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Faith in recovery?
Service user evaluation of faith-based alcohol treatment

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Find out more at alcoholchange.org.uk.

Opinions and recommendations expressed in this report are those of the authors.

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Executive summary

Against a background of dramatic reductions in funding for public health and social services, faith-based alcohol treatment services play an important role in the landscape of policy and practice. However, while the historical importance of religion and ‘faith’ in alcohol treatment is well known, the size, scope and significance of contemporary activities remain unclear. In order to address gaps in knowledge this research provides a systematic and detailed study of faith-based alcohol treatment services in England and Wales.

Key findings

- There are 135 faith-based alcohol treatment service providers representing over 300 groups/projects/initiatives/courses in England and Wales. There is clustering of organisations in larger urban areas and small towns, with rural services tending to be dominated by residential rehabilitation programmes. 76% of organisations define themselves as ‘Christian – other’ (non-Catholic), with 52% of those being ‘Evangelical’. The majority of faith-based organisations rely on funding from ‘umbrella’ religious organisations, partner churches and charitable donations. Only a small minority of organisations are registered with regulatory bodies such as the National Drug Treatment Monitoring or Care Quality Commission.

- 34% of all faith-based alcohol treatment providers make religious participation mandatory for service users, a figure that rises to 52% when residential faith-based alcohol treatment providers are considered. Alongside these 66 residential alcohol treatment centres provided by faith-based organisations, there has been a notable growth in church-based franchises running Twelve Step recovery courses.

- Against a backdrop of the combined impact of austerity, long standing restructuring including marketisation of health services in England, and changes in UK government policy, faith-based alcohol treatment is ‘filling the gaps’ not covered by national charities, private sector companies, or statutory funding. Despite the stated desire for secular and faith-based alcohol treatment service providers to work together, there remains significant suspicion with regards to evidence-based policy and the transparency of theology and practice, which is exacerbated by the competitive nature of funding opportunities. More specifically, key stakeholders and some faith-based alcohol treatment providers expressed concern about moral and judgmental views on alcohol; lack of expert knowledge and experience; lack of registration with regulatory bodies; clarity over ethics, theology and practice; and lack of safeguarding and equality and diversity knowledges and training.

- Service user accounts of faith-based recovery are diverse, with significant positive and negative experiences. Singing, prayer, faith and spirituality featured heavily in service user positive accounts of recovery. ‘Faking it’ and ‘playing the game’ were also seen as a widespread and pragmatic

engagement with group practices of prayer and worship. Our research suggests the need for a more effective assessment of the function and impact of both conscious and implied proselytisation that takes into account power dynamics within faith-based alcohol treatment.

- Service users often have sophisticated knowledge regarding pathways to treatment and provision and services in both secular and faith-based alcohol treatment, and their voices should be foregrounded in reviews of practice and policy.

Recommendations

- **Transparency:** faith-based alcohol treatment service providers should make public and easily accessible details of the ways in which theology and religious teachings inform the organisational ethos and day-to-day activities; clear guidance on the role of 'faith' and 'spirituality' as a putative active ingredient of treatment; clarify and define justification, processes and outcomes of 'disciplinary' processes; offer clear routes, and responses to service-users to make 'complaints'; monitor the socio-economic backgrounds of service-users and outcomes of treatment; offer details of expertise and training of staff and volunteers; ensure that all staff and volunteers undertake equality, diversity and safeguarding training.

- **Monitoring and regulation:** all faith-based alcohol treatment service providers should provide data on their activities and outcomes to the National Drug Treatment Monitoring System (NDTMS). The Care Quality Commission (CQC) or Care Inspectorate Wales (CIW) should ensure that faith-based alcohol treatment service providers are fully informed about criteria for registration[1].

- **Ethics, care and theology:** faith-based alcohol treatment service providers need to develop a more sophisticated understanding of the function and impact of both conscious and implied proselytisation with more attention being paid to power dynamics within faith-based alcohol treatment. Greater care should be given to spiritual autonomy of individuals in treatment in order to avoid religious coercion and spiritual abuse. Practitioners should receive professional training in alcohol dependency, addiction, and mental health. The UK's All-Party Parliamentary Group's Faith and Society 'Faith Covenant'[2] seeks to promote joint working between local councils and faith-based organisations; overcoming the reluctance of some councils to engage with faith groups. While principles of 'good practice' are worked out at a local level, we suggest this must go further than a commitment on the side of faith-based organisations not to engage in proselytising. Rather, the voices of current and past service users are better indicators of 'good practice' surrounding religious practices (including the 'ethics' of religious conversion).

- **Diverse and culturally appropriate services:** There is no typical service user. Individuals should be able to choose from a wide range of secular, theological and spiritual approaches in alcohol treatment and recovery, according to their preferential worldview. Religion and ethnicity do not

straightforwardly map onto each other. Specialist services for Black, Asian and Minority Ethnic backgrounds are important pathways for recovery for some individuals who disclosed stigmatising experiences in other treatment providers.

- **Pathways to treatment and recovery:** Public Health England and Public Health Wales should host information on faith-based alcohol treatment service providers alongside information about organisational approach and what service users can expect. Guidance must be developed to support the effective referral routes to faith-based alcohol treatment programmes. An independent 'myth busting' guide should be written to aid the work of commissioners, local authorities, and referral pathways (for instance, probation officers) that details and explains different practices, expectations and philosophies of various faith-based organisations.

