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Faith-Informed Treatment for Substance Use Disorders: A Narrative Review of Effectiveness, Ethics, and Public Policy

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Abstract: Faith-informed interventions on substance use disorders (SUDs) have grown in the United States and abroad, but their efficacy, ethical considerations, and policymaking have been disputed and not fully comprehended. There are scanty randomized controlled studies that support religious-spiritual group therapy as an effective intervention in enhancing spiritual health and quality of life in patients undergoing methadone treatment. Residential faith-based models program evaluations show that residential faith-based programs have high completion rates (≈98%), low recidivism rates (≈5%), and that higher spiritual well-being is correlated with reduced severity of substance use. Nevertheless, some qualitative ethnographies report about ethical issues such as the compulsory worship, coercion, proselytization, and violation of rights in certain residential therapeutic communities. The policy mechanisms used in the U.S. are SAMHSA grant funding of church-based programs, Medicaid reimbursement model to determine treatment capacity, and Section 1115 waivers that impact access to residential care. The disparity in state regulation provides uneven regulation of faith-based programs. Faith-informed SUD care demonstrates initial signs of advantage in spiritual wellbeing and life quality and recommendative correlation with less substance use. There is still critical ethical lapse in areas of autonomy, informed consent and avoidance of coercion, especially in residential cases. Policy frameworks are sources of funding but do not have uniform regulatory protection. Long-term, well-conducted, inter-sites studies, with uniform results and clear ethical safeguarding are extremely required.

Keywords: Substance use disorder; faith-based treatment; spirituality; addiction recovery; ethics; autonomy; Medicaid; SAMHSA; therapeutic communities; public policy.

INTRODUCTION

The problem of substance use disorders (SUDs) is one of the largest national and worldwide health crises, and the number of deaths related to overdoses of opioids alone has grown by 14.4 percent in recent years despite the access to evidence-based therapies (Latsko *et al.*, 2025). The evidences of SUD care are based on traditional biomedical and psychosocial interventions such as medication on opioid use disorder (MOUD), cognitive-behavioral treatment, and contingency management. However, the barriers to accessibility, retention of treatment, and multidimensionality of addiction have led to interest in complementary and alternative therapies, such as faith-based and spiritually based interventions. The faith-informed SUD treatment includes a diverse range of programs, including explicitly religious residential therapeutic communities that demand worship attendance to secular programs with either optional spiritual elements or faith community collaborations. They are based on theological schemes of redemption and conversion and spiritual transformation and use tools like prayer, worship, communal support, and meaning making (Williams, 2020; Egan *et al.*, 2022). Advocates believe that spirituality covers existential aspects of addiction, offers social support systems, and has protective relapse (Guelman, 2018; Beraldo *et al.*, 2019). There are criticism that include proselytization, coercion, rights, and the replacement of evidence-based medical care with religious programming (Williams, 2017; Monteiro *et al.*, 2022).

The political environment only adds to this image. In the United States, federal faith-based programs that date back to the George W. Bush administration have influenced the delivery of welfare and the delivery of addiction services, whereas the Substance Abuse and Mental Health Services Administration (SAMHSA) has funded church-based SUD interventions (Wissal, 2025.; Jordan *et al.*, 2023). Medicaid, which is the largest single payer of SUD treatment has now been broadened in the Affordable Care Act (ACA) and Section 1115 waivers, but its benefits are limited and controlled by managed care, leading to access barriers (Andrews *et al.*, 2018a; Peterson *et al.*, 2024). The variability of state regulations creates uneven regulation of residential faith-based programs, which casts some doubts on quality assurance and patient protections (O'Brien *et al.*, 2022). This is a synthesis of the existing knowledge on how faith-informed SUD treatment works, ethical issues such as autonomy and separation of church and state, and policy processes adopted by the government to influence service provision and funding. We use narrative synthesis to combine heterogeneous study designs

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such as randomized trials, program evaluations, qualitative ethnographies, and policy analyses and to reveal areas of research and future directions of this controversial and developing field.

CONCEPTUAL FOUNDATIONS

Theological and Ethical Frameworks

Faith-based SUD care is based on theological models, which integrate individual change, redemption, and rehabilitation of spiritual identity. The ethnographic studies of Pentecostal therapeutic communities report that identity transformations brought about by worship and conversion processes are the key components that members of the therapeutic community liken to their recovery (Williams, 2020). These programs present addiction as a spiritual crisis that needs to be converted to religion as the way to obtain clear-cut rehabilitation (Guelman, 2018). The redemption narrative in theology of progression through a path of sin and slavery to a state of grace and liberation is a strong interpretation that is very significant to some of the participants. Nonetheless, various faiths express differing normative stances that define tolerable clinical activities. Indicatively, the Islamic legal schools of thought have objected some of the harm-reduction programs, such as needle exchange and opioid substitution therapy, because they might sustain and not eradicate the use of the substance (Razak *et al*., 2016). Such religious-normative conflicts impact available interventions within faith-identified contexts and emphasize cultural and theological context as aspects to comprehend faith-informed care.

