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Ethical and spiritual frameworks in U.S. substance use prevention: A narrative review of faith-informed approaches

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Abstract

Substance use disorders (SUDs) have proven to be a long-standing public health issue in the United States and are therefore leading to a resurgence of interest in faith-based prevention and recovery. This review is a narrative discussing the ethical and spiritual models, processes, efficacy, and constitutional factors that form the bases of faith-based interventions. Practice is organized in three major styles: 12-step mutual aid focuses on personal spirituality and higher power qualities; faith-based organizational programs that combine religious teaching and community practice; and spirituality-focused clinical counselling that views spirituality as an instrument of therapy. There is even some evidence that culturally sensitive and truly voluntary faith-based programs can be used to improve the engagement and recovery process, especially in people with substantial levels of identification with their religious affiliations. Spirituality seems to work in mechanisms such as meaning-making, moral development, social support, and identity formation. Despite this, some major issues still prevail in the areas of coercion, church-state separation, constitutional compliance, and the boundary of the ethics of the profession, particularly when publicly funded. Other weaknesses that reduce the evidence base include methodological weaknesses, small samples, and limited comparative research in terms of effectiveness. The potential of faith-informed approaches is meaningful, yet to progress the field, it is necessary to conduct rigorous assessment, ethical protection, and adherence to the evidence-based practice of public health.

Keywords: Spirituality; Addiction; Prevention; Ethics**.**

1. Introduction

Substance use disorders (SUD) are a long-term issue of national human health conditions in the United States, as they impact millions of people and communities living under different demographic and geographic conditions. Spiritual and religious practices have been used to augment, and in some cases, to refute, traditional biomedical and psychosocial models of treatment, which mostly leave out the spiritual and religious aspects of prevention and recovery. The spectrum of faith-informed interventions is rather wide and may include peer-led mutual aid groups where the focus is made on personal spirituality and well-established Faith-Based treatment programs run by religious institutions on one end of the spectrum to clinical practice that allows using the spiritual beliefs of clients as a source of therapy. The incorporation of faith and spirituality in substance use treatment begs some basic questions related to effectiveness, ethics and constitutional limits. Advocates believe that spiritual models offer meaning, communal assistance, ethical principles and sources of coping that will improve recovery rates, specifically among highly religious populations or those that have low access to traditional services [1], [2], [3]. Cons criticism of coercion, the involvement of religion in the state, breach of the professional boundaries, and a risk of marginalization or exclusion of those not of the dominant religious orientation are raised [2], [10].

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This is a narrative review that summarizes the existing literature on the ethical and spiritual models in substance use prevention in the U.S., especially faith-based models. Based on an extensive search, identifying 209 likely relevant academic resources, the present review will consider the 30 most pertinent articles in order to address the following questions: (1) what are the major ethical and spiritual theories that define faith-informed interventions; (2) how spirituality is utilized in prevention and treatment mechanisms; (3) whether spirituality works; and (4) ethical, legal and constitutional issues. It is the goal of the review to offer a balanced evaluation to allow recognizing the possible advantages and the important risks of faith-informed approaches to influence evidence-based practice, the policy-making process, and the research. The homeland of faith and substance use treatment practices in the United States has a rich historical background. The 19th and early 20th century temperance movement was essentially a religious and moral movement, where alcohol consumption is viewed as sin and alcohol abstinence as spiritual virtue. The central point of the spiritual but strictly nondenominational model was the establishment of Alcoholics Anonymous (AA) in 1935, as the model aimed at a higher power and moral inventory [5], [7]. The 12-step model of AA evolved into predominance in American addiction treatment, impacting both peer mutual help programs and professional treatment programs.

Toward the end of the 20th century, explicitly Faith-Based treatment programs began to grow, run by religious groups and focusing on Christian doctrine and practice. The move in federal policy, such as Charitable Choice of welfare reform in 1996 and the 2001 creation of the White House Office of Faith-Based and Community Initiatives, enabled the public to fund the religious groups that offer social services, such as substance abuse treatment [2], [10]. These shifts in policies escalated the arguments surrounding the correct place of religion in publicly-funded services and theoretical limits on the separation of religion and the government. There are several conceptual frameworks that inform faith-informed substance use interventions, as they determine the goals, approaches, and moral orientations of the interventions. This disease model of addiction, that defines substance use disorders as a chronic form of medicine, is also in conflicting positions with moral and spiritual treatment that focus on individual moral responsibility, on sin and redemption [5], [22]. There are programs which strive to combine these two views and address addictions as a disease with spiritual aspects, but other programs focus more on one school of thought. Interventions conceptualize spirituality differently. Others draw a line between spirituality (personal contact with the sacred or transcendent) and religion (organized belief systems and practices) and some use the terms synonymously [3], [15], [27]. The 12Step tradition does not specify the nature of spirituality and has permitted individuals to create their own definition of higher power, which or otherwise could be related to conventional religious ideas [5], [7], [17]. Such religious traditions as Christianity are usually adopted by the programs of Faith-Based organizations and are usually incorporated in treatment along with the doctrine, script, and religious practice [4], [21], [24]. Clinical approaches based on spirituality overlay spirituality as a factor of client identity and a possible area of therapeutic involvement with the primary focus on client centered inquiry as opposed to provider-based religious edification [8], [15], [20].

