implemented and whether publicly funded faith-based programs achieve outcomes comparable to secular programs (Greenawalt, 2017). Policy debates also address whether public funding should support faith-based organizations that maintain religious hiring practices or integrate religious content into services. Proponents argue that such organizations provide valuable services and that excluding them from public funding violates religious freedom. Critics argue that public funds should not support organizations that discriminate or proselytize. These debates reflect broader tensions about the role of religion in public life.

Integration of Evidence-Based Practices

Another policy consideration is the integration of evidence-based practices into faith-based addiction services. Evidence-based practices, including medications for addiction treatment (MAT), cognitive-behavioral therapy, and trauma-informed care, have been shown to improve outcomes. However, some faith-based programs have been reluctant to adopt these practices, citing theological concerns or philosophical differences. The literature documents growing openness to evidence-based practices in some faith-based settings. Qualitative research with Black church leaders found that many welcomed harm reduction approaches, including MAT (Dankwah et al., 2024). Analysis of faith-affiliated treatment centers found variability in MOUD provision, with some centers integrating medications and others maintaining abstinence-only approaches (Anderson & Smith, 2020). Implementation partnerships between faith-based providers and clinical systems are discussed as pathways to facilitate integration.

However, barriers remain. Some faith-based programs view MAT as incompatible with abstinence-based recovery philosophies or as substituting one drug for another. Ethnographic research documented religious opposition to harm reduction interventions like needle exchange (Szott, 2020). Addressing these barriers requires dialogue, education, and demonstration of how evidence-based practices can be integrated with spiritual care in ways that respect theological values. Policy mechanisms to encourage evidence-based practice integration include funding incentives, technical assistance, and quality standards. Public funding could be contingent on the adoption of evidence-based practices, though such requirements must be balanced against respect for religious autonomy. Technical assistance and training can help faith-based organizations understand and implement evidence-based practices in ways consistent with their missions.

Ethical Considerations in Research and Evaluation

The literature also raises ethical considerations in research and evaluation of faith-based addiction services. Informed consent, confidentiality, and protection of vulnerable populations are paramount. Research involving faith-based programs must navigate the dual roles of clergy and lay leaders as both spiritual guides and research participants or gatekeepers. Moreover, evaluation of faith-based programs should employ culturally appropriate methods and measures. Outcome measures developed in secular contexts may not capture the spiritual dimensions of recovery that are central to faith-based programs. Qualitative and mixed-methods approaches that attend to participants' own understandings of recovery and well-being may be particularly valuable.

Implications for Policy and Practice

Ethical, legal, and policy considerations are central to the role of faith-based organizations in addiction services. Clear standards and safeguards are needed to prevent religious coercion, ensure inclusivity, and protect constitutional rights. At the same time, policies should not exclude faith-based organizations from partnerships and funding solely because of their religious identity, provided that appropriate safeguards are in place. Dialogue and collaboration among policymakers, healthcare providers, faith-based organizations, and affected communities can help navigate these complex issues. Such dialogue should address theological concerns, legal requirements, and practical considerations, seeking solutions that respect both religious freedom and individual rights. Research and evaluation are essential to inform policy. Empirical studies of the implementation and impact of publicly funded faith-based addiction services, the experiences of diverse participants, and the integration of evidence-based practices can provide an evidence base for policy decisions.

Research Gaps and Future Directions

Despite growing scholarship on religious responses to addiction in the United States, the evidence base remains underdeveloped in several critical areas. Most studies are qualitative, descriptive, or cross-sectional, with very few rigorous controlled evaluations. The near-absence of randomized or well-controlled comparative studies limits conclusions about effectiveness and prevents meaningful

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comparisons between faith-based, hybrid, and secular models. Longitudinal research is also scarce, leaving questions about the durability of outcomes, relapse trajectories, and long-term recovery capital insufficiently answered. The literature remains heavily focused on Christian congregations, with minimal attention to other faith traditions, despite the religious diversity of the U.S. population. Greater inclusion of non-Christian communities is essential for culturally competent and policy-relevant scholarship. In addition, while trauma-informed care is widely recognized as best practice in addiction treatment, little research addresses how trauma-sensitive principles can be integrated into spiritual care without reinforcing shame or religious harm. Mechanisms of change also remain poorly specified. It is unclear whether outcomes are driven primarily by spiritual practices, social support, identity transformation, moral frameworks, or their interaction. Research into tests shows that mediating and moderating pathways are needed. Finally, limited attention has been given to ethical safeguards, inclusivity, and implementation science approaches that support sustainable collaboration between congregations and healthcare systems. Strengthening methodological rigor, theoretical clarity, and inclusivity will be essential for advancing the field.

Implications for Practice and Policy

The findings of this review carry implications for congregational leaders, healthcare providers, policymakers, and researchers, particularly regarding capacity-building, collaboration, and ethical safeguards. For congregational leaders, addiction response should be understood as both a pastoral and public health responsibility. Strengthening institutional capacity through training in addiction science, trauma-informed care, and evidence-based practices is essential. Reducing stigma through theological reflection that integrates compassion with medical understanding can help improve help-seeking and community support. Sustainable engagement also requires formalized referral networks, partnerships with treatment providers, and clear safeguards ensuring voluntariness and inclusiveness. Basic program evaluation practices can further enhance accountability and effectiveness. Healthcare providers should recognize spirituality as a meaningful recovery resource for many patients. Routine assessment of spiritual needs, respectful engagement with faith identities, and collaborative relationships with congregations can enhance continuity of care. At the same time, providers must advocate for evidence-based treatment integration and remain attentive to potential coercion or exclusion in faith-based settings. Policymakers should acknowledge congregations as community-based partners while establishing clear standards that protect constitutional rights, prevent coercion, and promote inclusivity. Funding mechanisms and technical assistance can support responsible collaboration, but oversight and outcome monitoring remain essential. For researchers, advancing the field requires stronger methodological rigor, interdisciplinary collaboration, and translational scholarship that bridges theology and public health.

7. CONCLUSION

This narrative review synthesizes contemporary U.S.-based scholarship on religious responses to addiction and reveals a complex but consequential landscape in which congregations function as prevention sites, recovery communities, referral hubs, and informal safety-net providers. Across the literature, theological frameworks emerge as central drivers of institutional behavior: interpretations of addiction as sin, disease, or spiritual dislocation shape stigma, openness to medication-assisted treatment, and willingness to collaborate with healthcare systems. While many congregations engage in youth prevention, recovery ministries, and community reintegration efforts, rigorous outcome evaluation remains limited, and integration with evidence-based practices is uneven. Emerging partnerships between faith communities and clinical providers demonstrate promise but are often constrained by training gaps, resource limitations, and ethical concerns related to voluntariness, inclusivity, and public funding. Significant research gaps persist, including limited longitudinal data, insufficient attention to mechanisms of change, underrepresentation of non-Christian traditions, and the need for trauma-informed spiritual care models and implementation research. Despite these challenges, congregations represent a substantial yet underutilized component of the U.S. addiction response infrastructure. Realizing their potential requires strengthening capacity, advancing empirical rigor, fostering cross-sector collaboration, and ensuring that faith-based services remain evidence-informed, rights-respecting, and accessible to individuals of diverse beliefs and backgrounds.

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