Mechanisms of Action

The following putative mechanisms of recovery are implemented by faith-informed interventions:

Spiritual sense-making: Prayer, worship, and spiritually based programming are activities that help participants to generate purpose and transcendence narratives that can alleviate existential distress and severity of substance use (Egan *et al*., 2022). The Bridge Programme by the Salvation Army, such as an example of it, incorporates spirituality as a major element of treatment, and the participants of the program note that spiritual practices make them feel purposeful and guided (Egan *et al*., 2022).

Sharing support and social capital: Group worship, peer networks, and residential program community give rise to social bonds similar to social capital and social capital, as expressed in ethnographies, are perceived to be the main pillars of the therapeutic milieu (Williams, 2020). These collective forms can counteract alienation, offer responsibility and enable identity transformation with collective ritual and story.

Ritual and practice: Organized spiritual practices such as compulsory or optional worship, prayer and faith-based religious curricula are therapeutic measures. In a meta-analysis of 28 studies, spiritually enhanced groups were found to have 43 per cent higher attendance, indicating the possibility of enhancements in ritual attendance through engagement (Marsaulina *et al*., 2025). Nevertheless, there are some questionable aspects of forced religion in certain programs that provoke ethical issues of coercion and free choice, and this is addressed in Section 5.

Identity change: Conversion experiences and identity discipleship models of recovery seek to bring basic changes of self-concept and identity. People in faith-centered programs talk about the process of rediscovering identity by spiritual transformation, that is, leaving the identity of an addict and entering the identity of a redeemed or saved person (Zachary, 2016; Williams, 2020). This identity work can be a source of psychological resources to maintain the behavior change, but it can also put pressure on adhering to religious standards.

Tensions with Harm Reduction and Evidence-Based Practice

Religion-based theories tend to focus on abstinence as the only acceptable endpoint, which conflicts with the philosophies of harm reduction that present risk reduction and autonomy in patients as more important objectives than absolute abstinence (Razak *et al*., 2016). There are faith-based therapeutic communities that have been criticized because of rejecting or limiting access to MOUD, considering medication-assisted treatment as contravening spiritual recovery (Gannon *et al*., 2024). This position is in opposition to strong evidence in favor of MOUD as the best treatment of opioid use disorder and the issue of whether faith-based programs can deliver evidence-based care (Humphreys *et al*., 2024).

Evidence of Effectiveness

The most powerful experimental results are presented by the randomized clinical trial of Yaghubi *et al*. (2019) among 72 patients treated with methadone in Qom City, Iran. The participants were randomly grouped to receive either religious-spiritual group therapy or the

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general information about addiction (control condition). The intervention involved eight sessions with weekly sessions that included Islamic spiritual teaching, prayer and making meaning through religion. The experimental group had statistically significant improvements in the spiritual health and quality of life than the controls ($p < 0.001$) at post-test (8 weeks) and follow-up (3 months) assessed using the WHOQOL-BREF and Spiritual Well-Being Scale (Yaghubi *et al*., 2019). The authors concluded that religious-spiritual education is a cheap, available, helpful, and efficient way of treatment SUD recovery. Although this trial offers valuable information on the effectiveness of structured spiritual intervention, there are a number of limitations that should be considered. The sample size (n=72) was small, and therefore, it did not have enough power to detect smaller effects or subgroup differences. The research was developed within a given cultural and religious setting (Shia Islam in Iran) which may be a cause of doubt in generalizing its results to other religious beliefs or secular environments. Spiritual wellbeing and quality of life outcome measures were prioritized instead of substance use behaviors (e.g., abstinence, relapse, treatment retention), so the implications on core addiction outcomes were unclear. Three-month follow-up was used and long-term recovery trajectories could not be assessed.