2. Primary Ethical and Spiritual Frameworks

2.1. Step Mutual Aid Programs

The most common model of faith-based addiction recovery in the United States is the12 Step model, which started with the Alcoholics Anonymous and was modified to suit different substances and behaviors. The 12 Steps include the statements of powerlessness about addiction, admitting that someone is a higher power, a moral inventory, amends, and continued spiritual practice [5], [7], [14]. Although AA has indicated clearly that members are free to conceptualize their higher power in as many ways as make sense to them, the Christian nature of the program, as well as its language (making reference to God, praying, and spiritual awakening), establishes a paradigm that is fundamentally spiritual [5], [17]. Recent qualitative studies articulate AA in the concept of a lived-in religion that builds moral discourses of sobriety by telling stories, ritual, and accountability [5]. The members reframe their life experiences in spiritual terms, which formulates addiction as the spiritual crisis and recovery as the moral and spiritual transformation. The 12Step model serves as a therapeutic community and a sense giving system which gives identity, meaning, and affiliation [5], [7]. There is a conceptual integration model that determines various functions of spirituality in 12Step recovery, which include: developing humility, transcendence of meaning, moral development, and the supportive community [7], [17]. The model underlines the fact that spirituality is implemented on both individual and social levels (e.g., cognitive reframing, emotional regulation or peer support, accountability, shared values) [7]. The spiritual focus, however, might feel off-putting to non-spiritual and non-religious people, and the moral treatment of addiction can lead some participants to feel stigmatized and shameful [5], [14].

2.2. Faith-Based Organizational Programs

Faith-Based organizational programs are a wide variety of interventions that are run by a religious institution or organization involving an explicit inclusion of religious beliefs, practices and values in substance use treatment. There is a significant difference between the diversities of these programs in the context of religious integration. Religious activities are optional features in some of the programs that also provide evidence based clinical services, whereas with others the religious practice has been incorporated in comprehensive regimens and the treatment philosophy [3], [4], [24]. A qualitative study of Christian Faith-Based residential programs found a number of conceptual foundations, namely: addiction as spiritual issue that needs spiritual remedy; the transformative nature of religious conversion; value of Christian community and accountability; and importance of biblical teaching on every matters of treatment [24]. Employees in these programs tend to see religious conversion as part of recovery and recreational programs are in fact designed to evangelize their participants [21], [24]. This orientation begs serious ethical questions in the context of the suitability of proselytization in treatment facilities, especially when a program is publicly funded or works with court ordered clients [2], [10].

Religious programs tend to focus on moral responsibility, discipline, and respect for the teachings of religious codes of conduct. Other programs use authoritarian or confrontational formats, in which the addiction is conceptualized as moral failure and the recovery involves being subject to authority of God [1], [24]. Other Faith-Based programs however highlight the need to focus on compassion, grace and noncoercive spiritual support and acknowledge the autonomy and cultural relevance of clients [1], [4], [13]. Compared side-by-side analysis of religious versus nonreligious content in Faith-Based versus secular interventions established that Faith-Based programs were more likely to use prayer, scripture study, religious counselling and faith community involvement and the secular programs were based on evidence-based psychotherapies and pharmacological interventions [4]. Yet, numerous Faith-Based programs incorporated also the evidence-based practices and there are also secular programs that considered spirituality as a resource available to clients, which implies a significant overlap and dispersion across types of [4], [15].

2.3. Spirituality Integrated Clinical Counseling

Integrating spirituality with clinical counselling is one of the third frameworks that licensed mental health and substance abuse professionals allow the spiritual beliefs and practices of the clients to be incorporated in evidence-based treatment. This method grants spirituality as an aspect of cultural identity and a possible source of strength, meaning, and coping [8], [15], [20]. Spirituality integrated counselling, unlike Faith-Based organizational programs, is normally client centered, voluntary and under professional code of ethics that value informed consent, privacy and regard to client autonomy [10], [20]. The studies of how spirituality enhances the treatment of the alcohol issue focus on the significance of assessment, client readiness, and therapeutic alliance [15]. They motivate clinicians to evaluate the beliefs, practices, and issues of their clients regarding spirituality; determine the connection that exists between spirituality and substance use and other recovery processes; and assist clients in accessing spiritual resources that they find significant [15], [20]. This method does not force the religious convictions of the clinician but clearly delineates therapeutic exploration of spirituality and religious teaching or proselytization [10], [15]. The consumers and givers of services in the service field present varied ideas on integrating spirituality in counselling. Spirituality is considered by many clients as a valuable source of recovery and enjoy the chance to converse about spiritual issues during treatment [8], [30]. Some clients, however, report to be uncomfortable with religious matters or would like to remain spiritual apart from the clinical services [8]. The range of comfort and competence in dealing with spirituality is also similar among providers, some believe it to be fundamental to holistic care and others fearing a violation of boundaries or the imposition of values [8], [20], [28]. With regard to Chaplaincy Services in substance use outpatient treatment care, the perceptions held by healthcare providers towards spiritual care and its services indicate that there is appreciative insight of the possible beneficial nature of the practice of spirituality, as well as issues of scope of practice and professional boundaries exist [20]. A wide range of providers will facilitate the work of chaplains or specialists on spiritual care, who could serve clients with their spiritual needs and provide a high level of separation between the terms of the clinical and religious context [20].

