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Sources of Care for Alcohol and Other Drug Problems: The Role of the African American Church

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Abstract

African Americans experience significant disparities in treatment access, retention, and quality of care for alcohol and drug use (AOD) problems. Religious congregations, often the first point of contact for help with AOD problems, can play an integral role in improving access to treatment. However, little is known about the role of African American churches in addressing AOD problems. We administered a survey to a faith-based collaborative of 169 African American churches in Los Angeles to examine how AOD problems are identified in congregations, the types of support provided, barriers to providing treatment referrals, and factors associated with the provision of treatment referrals. Seventy-one percent of churches reported caring often for individuals with AOD problems. AOD problems came to the attention of congregations most commonly via a concerned family member (55%) and less frequently through individuals with AOD problems directly approaching clergy (30%). In addition to providing spiritual support, a substantial proportion of churches reported linking individuals to AOD services through referrals (62%) and consultation with providers (48%). Barriers to providing treatment referrals included lack of affordable programs (50%), stigma (50%), lack of effective treatments (45%) and insufficient resources or staff (45%). The likelihood of providing treatment referrals was greater among mid-sized versus smaller-size congregations (OR=3.43; $p<.05$) and among congregations with clergy that had attended seminary (OR=3.93; $p<.05$). Knowing how to effectively coordinate informal sources of care provided by African American churches with the formal service sector could make a significant impact on AOD treatment disparities.

Keywords

Alcohol and Other Drug Use; Barriers; African American church; Faith-based

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent

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

Introduction

African Americans are disproportionately affected by the adverse consequences of problematic alcohol and other drug (AOD) use. Despite similar rates of AOD use, African Americans suffer more severe social, health, and criminal related costs than Whites (Pouget et al., 2014; Wallace, Myers, & Osai, 2004), which may be partly due to significant disparities in substance abuse treatment. Only about 10% of African Americans with current AOD dependence or abuse obtain formal treatment (Cook & Alegría, 2011). Moreover, when African Americans do obtain treatment, they are significantly more likely to prematurely drop out and to receive lower quality of care than Whites (Guerrero et al., 2013; Wells, Klap, Koike, & Sherbourne, 2001).

Creating strategic partnerships between religious congregations and the formal service sector has been identified as one potential solution to improve African Americans' access to and engagement with AOD treatment (Blank, Mahmood, Fox, & Guterbock, 2002; Williams, Griffith, Young, Collins, & Dodson, 1999). Historically and presently, churches have played a central role in caring for the emotional, physical, and spiritual needs of African Americans (Pew Research Center, 2008; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). For many African Americans, clergy are often the first point of contact for help with AOD problems (Blank, et al., 2002; Taylor, et al., 2000). In a recent nationally representative survey of U.S. adults, African Americans were more likely than Whites to turn to clergy for alcohol-related problems (Bohnert et al., 2010).

As a trusted institution, African American churches can serve a pivotal role in reducing AOD related disparities by facilitating the early detection of AOD problems, shaping social norms and stigma regarding treatment, and establishing linkages to formal services and programs (Mattox & Sullivan, 2008; Milstein, Manierre, Susman, & Bruce, 2008). Moreover, staying connected to a religious congregation while in AOD treatment has been linked to a variety of improved outcomes including better treatment retention, longer durations of abstinence, and lower rates of recidivism (Petry, Lewis, & Ostvik-White, 2008; Suro et al., 2007).

Surprisingly little is known about the role of African American churches in providing support for AOD problems; even though it has been documented that many turn to churches when struggling with AOD use (Wang et al., 2005). To leverage the collective strengths of African American churches and the formal treatment sector, a better understanding is needed of how African American churches are addressing AOD problems within the contexts of their congregations and the challenges they are encountering in connecting with the formal service sector. In this study, we collaborated with a local, urban, faith-based collaborative of African American churches in a major metropolitan area to examine: (1) how AOD problems are being identified in congregations, (2) the types of resources and support that are being provided, (3) barriers to churches providing referrals to formal AOD services, and (4) factors associated with church referrals to formal AOD services. This information can help guide the development of strategic partnerships between African American churches and the formal AOD service sector to improve disparities in treatment access and engagement.

