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ORIGINAL PAPER

Urban Religious Congregations' Responses to Community Substance Use: An Exploratory Study of Four Cases

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Abstract

Faith-based drug treatment programs are common, and many are implemented through congregations; however, little is documented about how congregations conceptualize and implement these programs. We use case study analysis to explore congregational approaches to drug treatment; qualitative findings emerged in three areas: (1) religion's role in congregational responses to substance use, (2) relationships between program participants and the broader congregation, and (3) interactions between congregational programs and the external community. Congregational approaches to drug treatment can be comprehensive, but work is needed to evaluate such efforts. Congregants' attitudes may influence whether program participants become members of a sustaining congregational community.

Keywords Substance abuse · Religious congregations · Faith based · Case study · Health disparities

Introduction

In 2015, an estimated 20.8 million people over the age of 12 in the USA (7.8% of the total population) met criteria for substance use disorder (SUD), but only 3.7 million received treatment (Center for Behavioral Health Statistics and Quality 2016). This wide discrepancy indicates substantial unmet need. Moreover, certain subgroups, such as African-Americans and Latinos (Wells et al. 2001) and the uninsured

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(Center for Behavioral Health Statistics and Quality 2016), have a larger burden of unmet need than the general population (Jacobson et al. 2007; Perron et al. 2009).

Faith-based SUD programs could help address unmet need among African-Americans and Latinos given their high levels of religiosity compared with other racial-ethnic groups (Pew Research Center 2015). In 2008, there were 527 treatment facilities for SUD in the USA that were either faith based or were associated with a religious organization but not associated with a hospital (Substance Abuse and Mental Health Services Administration 2010). These faith-based treatment facilities were more likely than their secular counterparts to provide halfway or transitional housing support (24.1 vs. 10.4%), offer free SUD treatment to all clients (10.6 vs. 3.4%), and provide free treatment to clients who were unable to pay (59.4 vs. 45.2%).

There are approximately 300,000 religious congregations in the USA (Chaves 2004), and it appears that an increasing proportion provide services related to SUD. Analyses of the 2006 wave of the National Congregation Study (NCS) found that only 8% of US congregations reported having programs to address mental health or substance use issues (Frenk 2014). However, in the 2012 NCS, 38% of US congregations reported providing programs for substance use problems and 23% reported providing mental health programs (Wong et al. 2017). Unfortunately, there is little documentation describing the structure, operation, and characteristics of substance use treatment programs offered by religious congregations for their local communities. Travis et al. (2012) found that the primary determinants of congregational readiness to respond to SUD in the local community were congregants' attitudes toward addiction and recovery and their perceptions of self-efficacy in helping others. Other work on faith-based responses to SUD has focused on individual clergy's role in addressing SUD (Dominguez et al. 2006) or mental disorders more generally (Leavey et al. 2007; Wang et al. 2003), or on programs delivered by faith-based organizations other than congregations, such as the Salvation Army (McCoy et al. 2005; Neff et al. 2006). Finally, there are SUD treatment programs developed by researchers for congregation-based settings, but a systematic review of such programs in African-American churches found only three that focused on substance-related disorders other than tobacco (Hankerson and Weissman 2012).

This paper explores the characteristics of congregation-based SUD treatment programs in a diverse sample of urban religious congregations. Close examination of the structural components and dynamics of faith-based programs can provide critical understanding of on-the-ground responses to SUD. Better understanding of congregational programs can shed light on their contributions to substance use treatment, inform efforts to evaluate them, and identify where collaborations between faith based and secular providers may be most beneficial.

Methods

Data for this study come from a project exploring how congregations in Los Angeles County have responded to HIV and other health issues, including SUD (Derose et al. 2011). The larger study involved a case study of 14 congregations and was guided by a community-based participatory research (CBPR) approach (Israel et al.

1998, 2010), in which a community advisory board (CAB) of local clergy and public health leaders was involved throughout all stages, including development of study protocols, recruitment of congregations, interpretation of findings, and dissemination.