3. Integration Mechanisms and Implementation Approaches

3.1. Spiritual Narratives and Moral Framework

Faith-informed programs combine faith with the aspect of spirituality by the use of narrative practices to create recovery as moral and spiritual change. Storytelling is paramount in 12Step programs: the members talk about addiction testimonies, crisis, surrender, and recovery that follows a redemptive pattern [5]. These stories reconstrue previous experiences within spiritual frames with addiction being spiritual emptiness or lack of connection with a higher power and recovery being spiritual awakening and reconnection [5], [7]. By sharing narratives collectively, it establishes a moral fraternity that has common values and meanings so that sobriety is a spiritual identity [5]. Religious

programs in spiritually oriented organizations also appeal to spiritual narratives, typically, on religious conversion stories and biblical themes of sin, repentance, and redemption [21], [24]. Religious conversion is occasionally experienced as an essential part of recovery, and the programs focus on the transformative ability of submitting to Jesus Christ or the dedication to a religious faith [21], [24]. These stories can give strong meaning and inspiration to people whose identities revolve around their religious beliefs, which might seem foreign or turn away those who do not share the mainstream religious construct [2], [10].

3.2. Religious Practices and Rituals

Religious practices and rituals are incorporated in the day-to-day activities and the treatment programs through many faith-based programs. Practices, such as prayer (personal and collective), scripture study, worship, religious counseling, and involvement in activities of a faith community are common [4], [24], [25]. Religious practices can be integrated throughout the day in residential Faith-Based programs with morning devotions, mealtime prayers, evening worship and religious education sessions [24]. Studies of engagement in religious practices in contingency management treatment interventions revealed that more religious involvement was linked with improved substance use therapy outcomes such as an increased retention period and higher abstinence [25]. This implies that religion practices can offer some structure, social support, and alternative reinforcement that facilitates recovery [25]. But the analysis was not able to establish whether the reason is that religious involvement led to greater results or the fact that people who were more motivated in their recovery had greater chances to get involved in religious activity [25]. In a pilot study conducted at a Jewish residential treatment center, the predictors of retention were studied to determine the role of religious preference and religiosity/spirituality [26]. Although the study did not reveal any significant differences in retention in religious preference or religiosity scores, it demonstrated the significance of culturally sensitive Faith-Based programs that target certain religious groups [26].

3.3. Culturally Centered Adaptations

Faith-based programs that are culturally focused incorporate spiritual and religious materials into programs by customizing them according to cultural identities, values, and experience of particular groups of people. This practice acknowledges the fact that spirituality is a social construct and that effective interventions based on faith should be contextual to the lived experiences and community in the context of the participants [1], [4], [9], [13]. Metropolitan Community AIDS Network (MCAN) represents an example of culturally suitable Faith-Based services to African American substance users at risk of HIV [1], [13]. The program incorporated the African American cultural values, spirituality, and community strengths into the integrated service model comprising of case management, support group, HIV testing and counseling, and linkages with medical care [1], [13]. The Faith-Based approach focused on the use of spiritual as a source of resilience and healing among African American communities without being coercive or judgmental about the religious message [1], [13].

The assessment of MCAN program revealed that substantial decreases in substance use, HIV risk behavior, as well as psychological distress and increased financial self-sufficiency and spiritual well-being were observed [1], [13]. The success of the program was credited to its approach that was culturally relevant and noncoercive which respected the spirituality of the participants and offered evidence-based services [1]. This model shows that culturally oriented interventions, that are voluntary and have faith as an informed component, can be effective when they are provided as complete support services [1], [13]. Another culturally based, community-oriented Faith-Based project dealing with opioid use within African American communities is Imani Breakthrough project [9]. The project collaborated with black churches and community organizations to come up with interventions based on cultures that incorporated spiritual support, peer recovery coaching and referrals to treatment and harm reduction services [9]. The collaborative model focused on the community owning it, cultural and authenticity, and a structural barrier to care approach [9]. Collaboration with Native communities to create culturally based interventions to the use of substances helps comprehend the value of Indigenous spiritual practices and healing methods [12]. Substance use has devastated the Native American communities, which is mostly based on historical traumas, colonization, and cultural disruption [12]. Culturally based interventions combine traditional healing methods, religious rituals, and Indigenous knowledge systems with the evidence-based interventions as it has been acknowledged that healing has to cover a spiritual, cultural and community aspect [12].