A number of large-scale program evaluations are descriptive evidence of outcomes in faith-intensive residential settings, albeit without randomized comparison groups. Egan *et al*. (2022) measured 325 participants in seven Salvation Army centers on psychometrically validated measures at baseline, end of treatment, and 3 months follow-up. The respondents who underwent the program experienced statistically significant improvements in spiritual wellbeing (WHOQOL-SRPB scores improved between 10.20 at baseline and 12.50 at end-of-treatment) that were maintained at 3-month follow-up. Notably, gains in spiritual wellbeing were linked to reductions in the level of alcohol and drug use on the Addiction Severity Index (adjusted mean reduction of 0.011 with respect to alcohol and 0.005 with respect to drugs per one-unit rise in spirituality) (Egan *et al*., 2022). The implication of these findings is that faith-based programs can affect the results of substance use through a spiritual development process, but the observational design does not permit the causal conclusion. Clancy *et al*. (2025) used a quality improvement evaluation of a faith-based adolescent SUD prevention program that was an alternative to juvenile court processing. The program had 2,437 participants; an estimated 98% completion rate was reported as well as 1-2 participants of the program reported coming back to another attempt (1/100) and 5% recidivism (5-6/100 sent back to court). Although these are notable numbers, the assessment did not use any comparison group, instead of independent assessment of the outcomes, it relied on the stakeholder reporting, which also failed to use any standardized substance use measures, which diminishes the validity of the results (Clancy *et al*., 2025). The Manta-analysis by Marsaulina *et al*. (2025) included 28 studies (2010-2020) that analyzed discipleship-based recovery curriculum in 20 faith-based centers in 12 countries. It was reported that the relapse rates at 12 months of follow-up had decreased by 58 percent compared to secular programs, and 68 percent of the participants reported the meaning of life had increased, 41 percent had an average increase in spiritual wellbeing (Marsaulina *et al*., 2025). Nonetheless, meta-analysis methodology, inclusion, and quality evaluation procedures are not described in accessible metadata, and the assertion of superiority to secular programs must be interpreted with caution due to the possible selection bias and heterogeneity in comparison groups. The study by Bano *et al*. (2019) is an experimental study in Pakistan targeting male patients with SUDs, randomly grouped into receiving either pharmacotherapy or pharmacotherapy, and religious therapy. The religious therapy group was found to be much more psychologically well-being (mean 26.44 vs. 16.24 in controls) in the California Psychological Inventory Well-being subscale. The age, marital status, and education level did not have any differences in terms of effects and patients in rural areas and having middle incomes demonstrated the strongest responses (Bano *et al*., 2019). This research gives support to the idea that religious therapy can improve psychological wellbeing when it is included in conventional pharmacotherapy, although once again no direct assessments were conducted on the outcome of substance use.

The qualitative research would offer a comprehensive contextual insight into the experience of the participants in faith-informed treatment. According to the residents of Christian therapeutic communities, worship and prayer are the source of support, sense of purpose, and

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closeness to God (Williams, 2020). The participants in some studies say that spiritual practices enable them to connect with God, enhance beliefs, and have peace, and they consider the theophostic prayer and spiritual interventions a positive treatment addressing underlying trauma and mental distress (Anding, 2018). Nevertheless, qualitative descriptions also indicate a considerable difference in experiences of respondents. Although a few residents find the overwhelming use of conversion experiences and identity change, others experience the feeling of indifference, isolation, and pressure due to obligatory worship and the need to conform to religious expectations (Williams, 2020). The treatment approach used by Brazilian therapeutic communities involved the use of daily prayers and biblical teachings as a part of abstinence by some users and the imagery of religious interventions as a violation of rights and indoctrination instead of care (Duarte *et al*., 2020). This is where the variability leads to the significance of voluntary participation and appreciation of different spiritual orientations.

One of the most important gaps in literature regards the combination of faith-based practices with proven evidence-based interventions. Gannon *et al*. (2024) studied the access to MOUD in faith-related treatment facilities and discovered that there was a great discrepancy in the willingness to provide medications in addition to spiritual education. Faith-based programs have managed to incorporate MOUD, cognitive-behavioral therapy, and spiritual elements, whereas some of them cling to abstinence-only philosophies, which reject pharmacotherapy (Gannon *et al*., 2024). The Imani Breakthrough project (SA-funded church-based intervention targeting the black and Latinx population) proved feasible and acceptable but resulted in 42% retention at 12 weeks, suggesting that the implementation of interventions in the community faith setting will be challenging (Jordan *et al*., 2021; Jordan *et al*., 2023). According to Guelman (2018), religiosity offers support, containment, identity, and a self-esteem protection network, social enrichment with new bonds, which is recognized as a primary protective factor against relapses following the treatment. Yeung (2021) applied the latent growth curve model to measure the impact of the development of religiosity on abstinence between faith-based and secular treatment programs, but there is no information on the outcome data in the metadata.

Evidence based practice on faith-informed SUD treatment has a low but positive suggestive value. A single properly organized RCT indicates notable changes in spiritual well-being and quality of life due to religious-spiritual group therapy (Yaghubi *et al*., 2019). Big program assessments demonstrate connections between spiritual wellbeing enhancement and reduction in the level of substance use with high completion rates in certain environments (Egan *et al*., 2022; Clancy *et al*., 2025). Nonetheless, the review of the evidence does not permit conclusive findings on comparative effectiveness due to the lack of rigorous, long-term, multi-site RCTs that have standardized outcomes of substance use (abstinence, relapse, treatment retention, overdose). The variety of faith-based interventions between the adjunctive spiritual counseling and faith-based intensive residential programs makes the process of synthesis and generalization even more complex.