Geographic Setting and Case Identification

Our study focused on the three geographic areas within Los Angeles County that are most highly affected by HIV, according to county health department surveillance data. We compiled a list of 80 congregations that had been involved in HIV in the three study areas through the assistance of local experts and administered a brief telephone screening questionnaire (with a response rate of 88%). Using the screening data in consultation with our CAB, we identified a purposive sample of 14 congregations to obtain variation on our principal outcome of interest (level and type of HIV activities) as well as factors that are known to influence the implementation of HIV and other types of health programs in congregations, such as racial and ethnic profile of the congregation, religious denomination or faith tradition, and congregational size and resources (Tesoriero et al. 2000; Thomas et al. 1994).

Data Collection

Our research team employed a range of data collection methods during several visits over roughly a 1-year period for each case congregation, as reported elsewhere (Derose et al. 2011). The primary source of data for this paper consisted of interviews with 3–6 clergy and lay leaders per congregation, covering leaders' background and experience; congregational mission and priorities; congregational involvement in SUD and health-related activities; denominational and congregational policies regarding drug and alcohol use; leader and congregation attitudes, especially toward SUD; community characteristics; and collaborations between the congregation and community organizations. The interviews typically lasted 1.5 h (range 1–4 h), were audio-recorded, and transcribed verbatim.

Case Selection

Of 14 congregations, nine had developed an explicit response to SUD. For this analysis, four congregations were selected that (1) met certain criteria of data richness in order to sufficiently describe each SUD program and its relationship to the congregation (data richness was defined as having two or more respondents within a congregation discussed SUD programming, the topic came up in more than one exchange during interviews, and respondents discussed multiple themes related to SUD), and (2) represented a range of congregational types in terms of size, race ethnicity, faith tradition, and type of programmatic response to SUD. The five congregations that were not selected all had congregations whose compositions were predominantly African-American: three Mainline Protestant congregations whose denominations and type of SUD programs were similar to selected cases (12-step

approach, halfway or transition homes, and gang and drug prevention among youth); a Catholic congregation that was minimally involved (provided interview clothes for an outside rehab center); and a Pentecostal congregation that was also minimally involved in SUD (only had occasional speakers on the topic).

Analysis

As described elsewhere (Derose et al. 2011), we used Atlas.ti and content-coding procedures to mark quotations related to the major variables in our conceptual framework (Altheide 1996; Krippendorff 1980; Weber 1990); and we used an inductive approach to identify new themes and sub-themes (Miles and Huberman 1994; Strauss and Corbin 1990). Research team members worked in pairs using qualitative text management software (Muhr 2006) to test-code, then fully code, the interview transcripts, periodically double-coding transcripts at prescribed intervals to maintain inter-rater reliability, resolve discrepancies, and confirm emergent themes by consensus.

For this paper, we used codes related to the health activities of congregations, which included descriptions of SUD programs and activities, how they were organized and run, populations served, their extent and intensity, and changes over time. We also used codes from the attitudes and beliefs and religious doctrine sections of the coding tree, in particular the subcategories that focused on alcohol and drug use. Finally, we used codes related to community interactions between the congregation and external entities. Narratives were analyzed using categorical-content and categorical-form analysis (Lieblich et al. 1998). The process was iterative: A general question was posed (e.g., what is the structure of the congregational programs?) followed by more detailed questions. Interview responses related to specific research questions were further coded into thematic subcategories. Using a process of constant comparison of text in each thematic category, the categories were expanded, constricted, or refined to more accurately fit the data.