3.4. Clinical and Counseling Integration

The concept of clinical integration of spirituality encompasses the evaluation of the spiritual beliefs, practices, and concerns of clients and their solution in evidence-based treatment models. Spirituality has been considered a part of holistic care and not a specific or alternative mode of treatment as per this practice [8], [15], [20]. Studies regarding the integration of the underlying religious and spiritual beliefs of clients into the therapeutic process indicate that the

integration process may enhance the practice of substance abuse treatment among people of color [18]. Most of the clients with racial and ethnic minority backgrounds are highly religious and spiritual people whose worldviews, coping motives, and seeking motives are defined by these factors [18]. Disregarding or disowning these beliefs can negatively impact therapeutic alliance and engagement in treatment, whereas greater consideration of them can positively influence cultural competence and relevance to treatment [18]. A spirituality and substance user treatment focus group study revealed that respondents considered spirituality and recovery as a hand in hand [30]. According to the respondents, spiritual practices and beliefs were harmed in active addiction but were significant in recovery [30]. They were vociferously interested in voluntary spiritual discussion groups as part and parcel of standard treatment, and this was their preferred choice over the current options of either mandatory religious programming or total lack of spiritual content [30]. The beliefs of substance abuse counselors regarding religion and spirituality also determine their readiness and the attitude to implementing spiritual content during therapy [28]. Counselors who consider spirituality to be a factor of recovery will be better placed in assessing the spiritual needs of the clients, spiritual issues, and assist clients in utilizing spiritual resources [28]. Nonetheless, counselors equally have concern regarding exercise of their own beliefs, overstepping professional boundaries, and incompetence to deal with spirituality [28].

4. Evidence of Effectiveness

4.1. Faith-Based Program Outcomes

Faith-Based substance use research has been found in evaluation research to be initially effective, especially culturally-specific, noncoercive interventions. The review of the MCAN Faith-Based program of African American substance users revealed that there were major improvements in various areas [1], [13]. The participants who completed the interviews had a reduced use of substances (heroin and cocaine), HIV risk behaviors (needle sharing, unprotected sex), and psychological distress (anxiety and depression) at 6 and 12month follow-ups [1]. The participants also said that they experienced better financial self-sufficiency and spiritual wellbeing [1]. It was conducted in the form of a single-group, nonexperimental with repeated measures, making it impossible to establish causal relationships, although the pattern of improvement with multiple outcomes was consistent, which also indicates that the program was effective [1]. Another study on the religious conversion and outcome of treatment within a Faith-Based residential program established that participants who reported religious conversion during treatment showed improved outcomes at discharge like increased rates of programs completion and decreased substance use [21]. Nevertheless, the research was unable to establish the relationship between conversion and improved outcomes or the individuals who were more inclined to conversion or those who had stronger motivation or improved prognoses [21]. It is proposed that the religious conversion can be a significant experience to certain people in Faith-Based treatment, though it does not make it a prerequisite or a prerequisite to recover [21]. Faith-Based interventions have serious methodological challenges with program evaluation. There are several Faith-Based programs which are self-selected and can differ in a systematic way compared to self-selected in secular treatment and thus difficult to compare [1], [21]. The causal inferences are weak due to high attrition rates, absence of control groups and use of self report measures [1], [21]. There is also the heterogeneity of Faith-Based programs that are both very coercive to totally voluntary, and culturally specific to generalized one-size-fits-all problematic about Faith-Based treatment [3], [4].

4.2. Spirituality in 12Step Recovery

Spirituality has been studied regarding its role in 12Step recovery in various research methods. A qualitative study that created the Spirituality in Recovery Framework found several roles of spirituality in 12Step programs, such as providing transcendent meaning and purpose; offering humility and acceptance; supporting moral development and making amends; creating supportive community and belonging; and offering practices (prayer, meditation, service) that help maintain recovery [7]. The model stresses the fact that the framework of spirituality is gathered by personal psychological functions on the one hand and social processes inherent in the 12Step fellowship on the other hand [7]. In a study of moral narratives of sobriety in Alcoholics Anonymous, it was discovered that AA was a lived religion creating shared moral systems by means of narratives, ritual and joint accountability [5]. The sobriety identities are formed by the members out of attending the spiritual practices and narrative traditions of AA, which redefine their experiences in life through the prism of 12 Steps [5]. It seems that this meaning making process and Identity transformation is the key of success of AA among many participants [5]. The spiritual focus of 12Step programs may be an obstacle, however, to people who are not spiritual or religious. Others complain of being left out or feeling out of place with the spiritual terminologies and practices of AA especially the mention of God and praying [14], [17]. The movement to create more inclusive 12 step programs, like secular AA meetings or some other mutual aid groups (e.g., SMART Recovery), is an acknowledgment that the standard spiritual framework would not be effective at all people seeking support in recovery [14].

4.3. Clinical Integration Outcomes

The research evidence of the effectiveness of spirituality-based clinical counseling is insufficient but points to the possible benefits. An analysis of the incorporation of spirituality in alcohol treatment found that the spirituality-related intervention can have a beneficial effect on the results of some clients, especially on those with strong spiritual identities or interests [15]. The review, however, revealed that the current research was strongly limited in terms of methods, such as small sample sizes, absence of randomization, and sufficient control conditions [15]. A study of the perceptions of healthcare professionals providing substance use outpatient treatment on spiritual care identified that care providers are aware of the possible advantages of spirituality addressing potentially providing improved coping, meaning-making, and social support [20]. Nevertheless, integration barriers noted by providers were such as time constraints, training shortage, professional boundaries, and the indecisiveness on how and when to tackle spiritual issues [20]. These results indicate that spirituality needs proper training, well defined ethical codes, and organizational facilitation to be integrated into clinical practice [20].