Methods

Sample and Procedures

A faith-based community collaborative of African American churches in Los Angeles was asked to participate in a survey about church practices with respect to addressing AOD problems and related training needs and resources. The faith-based collaborative serves as a forum where information is disseminated about potential opportunities to partner on efforts related to addressing the social, economic, and health needs of the community. A contact list of churches that have attended any faith-based collaborative meetings is maintained and served as the sampling frame for the study. Of the 419 churches on the contact list, 145 churches could not be contacted (e.g., phone disconnected, could not locate working number, no answering machine). Of the 272 churches in which contact was established, 40% completed a survey (121 self-administered and 48 phone-administered), 18% (N=76) agreed to participate but never completed a survey, 8% (N=22) refused, and 2% (N=7) could not secure head clergy's consent (e.g., pastor ill, no pastor).

Measures

Congregational background—Information about congregations' denomination, size, years since established, and staffing were assessed using items from the National Congregations Study (Chaves & Anderson, 2008). Respondents were also asked whether clergy had attended seminary and whether clergy provide counseling for substance abuse problems.

AOD problems—Respondents were asked to rate on a 3-point scale (*often, sometimes, rarely*) how often their church cares for individuals who have problems with the following: alcohol, marijuana, cocaine/crack, heroin, prescription medications, or methamphetamines.

Identification of AOD problems—Respondents were asked to indicate how often (*often, sometimes, rarely*) their church finds out about AOD problems through: self-disclosure (i.e., person with AOD problem tells the pastor/others at church), recognition by concerned others (i.e., family/church member tells the pastor or others at church, pastor notices the problem), and referrals from other organizations (i.e., another church, health provider/agency).

Resources and support—Respondents were asked to indicate whether their church provides the following types of support specifically for AOD problems (*yes/no*): prayer/healing services, Bible studies about coping with AOD problems, classes about AOD problems, support for family members, recovery support groups, counseling, treatment referrals, advice to stay in treatment, and consultation with treatment providers so that individuals stay engaged in treatment.

Barriers to AOD treatment referrals—Respondents were asked to rate on a 4-point scale (*not at all true* to *extremely true*) the degree to which their church might not make a referral due to the following types of reasons: treatment-related factors (e.g., lack of affordable treatment, providers who respect religious beliefs), church-related factors (e.g., unsure whether problem required treatment, treatment could harm individual's faith), and

individual-related factors (e.g., shame/embarrassment). The percentage of churches endorsing barriers with *extremely true* or *very true* response options is presented.

Church referrals to AOD treatment—To assess recent church referrals to AOD treatment, respondents were asked the following, “In past six months, how many individuals from either your congregation or community has your church referred to substance abuse services?” A dichotomous variable was created to indicate whether a church had provided a recent referral to AOD services. Responses greater than zero were coded as *yes*=1 and zero responses were coded as *no*=0.

Analyses

The proportion of churches endorsing each type of identification of AOD problems, AOD support, and barriers to AOD treatment referrals were estimated. A multivariate logistic regression analysis was conducted to identify factors associated with church referrals to AOD services.

Results

Congregations that participated in the survey represented various denominational affiliations, the largest of which were Baptist (28%), Church of God in Christ (28%), and Non-Denominational Protestant (26%) (see Table 1). The majority of churches had congregations with fewer than 99 members (57%) or between 100 to 499 members (34%). A smaller proportion had 500 or more members (10%). Less than half of the congregations (42%) employed full-time paid staff and most had clergy that had attended seminary (69%) and that provide counseling for substance abuse (73%). At the time of the survey, congregations reported being in operation for a mean of 39.78 years ($SD = 27.95$). Nearly three-quarters of respondents were clergy, the remaining were lay leaders (10%), congregants (2%), or other (14%).

Overall, 71% of churches reported caring often for individuals with AOD problems. More than half of the churches reported caring often for individuals with problems with alcohol (60%) and marijuana (52%). Approximately 40% of the churches reported caring often for individuals with cocaine/crack (42%) and prescription medication (39%) problems. A smaller proportion of churches reported caring often for individuals with problems with methamphetamines (14%) and heroin (10%).

Churches reported most often learning about AOD problems through a concerned family member (55%) or a concerned church member (45%). In addition, nearly 38% of churches reported that often a pastor or church leader notices and approaches individuals with AOD problems. A smaller proportion of churches reported that individuals with AOD problems often directly tell the pastor (30%) or others at church (19%). Referrals from outside the congregation were infrequent, with only 15% of congregations reporting often receiving referrals from other churches and 7% reporting often receiving referrals from a health provider or agency.