Results

Case Congregation and Participant Characteristics

Four case congregations were examined to explore the range and types of congregational responses to SUD. Congregations were diverse in terms of racial-ethnic composition and denomination (see Table 1), as well as size. All four programs were founded by individuals who were in recovery, and most had individuals in recovery in their current leadership. The types of programs included rehabilitation homes, support groups, and mental health and substance use counseling. All the programs included an explicit spiritual, if not theological, component, and two incorporated 12-step approaches. Participants in all programs included both congregants and community members who were not congregants. Interview respondents were diverse in terms of race ethnicity, sex, and congregational role (see Table 2). Of the

Table 1 Summary of congregational substance abuse program cases ($n=4$)

Congregational type (religious denomination, predominant race ethnicity, and size)	Local program leadership	Primary substance abuse programming	Clientele for substance abuse programming	Key program characteristics
Protestant African-American 200 members	Person with history of substance dependence or abuse (clergy in training)	Christian 12-step support group for drugs and alcohol	African-American Primarily general community members and residents of a local transition home, but open to congregants	Substitution of 12 *spiritual* steps for 12-steps
Jewish (Reform) Primarily Caucasian 1000 members	Persons with history of substance dependence or abuse (laity)	Jewish 12-step support group for drugs and alcohol	Jewish Persons with HIV or at risk Congregants and general community members	Incorporates Jewish "flair" and teachings, but not explicitly religious Direct and evolving response to immediate congregation and community needs
Non-denominational (evangelical Christian) Latino (Primarily non-immigrant, English-speaking) 250 members	Persons with history of substance dependence or abuse and gang members (some clergy, some laity)	Rehabilitation homes, Bible study/prayer meetings	Latinos not targeted but are predominant group General community members, considered prospective congregants Persons with serious mental health issues screened out	Highly structured Evangelistic
Roman Catholic (charismatic) Latino (Primarily immigrant, Spanish-speaking) 10,000 members	Persons with history of substance dependence or abuse and gang members (laity)	Retreats, mental health and substance use counseling, family interventions	Latino Youth and their families Congregants and general community members	Addresses gang, substance abuse, and other health risk behaviors Explicit attention to multiple family and social factors of recovery, in addition to individual

Table 2 Interview respondent demographics ($n = 16$)

Characteristic	Number of interviewees
Race ethnicity	
African American	3
Latino	7
White	6
Sex	
Male	10
Female	6
Congregational role	
Clergy	6
Lay	10

six clergy interviewees, three had master's degrees and four had been ordained over 10 years (of the other three, one had an associate's degree and the other two had high school degrees and ministry training from their organizations).

Qualitative Results

Recurring themes that emerged from the analysis were grouped into three areas: the role of religion in each congregation's SUD programming; the relationship between program participants and the broader congregation; and the interactions between congregational SUD programs and the external community.

Theme 1: Role of Religion in Programmatic Responses to Substance Use

Each SUD program offered by the congregations was religious in nature. However, similar to findings by Dominguez et al. (2006), the specific role that religion played varied. We found two types of responses: (1) in two cases, religion added value and faith-specific meaning to 12-step treatment models; (2) in the other two cases, religion framed engagement with program participants more explicitly in terms of redemption from sin or salvation.

Type 1, Added Meaning In two cases, religion was framed as responding to an unmet but widely expressed need in the community. With these programs, respondents described a need for religiously themed recovery services to supplement or replace secular ones. The primary example of this was adding a more explicit religious component to the 12-step recovery narrative.

African American Protestant 12-step group A recovery program in an African American Protestant congregation was described by the pastor as: "A 12-step program. But it has, you know, some differences. We are a church. So, we do use the Bible. People who don't believe don't have to participate" [*African American female*]. This program developed its own version of the 12 steps to recovery to add specific religious value to the traditional, mostly theistically-neutral versions.