4.4. Limitations of Current Evidence

Faith-informed substance use interventions face serious limitations in the evidence that limit the inferences about the efficacy of the interventions. The majority are observational studies with a weak quasi-experimental design that restricts the ability to make a causal inference [1], [21], [26]. In part, this is because it is difficult to overcome the ethical and practical difficulties involved in randomizing people to religious versus nonreligious treatments [27]. They tend to have small sample sizes and the attrition rates are high and this decreases the statistical power, and may be skewed [1], [26]. A significant number of research is based on self-reported measures of substance use and other outcomes, which are prone to social desirability bias, especially in Faith-Based traditions where abstinence is a morality standard [1], [21]. Synthesis and generalization is not easy due to the heterogeneity of the faith-informed interventions. Programs can be religious or non-religious, with or without the level of coercion, cultural adaptation, incorporation of evidence-based practices, and can be aimed at various populations [3], [4]. The very fact that various interventions can be called the Faith-Based treatment blurs significant distinctions and can be misleading in conclusion [3], [4]. The research on comparative effectiveness is especially sparse. The direct comparisons between Faith-Based and secular interventions with adequate characteristics of selection bias and confounding are not present in many studies [4], [27]. The absence of such comparisons does not allow concluding whether the observed results can be ascribed to the spiritual or religious elements, to the other program elements (e.g., intensity, duration, social support), or to the features of self-selected participants [4], [27]. A meta-analysis of spirituality and religiosity and addiction recovery has arrived at the conclusion that despite certain studies showing that spiritual and religious variables are positively related to recovery, the evidence base is weak due to methodological limitations and absence of well-controlled comparative trials [27]. The review recommended future research that has stronger designs, especially not in the United States where most studies have been carried out [27].

5. Ethical Considerations and Constitutional Issues

5.1. Voluntariness and Coercion

One of the ethical issues related to faith-informed substance use treatment is voluntariness. The mandatory nature of participation of any person in any religious activity in either of the forms that could be program requirements, criminal justice requirements or by a sense of coercion itself infringes on the fundamental right of religious freedom, and autonomy [2], [10]. Study of Faith-Based treatment as required by law, it has been argued that the compulsion to join a religious activity through Faith-Based treatment programs is against the first amendment which was the Establishment Clause [2]. When there is no secular alternative, it has been held by the courts that requiring one to attend AA or other 12Step programs as a probation or parole requirement is unconstitutional [2]. Further than laws, other not so overt coercions may arise within Faith-Based programs. When programs provide systems in which religious participation is anticipated, rewarded, or required as a precondition to social acceptance, people may be coerced into participation even though this may appear to be voluntary on record [2], [10]. This is currently alarming in residential programs where residents are left to rely on the program in terms of accommodation, food, and other fundamental requirements [2], [10]. Ethical reviews note that Faith-Based programs should make a clear separation of religious activities that are mandatory and optional, offer true nonreligious options, and should not discriminate access to services, or quality of treatment or program status because of their participation or nonparticipation of religious activities [10]. The MCAN program is an example of ethical practice since it is based on spirituality as a voluntary tool and not a mandatory tool, and does not employ coercive, judgmental, or authoritative methods [1], [13].

5.2. Church State Separation and Constitutional Boundaries

Faith-Based substance use treatment has become a highly discussed issue on the constitutional limits of what these organizations can do through the use of taxpayer-funded public resources [2], [10]. The First Amendment, in its Establishment Clause, prohibits the government involvement in religion or over-entangling with it [2]. The constitutional issues involved in government-funding of religious organizations to offer substance abuse treatment, are that public money must not assist in funding religious activities and it must be a voluntary act, secular options must be available, the government must exercise oversight to ensure that this money is not employed in promoting religious activities, and that programs are not made discriminatory in hiring or providing services to people based on their faith [2], [10].In the case of publicly financing Faith-Based treatment, legal scholars argue that: (1) there must be a clear separation between religious activities and publicly funded services; (2) there Nevertheless, there are Faith-Based programs that do not comply with those requirements by stating that without the inclusion of religious content in treatment, the integrity and efficacy of the program is compromised [2], [24]. The so-called pervasively sectarian doctrine, the doctrine which historically denied any public funding to religious organizations whose activities were absolutely filled with religious contents, has been loosened by recent decisions made by the Supreme Court [2]. This has eased the allocation of greater amounts of funds of Faith-Based social services to treat substance abusers, yet it has also raised the issue of witch-hiking of church state involvement and the safeguards of individual rights [2], [10].

5.3. Professional Ethics and Clinical Boundaries

The code of professional ethics surrounding social workers, counselors, psychologists and other professionals working in the mental health industry lay down strict guidelines on the inclusion of religious and spiritual content in treatment [10], [20]. In general, these codes mandate practitioners to: respect client autonomy and self-determination; ensure that they do not impose personal values or beliefs; observe professional boundaries; ensure informed consent to all interventions; and practice within areas of competence [10], [20]. The addition of spirituality to clinical practice creates the issue of boundaries: When is the exploration of spiritual beliefs a religious education or proselytization? What can clinicians do to deal with spirituality without foisting their views on it? What is the required training and competence to effectively and ethically respond to spiritual issues? [10], [15] and [20]. Ethical principles also highlight the fact that spirituality integrated counseling ought to be client centered, participatory, and enclosed by therapeutic objectives [10], [15]. Clinicians are advised to evaluate the spiritual beliefs and interests of the clients, investigate the relation between spirituality and the presentation of problems and treatment objectives, and assist the clients in utilizing spiritual resources that have some meaning to them [15], [20]. Clinicians must however avoid prescribing certain religious beliefs or practices, proselytizing or using therapeutic relationship to further propagate their religious beliefs [10], [15]. Another ethical issue in the Faith-Based programs, especially when run by the religious organization, is confidentiality, which may not be compelled based on the healthcare privacy regulations [10]. The clients need to be educated on the boundaries of confidentiality and their use or disclosure in religious circles [10].