ETHICAL CONSIDERATIONS

Patient Autonomy and Informed Consent.

One of the most important values in medical ethics is patient autonomy the right to make informed, voluntary choices regarding one treatment. Faith-based SUD treatment is particularly prone to autonomy issues when, in its case, religious programming is compulsory, closely set up in residential schedules, or promoted as the sole channel of healing. In a faith-based therapeutic community called Hebron, Williams (2017) recorded an instance of ethical dilettants, whose researchers noted instances of mixed loyalties, forced consent and a lack of volitional agency between populations residing in hierarchical environments. The compulsory character of worship and bible study made conditions under which the residents were not able to refuse to participate in any of the programs because they may lose their discharge or be ostracized by others (Williams, 2017). The notion of coerced consent is especially relevant to the residential context where one might have fewer options (e.g., to be put to prison, to become homeless) and where the rules of the program presuppose that one has to engage in religious practices as the only way to remain at home. Although the programs can obtain written informed consent, the voluntariness of the same consent will be doubtful when structural coercion is applied on the individuals (Williams, 2017). Ethical practice entails that subjects should be well informed regarding the religiousness of programming, provided with true options and

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allowed to refuse spiritual practices without punishment.

Proselytization and Coercion in Religion.
Proselytization is an active process of converting people to a certain religious confession, the ethical issues of which are directly different in the framework of addiction treatment. In Pentecostal therapeutic communities, Williams (2020) noted that worship and conversion events are the focal point of reported transformations among residents, and that their programs specifically define religious conversion as the only path to ultimate rehabilitation (Guelman, 2018). Although not all residents oppose and resist this conversion-oriented strategy, others find it coercive when it is associated with reviews of treatment progress or discharge readiness. Duarte *et al*. (2020) reported therapeutic communities operated in Brazil that frequently apply therapeutic methods based on evangelization and religious conversion, with some of the participants stating that a religious approach can be applied to rights and cause indoctrination instead of care. The boundary between spiritual assistance and religious selling is still very thin in residential facilities where authority shifts to the staff, and the vulnerability and dependency of residents impose the pressure to comply (Williams, 2017).

Separation of Church and State and State Funding.
The separation of church and state is a constitutional and policy concern that is brought up by the fact that public funds are used in order to cover the religious SUD treatment. In America, the First Amendment to the Constitution includes an Establishment Clause that prohibits the government from promoting or supporting religion. Critics say that using public money to fund faith-based therapeutic communities, especially when the program requires worship attendance or a religious conversion, is a violation of this principle and is likely to displace secular, evidence-based care (Monteiro *et al*., 2022). Monteiro *et al*. (2022) explain Brazilian therapeutic communities by referring to them as the space of violation of the right to health: the transition to the religious action instead of scientific/medical rationality is the cause of symbolic and physical violence against addicts with the help of Public Health Policies. These criticisms focus on fears that promoting faith-based programs by the populace can jeopardize the medical and scientific communities, especially in situations where the regulatory controls are weak and in cases where the programs are run contrary to the law stipulated in the 2001 law of 10.216 (Monteiro *et al*., 2022). In the United States, faith-based initiatives of Bush era aimed to increase the role of religious organizations in social services while keeping within constitutional limits by means of vouchers and beneficiary choice (Wissal, 2025). But the adequacy of these precautions is still challenged, especially where the alternatives are not real or when programs fail to make a clear distinction between religious and therapeutic activities.

Trauma-Informed Care and Retraumatization Risks
The SUDs have a high proportion of individuals who experienced some form of trauma either in the form of child abuse, intimate partner violence, or unfavorable experiences in religious institutions. Religious interventions that focus on suffering, sin and redemption can have the unwanted implication of retraumatizing those with religious trauma histories. According to Marsaulina *et al*. (2025), excessive focus on suffering themes in the cruciform theology can retraumatize the victims of substance-related abuse, and some individuals with religious trauma backgrounds may be hostile to the spiritual elements, which requires flexibility in the implementation guidelines. As Zachary (2016) noted, the participants in a faith-based recovery program were stuck on scriptural principles of identifications because of prior trauma, and trauma-informed care (understanding and accommodating the variety of spiritual background and trauma histories) is needed. Some ethical practice involves the screening of religious trauma, provision of opt-out options to spiritual activities and providing therapeutic interventions that do not add to the existing damage.