One member of this congregation recounted the added power of the congregation's Christ-centered adoption of the 12-step model as he described specific interactions with persons living with HIV:

> The people that I have that come here-sometimes we have fifty to sixty people-sometimes it's standing-room only, I have to go find seats for them; that is suffering with the disease and not only suffering with the disease, but they're still suffering with the addiction. So you combine all that together and it's almost like, "I don't have no hope." You know, "I'm going to die from AIDS." "I'm going to die from," you know, it just, when your mind is cloudy like that, you really don't see hope, but because of the way we teach the twelve spiritual ways to recovery and Christ is involved in that, in the middle of that, we try to show them that there is hope. God is able to do anything. [*African American male*]

Jewish 12-step group When describing the program offered by the Jewish Reform congregation, one respondent similarly highlighted this added meaning:

> [It's different from regular 12-step groups] I'd say a little bit of Jewish flavor added to it. And we say the blessing over the bread. And occasionally the Rabbi will bring out references from the Torah [Hebrew Bible] that we get to pick apart, so, not so much spiritual, but with a Jewish flair…[*White male*]

Another interviewee described the history of the Jewish 12-step group and explained that the synagogue started the group as a service to members but eventually expanded to the larger Jewish community with the understanding that there was a relative lack of local 12-step groups emphasizing Jewish culture and spirituality. A third member of the synagogue, who is also a participant in the group, described how they often get the best attendance on High Holy Days such as Yom Kippur, where they hold the support group in between key services. In addition, this congregation provides a lecture series on Judaism and the 12 steps to recovery and holds a community workshop on methamphetamine abuse.

In both congregations, incorporation of faith-specific components added value to better fit the needs of religious participants or meet the needs of participants who were not always religious but for whom a religious framework was seen as helpful. Participants in these groups were often also involved in other, secular, groups, including other 12-step support groups, individual counseling, and residential treatment. However, the congregation-based groups provided a unique space for group participants who saw their recovery as being strongly connected to their own faith development.

Type 2, Sin and Salvation Framework In the other two cases, religion was incorporated into the response to substance use in a more evangelistic way, i.e., to "save" people and "heal" them of SUD, directly as a result of faith and connection to God. Leaders were motivated to provide services to substance users because of a religious calling and saw the introduction of religious-themed treatment services as useful and in fact necessary for the community.

Latino evangelical rehab homes In contrast with the programs that closely integrated religious narratives into traditional treatment models, the non-denominational Latino congregation that sponsored rehabilitation homes used a more comprehensively religious approach to treatment, as described by one interviewee:

> But in other words, what they're saying is, "Okay man, we're going to feed you, we're going to love you, it's going to be a family atmosphere. We're Christ-centered. You're going to go to church, you're going to learn the Bible, you're going to learn how to pray. And if that's not you, if that's not your cup of tea, you're looking for a secular program, then maybe this ain't the place for you. But, hey, you're not paying for it, it's free, you know what I mean?" It's proven, we have hundreds of people right here in our church that can say, "Hey, I went through the [rehab] home." [*Latino male*]

Another respondent in this congregation identified feeling lost but coming to know oneself in Christ as the mechanism for recovery from SUD:

> Like a lot of us, we-like myself, I was in a state rehab program and in and out of jail, institutions and everything I tried just couldn't help me get back on my feet, til I got involved with the spiritual part of my life. And that's what kept me. I was able to find myself, because I was so lost, you know, and that's why a lot of the people come into the rehab home; they're so lost that they can't even find a way out. So in a rehab home, once we start reading our Bible, we start praying and we actually start getting to know who we are, and we really find ourselves, like, "Wow, I am somebody. I could make it." The Word of God really encourages us, you know? [*Latino male*]

Latino Catholic multi-intervention program When describing the leader of this congregation's SUD program, one interviewee highlighted this calling:

> Yes, at least this young man [who founded the program], he was from around here and he felt called and was liberated [from addiction and gangs]. And he's a living testimony. God has called him so that people know how to get out of drugs, vices, and all of that. And that ministry has grown. This young man has been training at least in the area of psychology, for therapy. It's a very beautiful ministry. [*Latino female*]

The program itself is fairly diverse in scope (focusing on drug use, criminal and gang activity, and youth risk behavior) and methods (prayer, community building, psychotherapy, spiritual retreats, etc.). However, when discussed by congregational leaders, it is framed not as a response to social ills but as an evangelistic calling to address, using multiple approaches, what are, ultimately, spiritual ills.