5.4. Cultural Competence and Equity

The cultural competence demands that faith-based interventions should honor and address the different religious, spiritual, and cultural identities of clients [1], [4], [9], [12], [13]. Programs that presuppose one religious model (mostly Christianity) can be alienating, or even exclude people not in other religious traditions or those not religious [2], [10]. The described issue is especially alarming considering the fact that racial and ethnic minorities are overrepresented in criminal justice system and in demographics that suffer substance use disorder [1], [9], [13]. Religiously and culturally based initiatives show that spiritual integration may be useful and moral when applied to particular communities and cultures [1], [9], [12], [13]. These programs celebrate the spiritual cultures and practices of the communities in which they are provided, combine cultural values and cultural strengths, and overcome structural barriers and historical trauma [1], [9], [12], [13]. Equity issues do however come in when Faith-Based programs are the sole or major treatment provisions in some communities, especially rural ones or under-served neighborhoods of major cities [27]. In case the people had to make a decision between Faith-Based treatment and no treatment, religious freedom and access to the treatment is jeopardized [2], [10]. The equitable access means to have a sound structure of secular treatment choices with Faith-Based programs [2], [10]. To address the issue of collaboration between faith communities and the public health, engaging faith leaders on the harm reduction strategies, including syringe services programs, offers both opportunities and challenges of cooperation [6]. Numerous pastors are conditionally supportive of harm reduction and desire to know public health statistics which would offer a chance to collaborate [6]. Nonetheless, some religious and ethical issues regarding facilitating use of the drug continue to act as obstacles to certain religious leaders [6]. To successfully engage, it is necessary to apply respectful dialogue and educate people on evidence on the topic of public health and consider valid issues and values of the faith communities [6].

6. Provider and Community Perspectives

6.1. Counselor Beliefs and Practices

The attitudes of substance abuse counselors towards religion and spirituality are some of the key factors that determine how much they are willing and how they are willing to add the element of spiritual content in treatment [28]. The counselors who consider spirituality to have meaningful role in recovery are more likely to evaluate the clients in terms of their spiritual needs, talk in a spiritual issue in a session and assist clients in utilizing spiritual resources [28]. Nonetheless, counselors differ greatly in terms of their comfort when treating spirituality, and some see it as part and parcel of holistic care, whereas others report feeling uneasy or unconfident [28]. The obstacles to integrating spirituality in counseling are lack of training, fear of foisting personal beliefs, confusion on professional boundaries, and organizational policies that deter or ban religious material [28]. Counselors state that they require more specific ethical standards, enhanced preparation in culturally competent spiritual evaluation and intervention, and organizational assistance in the correct approach toward spirituality [28].

6.2. Faith Leader Engagement

Religious leaders can also have significant roles in creating community perceptions towards substance use, treatment and harm reduction. The study on the attitude of Black American Christian church leaders towards opioid use disorder and harm reduction revealed varying attitudes [16]. A few pastors consider addiction as something moral to highlight personal responsibility and spiritual change whereas some have more compassionate and other public health perspectives [16]. Others are concerned about harm reduction measures like syringe services programs because they believe that these measures allow people to continue using drugs but are receptive to education and consultations [6], [16]. To attract faith leaders to embrace syringe services programs, one must be knowledgeable of their theological structures, confront their fears with empirical evidence of health care, and establish a sense of trust by respectfully collaborating with the faith leaders [6]. Pastors say they would like to learn more about the effectiveness and community impact of harm reduction programs and many of them indicated their readiness to support these initiatives as long as they are convinced that it reduces harm without raising the drug use [6]. The willingness of the faith community to change in terms of substance abuse is quite divergent [23]. A national study reported that although, most faith communities have acknowledged the significance of substance abuse as a problem, they differ in their ability and readiness to support the services, collaborate with the treatment providers or to lobby the policy [23]. Theological thinking about addiction, some past experience of being a substance-user, leadership, and access to resources and training are the factors that affect readiness [23].

6.3. Client Perspectives

The attitudes of service recipients towards the integration of spirituality in treatment are varied and circumstantial [8], [30]. Spirituality is considered to be a valuable tool in the recovery of many clients and they are glad to discuss spiritual issues during treatment [8], [30]. In focus groups, clients stated that spirituality and recovery are like hand in glove and were very interested in voluntary spiritual discussion groups that are incorporated in the formal treatment [30]. Nonetheless, the tastes of clients differ depending on religious affiliation, previous religious experiences, and the situation of treatment [8]. There are certain clients who would rather separate spirituality and clinical treatment, either due to lack of spirituality or other negative experiences with religion [8]. Others can digest spiritual material, though they would like it to be voluntary instead of compulsory [8], [30]. The clients elaborate the significance of respect, voluntariness, and cultural relevance in faith-based programs [1], [8]. They value the programs that respect their religious values without forcing certain religious beliefs, the programs provide options in participation, and the incorporation of spirituality in a manner that is culturally significant [1], [8], [30].