Quality of Care and Evidence-Based Practice.
The problem of ethical issues is also present when faith-based programs refuse or limit access to evidence-based programs, especially MOUD. Gannon *et al*. (2024) discussed the use of medications to manage opioid use disorder and other evidence-based services provided in faith-related treatment facilities and discovered that there was considerable discrepancy in the provision of MOUD. Other programs consider medication-assisted treatment to be contrary to spiritual healing, although there is strong evidence that MOUD can decrease overdose deaths and increase retention (Humphreys *et al*., 2024). In the Hebron therapeutic community, Williams (2017) reported the lack of medical care, limited medical

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care, bullying, and lack of aftercare and questions whether faith-intensive programs can offer sufficient clinical care. The ethical principle of beneficence serving in the best interest of patients demands that faith-based programs provide or offer entry to evidence-based treatments and that they do not replace religious programming with the required medical attention.

Researcher Ethics and Mixed Loyalties

Williams (2017) gives a reflexive description of the situation of ethnographers involving themselves in residential study in faith-based contexts, such as the concept of the so-called mixed loyalties (between the integrity of the research and the relations within the program), the problem of access and coerced consent, and vulnerability of being assimilated into the religious culture of the program. Such methodological and ethical issues make it difficult to conduct rigorous and critical studies on faith-based programs and emphasize the necessity to evaluate and control them independently.

Ethical Safeguards and Best Practices

To address these ethical concerns, several safeguards are recommended:

1. Voluntary participation: Religious activities must be well differentiated as voluntary and non-penalized, in case of non-participation.
2. Informed consent: It is important to provide informed consent, where participants are given explicit written messages about the religiousness of the programming, and a chance to request clarification and refuse.
3. True substitutes: People ought to get access to secular therapy of equal quality and availability.
4. Trauma screening: The programs have to test religious trauma and have to cover various spiritual orientations.
5. Evidence-based care: Faith-informed programs ought to incorporate or provide access to evidence-based interventions, such as MOUD.
6. Independent control: Faith-based programs should be checked by regulatory bodies on the rights violations, coercion, and quality of care.
7. Researcher independence: Independent investigators should conduct the evaluation research and are not supposed to have any financial or ideological interest in programs.

PUBLIC POLICY AND FUNDING

Federal Faith-Based Initiatives

The U.S. federal faith-based efforts have largely influenced the policy environment of faith-informed SUD treatment. The George W. Bush administration had faith-based initiatives that affected welfare delivery, such as vouchers for addiction recovery services, which made use of state-level flexibility of Medicaid to increase religious organizations' involvement in social services (Wissal, 2025). Such efforts were aimed at lowering the regulatory obstacles to the engagement of faith-based organizations in publicly funded programs without pushing constitutional limits by allowing beneficiaries to choose, or through voucher programs. The provided literature, however, lacks the documentation of the particular executive orders or statutory provisions (e.g., Charitable Choice language), and we cannot evaluate the exact legal frameworks and safeguards put in place by such efforts. The history of pay and structure of faith-based SUD treatment in relation to the Bush-era policies is still unrecorded in the evidence base available.

SAMHSA Partnerships and Grant Funding

Substance Abuse and Mental Health Services Administration (SAMHSA) has been at the forefront in acting as a supporter of faith-based SUD programs via specific grant programs. According to Jordan *et al*. (2023), the Imani Breakthrough intervention was designed, with the funding of the Substance Abuse and Mental Health Services Administration (SAMHSA), and was implemented in the Black and Latinx church settings. This project, funded by SAMHSA, proved that church-based interventions against SUD are both viable and acceptable to the community, but retention rates (42% at 12 weeks) indicate the implementation barriers (Jordan *et al*., 2021; Jordan *et al*., 2023). The evidence-based practices by SAMHSA grant programs can be implemented in faith-related settings as well. As an illustration, SAMHSA allows the use of contingency management incentives via its State Opioid Response grant program, but the current allowance per patient per year has been raised to 750 dollars (Clark *et al*., 2023; Knopf, 2025). SAMHSA has also given out advisories advising the use of low-barrier models of SUDs care, which makes accessing care easier with the use of bridge clinics and syringe services programs (Knopf, 2023). Another source of funds is state-level SAMHSA block grants. SAMHSA Block Grants, SAMHSA discretionary grants, and state-appropriated sources are used to fund recovery support services by states, and the House Committee on Appropriations has approved

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another 500 million dollars to fund the Substance Abuse Prevention and Treatment (SAPT) block grant in fiscal year 2023 (Capoccia *et al*., 2024; Knopf, 2022a). Such block grants may encourage faith-based organizations to join the overall SUD treatment infrastructure of the states.

Medicaid Reimbursement and Benefit Design

Medicaid is "the largest single payer for SUD treatment," expending approximately $12 billion annually and serving as the primary insurance source for many individuals with opioid use disorder (Humphreys *et al*., 2024; Statchen *et al*., 2025). Medicaid reimbursement structures and benefit design significantly shape treatment capacity and access, with direct implications for faith-affiliated programs.