In both Latino congregations, religion took on a more predominant role than in the African American Protestant and Jewish Reform programs. Religion was described as compelling people to action and as the path not only to salvation from drugs but also from a sinful, unhealthy life.

Theme 2: Relationships Between Program Participants and the Broader Congregation

All four of the cases in this study were programs embedded within a larger congregational structure but were related to their congregations in different and telling ways. In particular, the extent to which a congregation's SUD program was oriented toward serving members of the congregation versus other individuals, or both, reflected differences in congregational missions, religious philosophies, and the degree of overlap in the demographic characteristics and self-identities of congregants and community members.

African American Protestant 12-step program Program participants were invited to church services, and the congregation provided bus transportation. Congregants also helped as volunteers with weekly support group meetings, providing food. In general, there were relatively clear lines of demarcation between congregants and participants of the 12-step program, but these appeared to be based less on moral distinctions than on social and class standings. For example, as described below by one interviewee, it appeared that some congregation members did not identify with the program participants:

> But the problem with that, they [general members of the congregation] don't know nothing about drugs and alcohol. They're good people, they want to help but, you know, but one alcoholic, addict helping another one is what the baby book talks about. For folks who've never used drugs and alcohol before, they don't quite understand what are these people talking about? You know, [they say,] "[How] come they just can't quit?" So, there's a divide there…[*African American female*]

Another respondent from the same congregation described how class issues can surface:

> It is a big issue in a lot of churches; they do have that problem because this is what happens, people that are middle-class people, right, folks get comfortable with where they are. They don't want to go back across that line. It's almost like, "I'll forget about what God done for me." A lot of people have that, too. They might not actually be thinking in those terms, but that's what happens. A lot of churches, when we tried to start, they didn't want the people to come to the church. [*African American male*]

Jewish 12-step group The 12-step program started as a support group consisting entirely of congregational members. Thus, group participants were not considered to differ substantially from other congregants aside from having to live with and manage a SUD. Later, the group began to attract members from outside the congregation but with similar religious and social backgrounds as current members. Consistent with the lack of proselytizing among most Jewish denominations, the group did not recruit for the congregation, although new 12-step members who joined the synagogue were certainly welcomed.

Latino evangelical rehab homes In this congregation, recovery from SUD was central to the mission of the church. Promise of recovery was a primary vehicle for evangelizing new congregants and growing the congregation. Many congregants had first come to the church with SUD, seeking treatment through the rehab home. Program clients staying in the resident home were clearly defined as a separate group from congregants. The congregational and program leadership's perception about program clients implied, for one interviewee, that program leaders need to be especially tough and ready to deal with challenges:

> The person who's going to run the rehab home, they've got to make a commitment. It's nothing that you can just walk in there and think it's like going to be easy, because like especially the type of people we work with. You know, we're working with people that had no hope, people that were lost, very dysfunctional, very low self-esteem, people that family members never wanted to see again; and they come in out of prison; prostitutes; they're real conniving. [*Latino male*]

There were also structured opportunities for interaction between rehab home participants and congregants: rehab home participants were required to attend congregational services and Bible study as well as daily Bible studies and prayer meetings just for rehab home participants. Likewise, congregational members brought food and other donations to the rehab homes. But there were restrictions on just how much interaction was encouraged, as described by another interviewee at this church:

> …the guys in the home and the women in the home, they're not allowed to just walk around freely in the church, you know, fellowshipping with people, because they're in the program. If we don't have certain restrictions, then it's a "free for all." There has to be order because a lot of the people who come to the home, their life was that they didn't have order, no boundaries. So, they have to get used to that structure. [*Latino male*]

Nevertheless, there was a demonstrated path for participants graduating from the homes and becoming members and even leaders of the congregation. This process mirrored the redemptive narrative of the congregation's religious philosophy. One of the pastors had, for years, taken people struggling with addiction into his family home, while they tried to sort out their lives. Further, most of the leaders of these SUD programs were in recovery themselves and used their own narratives as examples of how redemption is possible.