7. Discussion

This narrative review outlines three major models within which faith and spirituality are merged within the U.S. substance use prevention and treatment: 12Step mutual aid which focuses on personal spirituality and higher power notions; Faith-Based organizational programs which integrate religious doctrine and practices; and spirituality integrated clinical counseling which views spirituality as a source of therapeutic resources. The ethical orientations, implementation strategies and evidence bases of each of the frameworks are different. It has been indicated that culturally-appropriate, noncoercive faith-based programs can be used to improve engagement and outcomes, especially among African Americans and other minority groups, who have strong religious affiliations [1], [9], [13]. The MCAN program confirms that Faith-Based treatment based on the spirituality as a voluntary resource, along with evidence-based services and culturally relevant supports, can decrease substance use, HIV risk behavior, and psychological

distress, and also enhanced spiritual wellbeing [1], [13]. Spirituality supports the recovery process in various ways: it gives transcendent meaning and purpose; promotes moral growth and identity change; creates supportive community and sense of belonging; offers coping mechanisms including prayer and meditation; and promotes the connection to cultural traditions and values [5], [7], [27]. These functions work both individually in the form of psychological processes, and social processes inherent in faith communities and recovery fellowships [5], [7]. Nonetheless, there are still serious ethical issues in terms of voluntariness, coercion, separation of church and state, and constitutional limits [2], [10]. Compulsory Faith-Based treatment is unconstitutional protection of the religious right, and even the officially voluntary programs can be associated with unspoken pressure when the involvement in religious practices is anticipated or compensated [2], [10]. The Constitution places certain considerations on the public funding of Faith-Based programs that maintain the separation of religious activities and publicly funded services, provision of secular alternative and avoidance of discrimination [2], [10].

A number of tensions and contradictions arise in the body of literature of faith-informed substance use interventions. The first is the fact that there is a conflict between the idea of addiction as a disease that must be treated by a medical team and the idea of addiction as a moral or spiritual issue that should be changed through a religious process [5], [22], [24]. Other programs combine these visions whereas some focus on a specific framework causing inconsistencies in the message and confusion of the clients [5], [24]. Second, it is a conflict between the personal spirituality that is emphasized in 12Step programs and the more specific methods of most Faith-Based organizational programs [5], [7], [24]. Although in 12Step programs one can set his/her own higher power, not all Faith-Based programs are inclusive of other traditions and many may end up excluding or isolating individuals with different traditions [5], [24]. Third, the tension exists between the cultural relevance objective and the danger of imposing the common religious paradigms on various groups of people [1], [2], [9], [13]. The culturally based interventions prove that the faith-informed ones may prove to be effective in the context of certain communities, although this demands the actual community collaboration and the acknowledgment of the various spiritual cultures instead of a religious cure-all and a one-fits-all approach [1], [9], [12], [13]. Fourth, there is the conflict between the wish to incorporate spirituality into holistic treatment and the necessity to preserve professional distance and not to proselytize [10], [15], [20]. Clinicians are confused about the timing and way to approach spirituality, and the lack of clear guidelines and training has led to inconsistent and even inappropriate practices [20], [28].

There are critical knowledge gaps that restrict the inferences made regarding efficacy and the suitable position of faith-based substance use interventions. Above all, there is a lack of rigorous comparative effectiveness research. There is very little research that directly compares Faith-Based to secular intervention and has sufficient controls to overcome selection bias and confounding [4], [27]. In the absence of such comparisons, one cannot ascertain whether the noted outcomes can be ascribed to spiritual or religious aspects or other aspects of the program [4], [27]. The processes of spirituality and the recoveries are not well known. Although theoretical perspectives mark several possible mechanisms of meaning making, social support, coping practices, moral development empirical studies to test these mechanisms are scanty [7], [27]. Mediation analyses of the effect of spirituality on outcomes via particular pathways would represent a stronger evidence base [27]. The study of faith-based interventions is quite intensive in the United States and is mostly based on Christian paradigms [27]. There is a lack of evidence in other countries and religious backgrounds, which limits generalization and comprehension of the cultural and religious background influence on the role of spirituality in recovery [27].

There is also a lack of long-term outcomes of faith-informed interventions. Most of the assessments look at short term outcomes (612 months) yet substance use disorders are long term problems which need long term recovery efforts [1], [21]. Studies to determine whether faith-based interventions can be used to achieve long-term recovery and relapse prevention are required [27]. Lastly, there is a lack of studies on ethical application of faith-based interventions. Even though legal and ethical frameworks can determine principles that support the protection of voluntariness, the preservation of the relationship between church and state, and cultural competence, there is limited empirical studies on how all these principles are put into practice and how they influence client experiences and outcomes [2], [10].