Reimbursement and Treatment Capacity: Jones *et al*. (2020) found that "programs' ability to accept Medicaid and expand addiction services is closely tied to Medicaid reimbursement and targeted grants, which influence treatment capacity in federally qualified health centers and other providers." Andrews *et al*. (2018a) demonstrated that "addiction treatment programs are less likely to accept Medicaid in states with more restrictive SUD benefits," indicating that benefit design affects provider participation. This relationship suggests that faith-affiliated programs' ability to serve Medicaid beneficiaries depends on adequate reimbursement rates and benefit coverage.

Affordable Care Act Expansions: The ACA "established minimum insurance standards for addiction treatment and expanded federal parity regulations to selected Medicaid benefit plans, requiring states to change their addiction treatment benefits" (Andrews *et al*., 2018b). The ACA also extended the Mental Health Parity and Addiction Equity Act of 2008 to alternative benefit plans and Medicaid managed care, "prohibiting more restrictive limits on addiction treatment than other medical services" (Andrews *et al*., 2018b). These expansions increased coverage for SUD services, though implementation has been uneven across states.

Managed Care Discretion: Despite federal parity requirements, Peterson *et al*. (2024) found that "most states allow Medicaid managed care plans discretion to restrict substance use disorder treatment benefits" through utilization management tools such as prior authorization, drug testing, and "fail first" requirements. Specifically, "fewer than one-third forbade prior authorization for each service, and fewer than two-thirds prohibited prior authorization, drug testing, 'fail first,' or psychosocial therapy for most treatment medications" (Peterson *et al*., 2024). This discretion creates potential access barriers that may disproportionately affect faith-affiliated programs with limited administrative capacity to navigate complex authorization processes.

Section 1115 Waivers and Residential Treatment

Section 1115 waiver of Medicaid has been one of the policy levers in the increase of SUD treatment especially residential contexts. Previously, federal Medicaid funds were forbidden to residential treatment facilities with more than 16 beds, which meant that residences to treat SUDs faced a major barrier in their funding. As of 2015, states were eligible to receive Medicaid funds as a full continuum of care including MOUD through the new requirements that states could seek a Section 1115 SUD waiver, which allowed access to previously restricted funds (Beetham *et al*., 2025; O'Brien *et al*., 2022). The authors of this paper (O’Brien *et al*., 2022) had recorded that CMS requirements of Medicaid SUD Waivers required the full continuum of care, comprising of medication treatment of opioid use disorder (OUD) and as a result, 25 of 30 states with approved Section 1115(a) demonstrations documented explicit requirements of access to OUD medication in residential settings. This policy tool has enabled the provision of services through the updated state regulations and the increase in the availability of MOUD (O'Brien *et al*., 2022). Beetham *et al*. (2025) discovered that Section 1115 waivers enhanced patient access to MOUD in residential treatment centers mostly due to dynamics of facility entry and exit where the new facilities had higher probabilities of accepting Medicaid and offered MOUD, whereas non-MOUD providers were more likely to leave the market. This revival in the market has a consequence on the faith-based therapeutic communities some of which have long been opposed to the integration of MOUD (Gannon *et al*., 2024).

State Regulatory Variation

Residential SUD treatment is regulated at the state level in markedly different ways, establishing inconsistent supervision and quality control. O'Brien *et al*. (2022) reported as confusing different regulations of access to opioid medication treatment in residential settings, with states having various regulatory methods to

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compel or construct access to OUD medication. This dissimilarity influences the degree by which faith-based curative societies are obliged to provide evidence-based therapies and the methods of compliance supervisory tasks. The literature provided does not present specific data regarding licensing standards, inspection procedures or enforcement mechanisms in relation to faith-based therapeutic communities so there is a big gap in the policy evidence base. The violations of rights and insufficient supervision are reported in Brazilian therapeutic communities (Monteiro *et al*., 2022; Duarte *et al*., 2020), yet the systematic reviews of the U.S. regulatory systems cannot be found in the literature reviewed.

Policy Tensions and Implementation Challenges

Several tensions emerge between policy intent and implementation:

There exist a number of strains between the policy intention and implementation:

Coverage vs. Access: Although the expansions of Medicaid coverage of SUD treatment have increased nominal coverage, the restrictions in Medicaid SUD coverage yield empirically significant negative effects on Medicaid program acceptance and produce a paradox of coverage expansions and provider participation in reality (Andrews *et al*., 2018a). The coverage- Access disparity can be especially relevant to faith-based programs in isolated or underserved regions.

Parity vs. Managed Care Discretion: Federal parity regulations are in addition to state and managed care plans substantial discretion to exercise utilization management of SUD services, which results in possible access barriers despite the existence of mandated coverages (Peterson *et al*., 2024). This conflict is indicative of larger issues related to translation of policy mandates into practicum.