Latino Catholic multi-intervention program In this Catholic congregation, many program volunteers came from the congregation and many program participants were connected to the congregation through family members. However, despite a strong charismatic and evangelistic orientation, there were no clear mechanisms or historical precedents for program participants to transition into more active congregational participation. This may reflect a traditional Catholic definition of a congregational parish that includes all residents in a circumscribed area, which results in a more fluid boundary between the internal congregation

and external community (compared with strong demarcation between unconverted local neighbors and believing congregational members, as in the evangelical Latino church, or formal membership registration and dues, as in the Jewish Reform congregation).

Theme 3: Interactions Between Programs and the External Community

All four congregations tended to draw on partnerships with a larger support network in the community. A number of patterns emerged in how these programs access or do not access community resources.

Funding Funding for the programs varied from no external financial contribution to contributions from multiple sources. The 12-step groups at the African American and Jewish congregations had low resource requirements and important components were provided in-kind, thus they were not dependent on external funding. The rehabilitation home run by the Latino non-denominational congregation, while receiving some tangible support from the congregation (food, clothing, etc.), was primarily supported financially by participants working in the community and contributing to rent, food, and general upkeep. This program relied on connections to external employers established by rehab home leaders to support itself financially. Finally, the Latino Catholic congregation funded its program by its incorporation as a separate 501c3 non-profit eligible for government funding and tax-deductible private donations.

Partnerships All four programs partnered in some way with people and organizations external to the program and congregation. Guest speakers were often brought into supplement the expertise of group leaders. Two of the programs (African American Protestant 12-step and Latino evangelical rehab home) had close partnerships with secular drug treatment programs, sharing clients and treatment resources. Other partnerships included relationships with tattoo removal specialists and potential employers. Finally, three of the four programs (all except the Jewish Reform) received referrals from the legal system.

Like their secular counterparts, these programs made use of external support depending on their existing internal resources. This was sometimes as simple as taking referrals or inviting guest speakers, but it also included more extensive resource exchange, such as well-established partnerships with other churches' treatment programs.

Discussion

This study sought to advance knowledge of faith-based responses to SUD by examining specific congregational dynamics that often shape how such services are delivered. Findings from this study provide insight into the nature of congregational responses to community SUD. The findings roughly fell into three categories.

Philosophical Orientation: How Central is Religion?

Religion manifests in two primary ways in the congregational program models that we studied—either by adding value to existing 12-step models of treatment or providing a framework for defining recovery as a redemptive process. As noted by Neff and MacMaster (2005), faith-based programs exhibit considerable variation in their degree of emphasis on religious or spiritual content. In congregations that view SUD as an inherently spiritual matter, secular approaches and goals are less in the foreground than they are in the "value-added" model and the essential issue is not the SUD, per se, but sin and salvation. The evangelistic focus of such programs raises questions as whether expected outcomes are fundamentally different from those of secular groups. The dilemma of two, potentially competing, frameworks for defining successful SUD treatment has been raised by Bourgois and Hart (2010) as they examined biomedical and faith-based programs for SUD. They argue that increased recognition of and funding for faith-based programs coupled with a general absence of dialogue between biomedical and faith-based providers might lead to confusion regarding which type of solution will work for specific populations. These concerns have been raised by others as well (Allamani 2010; Sloboda 2010). For example, research has found that SUD treatment providers who prefer a redemption narrative are more likely to feel alienated by more secular treatment frameworks and that this can harm clients, since it can reduce coordination between faith-based and secular service providers (Davis 2008).

Intra-congregational Relationships: How are the Program and Its Participants Seen in Relation to the Congregation?