Virtually all congregations reported providing spiritual counseling (96%), prayer/healing services (94%) or pastoral counseling (92%) for individuals with AOD problems (see Table 1). A substantial proportion reported connecting individuals to AOD services through encouragement to stay in treatment (85%), referrals (62%), and consulting with providers to help individuals remain engaged in treatment (48%). Moreover, many churches provided AOD-focused programs such as Bible studies (49%), recovery support groups (39%), and educational classes/workshops (33%). Auxiliary support such as help with basic needs (72%) and support for family members (67%) were also common. No significant differences were found across church size; although one finding approached significance with mega-churches appearing to be more likely to provide classes or workshops on AOD problems relative to the other sized churches ($p=.06$).

The most frequently endorsed barriers to providing referrals to AOD treatment included lack of affordable programs (50%), individuals not wanting treatment because of embarrassment (50%), lack of effective treatments (45%) and insufficient resources or staff (45%) (see Table 2). Concerns about the lack of providers who are culturally sensitive or respectful of religious beliefs also figured prominently with approximately 40% of churches endorsing these as barriers. About a fifth of churches cited being able to handle AOD problems without treatment or being unsure whether a problem is serious enough to require treatment as reasons for not referring. A very small proportion of churches endorsed spiritual-related barriers such as beliefs that AOD problems are primarily due to sin-related issues (13%) or that treatment could harm an individual's faith (9%).

More than a third of churches (36%) reported providing a referral to substance abuse services in the past six months. Table 4 presents the results of the multivariate analysis examining factors associated with the provision of referrals to substance abuse services. Only congregational size and clergy seminary training were significantly associated with substance abuse treatment referrals. Mid-sized congregations (100–499 members) were significantly more likely to provide substance abuse treatment referrals ($OR=3.43$; $p<.05$) than smaller sized congregations (99 or less members). Congregations with clergy that had obtained seminary training were significantly more likely to provide referrals to substance abuse services ($OR=3.93$; $p<.05$) than congregations with clergy that had no seminary training.

Discussion

Our findings suggest that African American churches play an important role in caring for individuals across a wide variety of AOD problems. This is consistent with prior research showing that twice as many clergy from African American churches compared to clergy from other churches spend a substantial portion of their pastoral counseling on addressing AOD problems (Mollica, Streets, Boscarino, & Redlich, 1986). As evidenced in this study, many African American churches may be providing care that is akin to recovery supports and services (RSS) (e.g., recovery support groups). In a California survey of county AOD program administrators, nearly 70% reported that faith-based/recovery ministries are providers of RSS within their county and that spiritual/faith-based support is important to an individual's recovery (Cousins, Antonini, & Rawson, 2012).

In addition to providing RSS and spiritual-related support for AOD problems, many African American churches are also actively engaged in connecting individuals to formal AOD treatment. A significant proportion of African American churches are involved in making referrals to AOD services, encouraging individuals to stay in treatment, and consulting with treatment providers to help keep individuals engaged in treatment. Receptivity to collaborating with AOD treatment providers may be due to African American churches' involvement with social service agencies and disposition toward social justice theological attitudes (Aten, Topping, Denney, & Bayne, 2010; Barnes, 2004). At least with respect to the formal mental health service sector, African American churches appear to be more willing to refer and collaborate than other religious congregations in general (Aten, Topping, Denney, & Byane, 2010; Chang, Williams, Griffith, & Young, 1994; Dempsey, Butler, & Gaither, 2016; Hankerson, Watson, Lukachko, Fullilove, & Weissman, 2013; Pickett-Schnek, 2002).

Nonetheless, significant barriers to making referrals to formal AOD services were documented. One of the most highly endorsed barriers was individuals avoiding treatment because of shame or embarrassment. Although there have been efforts to develop church-based interventions that target HIV-related stigma (Derose et al., 2014; Derose et al, 2016), investigations focused on addressing AOD-related stigma in partnership with religious congregations are lacking and sorely needed. Other highly endorsed barriers such as lack of effective and available treatment and culturally- and religiously-sensitive providers reflect challenges inherent within the larger system of care. These include an addictions workforce that is short in supply, insufficient training of providers to deliver effective treatments, and few providers that represent the diverse population in need of treatment (The National Center on Addiction and Substance Abuse at Columbia University, 2012). Other reported barriers such as being unsure if AOD treatment is warranted could be addressed by training congregational leaders in evidence-based screening, brief intervention, and referral to treatment (SBIRT) (SAMHSA, 2010). Although training clergy in SBIRT has been touted as a promising means to addressing unmet AOD needs (Babor et al., 2007), no systematic research has been conducted to examine the effectiveness of SBIRT within congregational settings.