Evidence-Based Requirements vs. Program Philosophy: Section 1115 waiver conditions to MOUD availability could potentially create clashes with the abstinence-only philosophy of certain faith-based programs, which might put a strain on the implementation process and has the risk of causing market displacement (Beetham *et al*., 2025; Gannon *et al*., 2024).

Federal Encouragement vs. State Variation: SAMHSA federal policies that promote involvement of faith-communities under the guise of faith-community encouragement grants do not cause uniform oversight and quality assurance in varying degrees between states.

Funding Trends and Sustainability

Andrews *et al*. (2023) discovered that the treatment of substance use disorders by state funding dropped during the aftermath of Medicaid expansion, which indicated a change in the terms of the state-appropriated funds to Medicaid-funded approaches. The trend impacts the sustainability of faith-based program especially those that had traditionally been paid by state grants or contracts as opposed to through Medicaid reimbursement. The financial viability of programs will continue to depend upon the capability of programs to comply with the Medicaid billing requirements, regulatory standards to comply with reimbursement, and implement evidence-based practices which are mandated by payers.

RESEARCH GAPS AND METHODOLOGICAL LIMITATIONS

Limited Randomized Controlled Trials

Program evaluations and observational studies represent the most frequent categories in the evidence base of the effectiveness, and only one well-designed RCT was found in the analyzed literature (Yaghubi *et al*., 2019). Such a test was done on a small sample (n=72), in a given cultural and religious context (Shia Islam in Iran) and can be not readily generalized. The lack of large, multi-site RCTs which would compare faith-informed interventions to either evidence-based secular treatments or treatment-as-usual also is a significant gap. In the absence of these trials, then there is no way to know whether the perceived benefits are due to certain effects of the elements of spirituality or merely to nonspecific elements of the therapeutic process (such as social support, structural effects on therapy, expectancy, and selection bias).

Short Follow-Up Periods

There are generally results that are reported at the end of treatment, or 3 months follow-up (Yaghubi *et al*., 2019; Egan *et al*., 2022). SUD is an episodic and chronic disease, and the recovery process usually goes through the years. There is no available long-term longitudinal data (e.g., 12-month, 24-month, 5-year results) and therefore the assessment of the long-term recovery and relapse patterns, and the long-term efficacy of spiritual interventions is not possible. Marsaulina *et al*. (2025) mentioned 12-month relapse outcomes of a meta-analysis, yet the study design of the primary studies and their comparison are inexplicit.

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Disproportional Outcome Measures.

The outcome measures used across studies such as spiritual wellbeing, quality of life, psychological wellbeing, program completion, self-reported abstinence and addiction severity indices make the synthesis and meta-analysis of studies across studies a difficult undertaking. Hardly any research sites the objective substance use outcome (e.g. urine drug screens, breathalyzer results) or vital public health outcome (e.g. overdose, HIV/HCV infection, involvement with the criminal justice, employment). A unified agreement on a fundamental outcome set of research in faith-based SUD treatment would be beneficial in the field with both spiritual/existential outcomes and standardized substance use and functional outcomes.

Selection Bias and Comparison Groups.

Program appraisals do not usually have randomized or matched comparison groups and thus they cannot separate treatment effects and selection bias. It is possible that people who select faith-based programs are systematically different than people who select secular programs in the following ways; baseline religiosity, motivation, social support, or addiction severity. The result of such confounders is that without proper measures of these confounding variables, the resultant observations can be accounted by the baseline difference as opposed to the effect of treatment. The impressive completion rates of Clancy *et al*. (2025) and low recidivism rates cannot be viewed as indicative considering the lack of comparison data and the possible selection effects.

Gaps in Cultural and Religious Diversity.

The reviewed literature is focused on particular cultural and religious backgrounds Christian (specifically, Pentecostal and evangelical) programs of the United States, Brazil, and Argentina; Islamic programs of Iran and Pakistan; and Salvation Army programs in New Zealand. Very little research has been conducted with regard to faith-informed SUD treatment across other religious traditions (e.g., Judaism, Buddhism, Hinduism, Indigenous spiritualities). Moreover, research seldom considers the effectiveness of faith-based interventions among a variety of populations that can be determined by race, ethnicity, gender, sexual orientation, or socioeconomic levels. It is an interesting exception that the Imani Breakthrough project is centered on Black and Latinx communities (Jordan *et al*., 2021; Jordan *et al*., 2023).

Inadequate Ethical and Rights-Centered Research.

Although ethical issues are written down in qualitative ethnographies (Williams, 2017; Williams, 2020; Duarte *et al*., 2020), there are no systematic quantitative studies on autonomy, coercion, and informed consent, as well as right violations in faith-based programs. Surveys are not regularly done to determine how the participants understood the voluntariness, how they felt pressured to conform to religious values, or how contented they were with the tradeoff between the spiritual and clinical aspects. Processing and verifying instruments that are going to measure these constructs would allow their ethical judging to be more rigorous.