In line with findings from Travis et al. (2012), the perceptions and attitudes of congregants played a key role in how the treatment space and relationship were constructed. For some interview respondents, program participants were seen as troubled and untrustworthy. However, this negative view often existed within a transformative and compassionate framework in which a client was seen as living in sin but was provided a supportive environment within which to seek redemption, reform, and salvation. This conceptualization places the origin of SUD squarely on the sinful nature that the individual shares with all of humanity. While this framing of the problem does not necessarily ignore how program participants were seen within the congregation, it clearly points to a solution that involves personal, individual rehabilitation and redemption, but *within a community*. Across and within congregations, multiple respondents spoke of their own experiences with SUD and how the supportive environment of the congregation and their faith had helped them meet the challenges. The social support provided by a network oriented toward recovery appears to facilitate recovery (Humphreys et al. 1999). The needs of individuals in recovery go well beyond attaining abstinence and include employment and education, housing, and social and family relations (Laudet and White 2010). When SUD treatment services are provided in the context of a religious community,

social support may extend beyond the struggle to recover from addiction and facilitate the fulfillment of other needs as a member of that community. In most cases, interviewees fully expected clients to mature and ultimately overcome their SUD. Nevertheless, some showed ambivalence by expressing negative views that may have emerged from classism, a lack of understanding of the experience of SUD, overgeneralization from personal experience, or moral judgments that SUD resulted from distance from God and made program participants inherently untrustworthy. How such attitudes are perceived by program participants and affect them are important topics to explore in future research.

The four programs differed in how they distinguished the status and roles of participants from those of other congregation members. However, in no case was the program truly a stand-alone response to community SUD. Participants accessed services within a program that reflected the values and agendas of the congregations that created and implemented them.

Program Relationship to the Larger Community

All of the programs regularly interacted with the community and tapped into outside resources and expertise, not unlike congregational health programs more generally (Trinitapoli et al. 2009). Examination of these relationships suggests possible types of collaboration. For example, programs in our study tended to interact with external organizations that either provided clients for their programs (e.g., residential treatment agencies, drug courts) or provided services for their clients that they themselves could not provide (e.g., employment, tattoo removal).

Limitations

Although our sample included congregations of diverse racial-ethnic composition, faith traditions, and sizes, its generalizability is limited by being focused on one metropolitan area and involving a small number of cases. Future studies might examine possible regional and international differences in congregational SUD programs and other types of congregations. In addition, this study did not assess program effectiveness; its focus was on congregational dynamics and processes related to SUD programs. However, its results suggest that the following factors need to be considered in assessing outcomes: (1) the conceptual model of individual change and recovery employed by a congregational program, (2) the level and nature of support for the program within the larger congregational community, and (3) the internal and external resource and partnership availability for the program. Perhaps the most important study limitation is the lack of data from program participants, though some of those interviewed had progressed through these or similar programs previously. Incorporating the voices and experiences of participants would shed light on how the religious principles and contexts of these congregational programs fulfill the needs and expectations of those seeking SUD treatment.

Conclusion

Congregation-based SUD treatment programs, often provided free or at low cost, could potentially play a role in shrinking the sizable gap between the number of people needing and receiving treatment, a gap that is especially large among African-Americans, Latinos, and the uninsured. Treatment programs offered by religious institutions are more likely than their secular counterparts to provide support services such as transitional housing, which parallels the secular approach of providing recovery support services to people with SUD to improve quality of life and reduce stressors that make relapse more likely. Nevertheless, congregational responses to SUD have received little research attention. This case study of four congregations reveals potentially important variations in the centrality of religion in congregational responses to SUD and how program participants are viewed by congregation members. When treatment goals are seen by congregants and program participants as part of a larger transformative process of redemption, evaluating program outcomes solely in terms of sobriety may be inappropriate. Further research is needed to better understand broad treatment goals in religious settings and to identify outcome measures that reflect those goals. Results also suggest that the attitudes of congregants toward program participants may be important in determining whether, over time, participants can become accepted members of a sustaining congregational community.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval This study was approved the by authors' institutional review board.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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