Future Directions and Recommendations

- Research Priorities

The importance of future studies should be rigorous comparative effectiveness research comparing Faith-Based and secular interventions that adequately controls selection bias. Randomized controlled trials can be ethically and practically difficult, whereas quasi-experimental studies that properly match propensity scores or otherwise attempt to adjust against confounding variables are possible [27]. There is a need to conduct mechanistic studies on the effect of spirituality on recovery outcomes. Mediation tests of pathways to specific meanings including meaning making, social

support, coping practices, and moral development would be more illuminating on the most significant elements of faith-informed interventions and to whom [7], [27]. The studies should study heterogeneity of faith-based interventions and compare the programs in terms of religious intensity, coercion level, cultural adaptation, and incorporation of evidence-based practices. This would go beyond the simplistic Faith-Based and secular comparisons to identify the particular program characteristics that correlate with improved results and a reduced number of ethical issues [3], [4]. Prospective studies of long-term follow-up of recovery, relapse prevention and quality of life outcomes are required. It should also be researched on possible adverse consequences such as religious trauma, shame, or loss of engagement with the treatment in those who are non-responsive to Faith-Based methods [5], [14]. It is important that implementation research should be conducted to determine the translation of ethical principles into practice. Research needs to be conducted to determine how programs are voluntary, keep separation between church and state, safe confidentiality, and offer culturally competent care, and how these activities influence client experiences and outcomes [2], [10]. Lastly, the research must extend beyond America and Christian paradigms, to study the faith-based interventions in other cultural and religious settings. This would promote the knowledge of the role of spirituality in recovery within various traditions and educate culturally responsive practice in the world [27].

- Policy Recommendations

Policy must make sure Faith-Based substance use treatment programs publicly funded do not violate constitutional provisions such as clear distinction of religious activities with publicly funded services, true voluntariness of religious participation, and secular alternatives [2], [10]. Compliance should be checked by means of oversight mechanisms, and the rights of the clients could be safeguarded [2], [10]. Without providing alternatives such as secular services, criminal justice systems ought not to force individuals to attend Faith-Based treatment or 12Step programs. Such mandates have always been unconstitutional, and the policy should take the initiative to stop the abuse of religious freedom [2]. Development and assessment of culturally focused faith-based programs, which are community based, culturally sensitive, and combined with evidence-based services and harm reduction strategies should be given priority to be funded [1], [9], [12], [13]. These models show that they can mobilize underserved groups without violating cultural and spiritual diversity [1], [9], [13]. Training on substance abuse counseling and other providers should be encouraged by policy support on culturally competent spiritual assessment and intervention. Ethical limits, client centered training, and respect towards various spiritual and religious identities should be trained [15], [20], [28]. Lastly, there should be policy that encourages interaction between the communities of faith and the health systems of the people without crossing boundaries. Religious leaders may also be significant in alleviating stigmatization, helping people recover, and referring them to services, yet partnerships should not violate religious freedom and health promotion values [6], [16], [23].

- Practice Implications

Spiritual beliefs, practices and concerns should be assessed by the practitioners to the clients as part of holistic care because spirituality is a possible resource to recover [8], [15], [20]. The evaluation must be client-centered, voluntary and sensitive to other spiritual identities, such as non-religious views [15], [20]. In the application of spirituality in treatment, the practitioner is advised to uphold strong professionalism by not proselytizing and imposing personal faith [10], [15]. Counseling integrated with spirituality must assist the client to utilize the spiritual resources that have meaning to the client other than enforcing certain religious beliefs and practices [15], [20]. There must be a clear separation of religious activities that are mandatory or optional with religious activities being genuinely voluntary and secular alternatives must also be available to those who do not want to attend to religious content [2], [10]. Programs are not to be coercive, authoritarian or judgmental but address spirituality as voluntary resource and source of support [1], [10]. Culturally based practice entails authentic community collaboration, sensitivity to various spiritual approaches, and assimilation of cultural values and strengths [1], [9], [12], [13]. They should not take over other groups with their religious paradigms but must match spiritual material to culturally specific populous and affiliated identities of their communities [1], [9], [13]. Lastly, practitioners and programs must be involved in continuous moral consideration and assessment, which includes looking into whether their practices uphold voluntariness, diversity, uphold professional limits, and equitable access to care [10]. Continuous improvement of faith-informed approaches should be informed based on client feedback [8], [30].

8. Conclusion

The faith-informed substance use prevention, and treatment has an ambivalent role in the U.S. healthcare system and incorporates all three ethical and spiritual aspects in three main frameworks: 12-Step mutual aid, faith-based organizational programs, and spirituality-incorporated clinical counseling. When voluntary and culturally sensitive, such strategies can promote engagement and recovery through creating meaning-making, moral growth, social support,

and identity. Nevertheless, ongoing ethical and constitutional issues, such as the danger of coercion, church-state entanglement and insufficient protection of religious freedom, require special care and attention, especially when publicly funded. The existing body of evidence is still limited by methodological flaws, lack of comparison effectiveness studies and a close focus in U.S. Christian settings. To develop the field the field needs high quality research, extended outcome assessments, and more explicit mechanistic insights, and policy and practice frameworks that place voluntariness, professional limits, cultural competency and constitutional adherence as their principles. The potential of faith-informed interventions is significant though it cannot be legit and effective without adhering to the ethical principles, evidence-based standards, and respect to various beliefs.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

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