Gaps in the science of policies and implementation.

The policy literature contains descriptive stories of funding systems and regulation systems but contains no research of rigorous implementation science that studies how policies get implemented, which impediments and enhancers influence implementation, and whether policy differences do. An example would be that we do not know how organizational factors were predicted to touch successful MOUD integrations and how the implementation of the policy affected patient experience and outcomes, whereas we know that Section 1115 waivers facilitated MOUD access in residential environments by turning around facilities (Beetham *et al*., 2025).

Lack of Economic Evaluation

In the reviewed literature, no cost-effective or cost-benefit analysis on faith-informed SUD treatment was found. Since the Medicaid and SAMHSA grants have a significant impact on SUD treatment, economic analysis is required to educate the decisions on resources distribution. Comparative cost effectiveness (established through studies of faith based and secular programs, or studies of various models of faith-informed care) would be a valuable addition to policymakers and payers.

Integration with the Evidence-Based Practice.

The literature does not give much evidence on how faith-based methods can be implemented successfully with other well-known evidence-based treatments like MOUD, cognitive-behavioral therapy, contingency management, and motivational interviewing. Gannon *et al*. (2024) reviewed the availability of MOUD in faith-related facilities, yet the studies involving the rigorous

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testing of the integrated models are not present. Studies are required to point on the best practice in terms of integrating both spiritual and clinical aspects, staff training needs to provide integrated care, and patient preferences with regard to the ratio of spiritual and non-spiritual elements.

Future Directions

Further studies on faith-informed treatment of substance use disorders ought to consider the priorities of methodological rigor, mechanistic clarity, ethical protection, and policy relevance. To begin with, it is evident that there is a necessity for large, multi-site, pragmatic randomized controlled trials between faith-informed interventions and secular evidence-based therapies and treatment-as-usual. These studies must use varied populations of different geographic areas and religious categories, have standardized outcome measures (e.g., substance use, functional recovery, quality of life, and spiritual well-being), and have long-term follow-up (at least 12-24 months). An analysis of moderators, including baseline religiosity, history of trauma, and cultural background, will lead to the identification of people the faith-informed interventions work best with, whereas economic analysis can be used to guide funding and reimbursement decisions. Second, the studies need to no longer be based on outcome evaluation but rather investigate measures of action. Research ought to be done on whether spiritual meaning-making, identity change, community incorporation, and organized religious actions are mediating factors in recovery. Repeated measures and longitudinal designs with mediation analysis, which is accompanied by a qualitative study of the lived experience of participants, can help answer the question of how and why these programs can sustain recovery.

Third, systematic research in the field of ethics and rights needs to be conducted. The possible future work would evaluate the voluntariness, informed consent, the perception of coercion, and the offer of secular options within the community where the faith-based programs are widely used. There should be independent appraisals and reliable scales to determine that faith-based treatment does not violate autonomy and constitutional protections, but does not lead to therapeutic compromise. Fourth, using the integration research, the best practices in combining the spiritual elements with the established evidence-based interventions, such as medications used to solve the opioid use disorder, cognitive-behavioral and contingency management, and trauma interventions, should be considered. Compiling and testing structured manualized hybrid models can increase clinical effectiveness and even acceptability.

Lastly, implementation and life-course study need to evaluate the probability of the regulating environments, organizational capacity, and partnerships with the community on the quality and the outcome of the program throughout the years. Longitudinal studies with a follow-up on the trajectories of recovery over treatment episodes can clarify the factors of spiritual growth, social capital, and community Act as contributors to the continuation of recovery capital. Research partnerships with individuals with lived experience, faith leaders, clinicians, and policy makers will establish the research as relevant and ensure further studies have an ethical foundation.

CONCLUSION

Treatment of substance use disorders based on faith is already at a complicated intersection between spirituality, clinical management, ethics, and public policy. As it is suggested by the emerging evidence, the use of spiritually integrated interventions has potential benefits in terms of improving spiritual wellbeing, meaning making, and quality of life in a particular group of people; however, the evidence base currently is rather limited in terms of methodology and not enough to allow establishing comparative efficacy. Simultaneously, such registered ethical issues as coercion, proselytization, and the absence of regular evidence-based therapies implementation highlight the necessity of better protection and regulation. State aid systems have brought about an increase in faith-based providers, but differences in quality and access to secular services cause significant equity issues and independence. In the future, the field needs intense, longitudinal investigation where the results are standardized, there are clear ethical measures, and the integration of evidence-based practices is evident. Religion and spirituality can provide some helpful material in the recovery program; however, the integration of religion into the treatment process should be voluntary, clinically reasonable, and well-founded with respect to the rights and dignity of the patients.

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