Findings also underscore African American churches' vital role in helping identify individuals in need of AOD treatment. Nearly half of the churches reported that individuals who are struggling with AOD problems often come to the attention of churches because of a concerned family member, church member, clergy, or church leader versus individuals self-disclosing. Given that 95% of U.S. individuals who meet criteria for AOD abuse or dependence do not feel that they need treatment (SAMHSA, 2009), African American churches may fill a critical juncture in facilitating the recognition of AOD problems and access to treatment.

Clergy with seminary training were significantly more likely to provide recent referrals to substance abuse programs than those who did not have comparable training. It is possible that the seminary training that clergy obtained may have included AOD education or that clergy who obtain seminary training may have been exposed to other AOD education opportunities that increased the recognition and referral of individuals with AOD problems to formal services. Although prior research suggest that only about 12% of clergy complete

AOD related coursework during seminary training, more than two-thirds of clergy report pursuing training on their own to assist with congregants who present with AOD problems (National Center on Addiction and Substance Abuse, 2001). Moreover, even though clergy report a lack of confidence in handling AOD problems (Moran et al., 2005), only about a quarter of schools of theology or seminary require coursework related to AOD (National Center on Addiction and Substance Abuse, 2001). Integrating AOD education as part of clergy training via seminary or ongoing workshops through denominational structures and ministerial associations may be potential avenues to strengthen the capacity of churches to address AOD problems.

Congregation size also was significantly related to the provision of recent AOD service referrals. Mid-sized churches (100–499 members) had three times the odds of providing a recent referral compared to smaller-sized churches with less than 99 members. Congregation size has been shown to be positively correlated with the provision of a greater number of social services (Chaves and Tsitsos, 2001). Mid-sized churches may have a larger staff and more resources that can better facilitate the identification of individuals who are in need of referrals to AOD services. Interestingly, larger churches with 500 or more members were not significantly more likely to provide recent AOD service referrals than smaller-sized churches. This may be due to larger churches affording greater anonymity to congregants where AOD problems may not be as readily detected and addressed. In addition, larger churches may have more internal resources to address AOD problems, which may offset referrals to AOD services. Further research is warranted to better understand what types of factors assist or hinder referrals to AOD services across congregations that are differently sized or structured.

Findings should be considered in light of certain limitations including relying on a local, faith-based, collaborative of African American churches covering a single urban area; although the faith-based collaborative did represent a diverse set of religious denominations and congregational sizes. Additional research is needed to understand whether the breadth and pattern of involvement in the provision of informal AOD services are similar to other African American churches that may operate within different network structures or in other geographic regions. Nonetheless, this is the first study to the authors' knowledge that has examined barriers and factors associated with the provision of referrals to AOD services among African American churches.

This study takes an important first look at African American churches' responses to AOD problems and areas where stronger partnerships with the formal sector could yield promising outcomes. Findings emphasize how African American churches' can be involved in the full spectrum of care from intervening when individuals may not yet acknowledge AOD problems to ensuring individuals get connected and stay engaged in formal treatment to providing a range of recovery support services. Knowing how to effectively coordinate these informal sources with the formal service sector could make a significant impact on AOD disparities.

References

- Aten JD, Topping S, Denney RM, Bayne TG. Collaborating With African American Churches to Overcome Minority Disaster Mental Health Disparities: What Mental Health Professionals Can Learn From Hurricane Katrina. *Professional Psychology: Research and Practice*. 2010; 41(2):167–173.
- Babor TF, McRee BG, Kassebaum PA, Grimaldi PL, Ahmed K, Bray J. Screening, Brief Intervention, and Referral to Treatment (SBIRT) Toward a Public Health Approach to the Management of Substance Abuse. *Substance Abuse*. 2007; 28(3):7–30. [PubMed: 18077300]
- Barnes SL. Priestly and prophetic influences on Black church social services. *Social Problems*. 2004; 51(2):202–221.
- Blank MB, Mahmood M, Fox JC, Guterbock T. Alternative mental health services: The role of the Black church in the South. *American Journal of Public Health*. 2002; 92(10):1668–1672. [PubMed: 12356619]
- Bohnert ASB, Perron BE, Jarman CN, Vaughn MG, Chatters LM, Taylor RJ. Use of clergy services among individuals seeking treatment for alcohol use problems. *The American Journal on Addictions*. 2010; 19(4):345–351. [PubMed: 20653642]
- Chang PMY, Williams DR, Griffith EEH, Young J. Church-agency relationships in the black community. *Nonprofit and Voluntary Sector Quarterly*. 1994; 23(2):91–105.
- Chaves M, Anderson SL. Continuity and change in American Congregations: Introducing the second wave of the National Congregations Study. *Sociology of Religion*. 2008; 69(4):415–440.
- Chaves M, Tsitsos W. Congregations and social services: What they do, how they do it, and with whom? *Nonprofit and Voluntary Sector Quarterly*. 2001; 30:660–683.
- Cook B, Alegría M. Racial-ethnic disparities in substance abuse treatment: the role of criminal history and socioeconomic status. *Psychiatric Services*. 2011; 62(11):1273–1281. [PubMed: 22211205]
- Cousins SJ, Antonini VP, Rawson RA. Utilization, Measurement, and Funding of Recovery Supports and Services. *Journal of Psychoactive Drugs*. 2012; 44(4):325–333. DOI: 10.1080/02791072.2012.718924 [PubMed: 23210381]
- Dempsey K, Butler SK, Gaither L. Black churches and mental health professionals: Can this collaboration work. *Journal of Black Studies*. 2016; 47:73–87.
- Deroose KP, Bogart LM, Kanouse DE, Felton A, Collins DO, Mata MA, ... Williams MV. An intervention to reduce HIV-related stigma in partnership with African American and Latino churches. *AIDS Education Prevention*. 2014; 26(1):28–42. DOI: 10.1521/aeap.2014.26.1.28 [PubMed: 24450276]
- Deroose KP, Griffin BA, Kanouse DE, Bogart LM, Williams MV, Haas A, Flórez KR, Collins DO, Hawes-Dawson J, Mata M, Oden CW, Stucky B. Effects of a pilot church-based intervention to reduce HIV stigma and promote HIV testing among African Americans and Latinos. *AIDS and Behavior*. 2016; 20(8):1692–705. [PubMed: 27000144]
- Guerrero EG, Marsh JC, Duan L, Oh C, Perron B, Lee B. Disparities in completion of substance abuse treatment between and within racial and ethnic groups. *Health Services Research*. 2013; 48(4):1450–1467. [PubMed: 23350871]
- Hankerson SH, Watson KT, Lukachko A, Fullilove MT, Weissman M. Ministers' perceptions of church-based programs to provide depression care for African Americans. *Journal of Urban Health*. 2013; 90:359–83. [PubMed: 22956267]
- Mattox R, Sullivan G. Treatment: "Just What the Preacher Ordered". *Psychiatric Services*. 2008; 59(4):349. [PubMed: 18378828]
- Milstein G, Manierre A, Susman VL, Bruce ML. Implementation of a program to improve the continuity of mental health care through Clergy Outreach and Professional Engagement (C.O.P.E.). *Professional Psychology: Research and Practice*. 2008; 39(2):218–228.
- Moran M, Flannelly KJ, Weaver AJ, Overvold JA, Hess W, Wilson JC. A study of pastoral care, referral, and consultation practices among clergy in four settings in the New York City area. *Pastoral Psychology*. 2005; 53(3):255–266.

- Petry NM, Lewis MW, Ostvik-White EM. Participation in religious activities during contingency management interventions is associated with substance use treatment outcomes. *American Journal on Addictions*. 2008; 17(5):408–413. [PubMed: 18770084]
- Pew Research Center. U.S. Religious Landscape Survey: The Pew Forum on Religion & Public Life. 2008.
- Pickett-Schenk SA. Church-based support groups for African American families coping with mental illness: Outreach and outcomes. *Psychiatric Rehabilitation Journal*. 2002; 26:173–180. [PubMed: 12433220]
- Pouget ER, West BS, Tempalski B, Cooper HL, Hall HI, Hu X, Friedman SR. Persistent racial/ethnic disparities in AIDS diagnosis rates among people who inject drugs in U.S. metropolitan areas, 1993–2007. *Public Health Reports*. 2014; 129(3):267–279. [PubMed: 24791025]
- SAMHSA. Results from the 2008 National Survey on Drug Use and Health: National Findings. Rockville, MD: Office of Applied Studies: Substance Abuse and Mental Health Services Administration; 2009.
- SAMHSA. Office of Applied Studies. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2010. The NSDUH Report: Substance Use among Black Adults.
- Suro, R., Escobar, G., Livingston, G., Hakimzadeh, S., Lugo, L., Stencel, S., ... Chaudhry, S. *Changing Faiths: Latinos and the Transformation of American Religion*. Washington, D.C: The Pew Forum on Religion and Public Life; Pew Hispanic Center; 2007.
- Taylor RJ, Ellison CG, Chatters LM, Levin JS, Lincoln KD. Mental health services in faith communities: The role of clergy in Black churches. *Social Work*. 2000; 45(1):73–87. [PubMed: 10634088]
- The National Center on Addiction and Substance Abuse at Columbia University. *Addiction Medicine: Closing the Gap between Science and Practice*. New York, NY: The National Center on Addiction and Substance Abuse at Columbia University; 2012.
- Wallace, JM., Myers, VL., Osai, ER. *Faith Matters: Race/Ethnicity, Religion and Substance Use*. Annie E. Casey Foundation; 2004.
- Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Archives of General Psychiatry*. 2005; 62(6):629–640. [PubMed: 15939840]
- Wells K, Klap R, Koike A, Sherbourne C. Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *American Journal of Psychiatry*. 2001; 158(12):2027–2032. [PubMed: 11729020]
- Williams DR, Griffith EE, Young JL, Collins C, Dodson J. Structure and provision of services in Black churches in New Haven, Connecticut. *Cultural Diversity & Ethnic Minority Psychology*. 1999; 5(2):118–133. [PubMed: 15605682]

Table 1

Descriptive Statistics of African American Churches (N=169)

Characteristics	N	%
Years since founded	<i>M</i> = 39.78	<i>SD</i> = 27.95
Congregation size (number of regular attendees)		
0–99	86	57
100–499	51	34
500+	15	10
Denominational Affiliation		
Baptist	48	28
Church of God in Christ	47	28
Methodist	12	8
Pentecostal	13	9
Non-Denomination Protestant	43	26
Number of paid staff	69	42
Clergy had seminary training	108	69
Clergy provides counseling for substance abuse	122	73
Survey respondent		
Clergy	125	74
Lay leader	16	10
Congregant	4	2
Other	23	14
Provided referral to AOD services in past 6 months	52	36

Table 2

Percentage of churches providing resources for alcohol and other drug (AOD) problems (N=169)

Resources for AOD problems	N	%
Prayer or healing services	157	93
Pastoral counseling	155	92
Encouragement or advice to stay in treatment	143	85
Help for basic needs	119	71
Support for family members	111	66
Referrals to AOD treatment	105	62
Consultation or advice to treatment providers	81	48
Bible studies on coping with AOD problems	78	46
Recovery support groups	66	39
Classes or workshops on AOD problems	56	33
Counseling with a licensed Christian counselor	56	33
Counseling with certified AOD provider	49	29

Table 3

Percentage of churches endorsing barriers to alcohol and other drug (AOD) treatment referrals (N=169)

Barriers	N	%
Lack of affordable treatment	85	50
Individual does not want treatment because of shame	85	50
Lack of effective treatment	74	46
Insufficient resources/staff to make referrals	74	45
Lack of available AOD treatment	70	42
Lack of providers who respect religious beliefs	70	41
Lack of culturally sensitive providers	64	38
Individual fears getting in trouble with the law	57	34
Waitlist times for treatment	56	33
Individual wants to rely on the church alone for help	47	28
Church able to handle without treatment	37	22
Unsure whether problem serious enough to require treatment	35	21
AOD problem primarily due to sin-related issues	22	13
Treatment could harm an individual's faith	15	9

Table 4

Multivariate logistic regression predicting recent church referral to substance abuse services

Variable	OR	95% CI
Congregation size (number of regular attendees) ^a		
100–499	3.43 *	1.24 – 9.51
500+	2.41	0.35–16.37
Religious Affiliation ^b		
Baptist	0.89	0.23 – 3.39
Church of God in Christ	1.92	0.54 – 6.80
Methodist	1.79	0.25 – 12.37
Pentecostal	0.17	0.01 – 1.89
Number of paid staff	1.06	0.87 – 1.29
Years in operation	0.98	0.96 – 1.00
Clergy had seminary training	3.93 *	1.27 – 12.25
Clergy provides counseling for substance abuse	0.73	0.22 – 2.47

Comparison variables:

^a Congregations with less than 100 regular attendees,^b Protestant Non-Denominational*
 $p < .05$.