Research design and methodology

This project adopted a multi-methods research design. Specifically, the research included national surveys of faith-based alcohol treatment services in England and Wales in order to establish patterns related to size, capacity, theological/practical approaches, religious ethos and affiliation, approaches to treatment, demographic and staffing structures, funding sources, referral routes, treatment requirements, religious expectations and professional registration. Five organisations were then purposefully sampled from the national surveys as case studies and qualitative research methods were used in order to enable an in-depth investigation into the practices and experiences of faith-based alcohol treatment through: in-depth interviews with key national stakeholders (n=9); in-depth interviews with staff representatives from the five case study organisations (n=11); in-depth interviews with service users from the five case-study organisations (n=22); and participant observation (3-5 days in each case-study organisation involving approximately 40 service users and 10 service providers).

Pseudonyms have been used to protect the identity of all individuals and organisations mentioned in the report.

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1 Background to the study

Against a background of dramatic reductions in funding for public health and social services, faith-based alcohol treatment services play an important role in the landscape of policy and practice (Arie 2013). However, while the historical importance of religion and 'faith' in alcohol treatment is well known (Valverde 1998), the size, scope and significance of contemporary activities remain unclear (Nicholls and Kneale 2015). Indeed, the role of faith-based interventions in the field of alcohol treatment has been challenged with regards to concerns related to 'indoctrination', 'proselytisation', and associated questions of 'ethics', 'good practice' and 'effectiveness'. This research project provides an evidence base to explore the role, importance and efficacy of faith-based services within a broader context of policy and practice. In doing so, we respond to challenges laid down in critical alcohol studies regarding the need for 'a "critical" [understanding of] … addiction recovery' which measures and 'captures the multi-dimensional nature of recovery and the views of multiple stakeholder groups, including service users, providers and funders' (Laudet 2009 in Neale et al 2016: 32).

In order to address gaps in knowledge this research provides a systematic and detailed study that 'maps' the size, scope and activities of faith-based alcohol treatment services in England and Wales. In doing so we contribute to geographical research that has highlighted the ways in which space and place are not passive backdrops, but are active constituents of alcohol, drinking and drunkenness with regards to: urban and rural public and commercial spaces; legislation, policy and policing strategies; pub/club life and identity; drinking at home; wine production and consumption; masculinity and femininity; ethnicity and religion; young people; intergenerational transmission of drinking cultures; mobilities; children, childhood and family; temperance; harm reduction; health, alcohol treatment and recovery; and assemblages of human and non-human actors bound up in the emotions, embodiment, and effects of alcohol, drinking and drunkenness.[3]

In this research, which is the first geographical study of faith-based alcohol treatment in the UK, we draw on theoretical engagement with, and generate empirical evidence regarding, organisational ethos, theological/practical approaches and the extent to which faith-based services offer pathways through, or create barriers to, treatment and recovery. The study also highlights the ways in which treatment cannot be understood solely by focusing on 'institutional' spaces of service providers by offering insights into the sophisticated role of 'faith' in the everyday lives of service users within and beyond 'formal' contexts of treatment where the voices and agency of service users take centre stage. This approach highlights the embodied, emotional and atmospheric aspects of religious experience, as well as the practical ways people construct, negotiate, perform, contest and experience the spaces, beliefs and identities of faith-based treatment (Williams 2012, 2013, 2016). In doing so, we offer a more nuanced understanding of the therapeutic, spiritual and regulatory geographies of life in and around faith-based treatment spaces. The research also adds to knowledge by creating an evidence base focused on theological constructions of 'addiction'. It explores how 'faith' is positioned as an 'active ingredient' of treatment and the moral expectations and identities bound up with diverse service users' access to, and experiences of, treatment and recovery. In

providing an in-depth examination of the variegated experiences of service users in faith-based alcohol treatment, the research offers a greater understanding of the pathways (and experiences) of minority groups and hard-to-reach communities' access to, and experience of, alcohol treatment and recovery.

Research objectives

This research asks questions of faith-based alcohol treatment by:

- 'mapping' the size, scope and activities of faith-based alcohol treatment services; including organisational ethos, theological/practical approaches etc. generating robust data sets to better understand the role of faith-based services in broader landscapes of policy and practice;
- exploring the ways 'faith' is positioned as an 'active 'ingredient' of treatment and the moral expectations and identities bound up with service users' access to, and experiences of treatment;
- providing an in-depth examination of the variegated experiences of service users in faith-based alcohol treatment, paying specific attention to minority groups and hard-to-reach communities.

Research design and methodology

This study used quantitative and qualitative mixed methods in order to achieve a systematic and detailed study of faith-based alcohol treatment services in England and Wales. The research project had two distinct elements.

Firstly, the research team undertook national surveys. We began with a rigorous web-based 'mapping' of faith-based alcohol treatment service providers based on contacts gathered from the websites of the Charity Commission, Companies House, Care Quality Commission, NHS and Rehab Online. Other organisations were located through internet searches, Twitter networks, advisory group advice, and a question in our survey that allowed respondents to suggest similar, associated, and/or partner organisations.[4] This was followed by a telephone and online questionnaire survey collecting information regarding size, capacity, theological/practical approaches, religious ethos and affiliation, approaches to treatment, demographic and staffing structures, funding sources, referral routes, treatment requirements, religious expectations and professional registration.

Our search for faith-based alcohol treatment service providers in England and Wales revealed 135 organisations representing over 300 groups/projects/initiatives/courses. We received 71 (53%) overall responses to the survey, with 55 (41%) full completions.

Secondly, ethnographic case-study research included:

In-depth interviews with key stakeholders (n=9) collecting data regarding knowledge and experience of the working practices of faith-based alcohol treatment

organisations and potential strategies/plans/barriers to increasing/improved partnership working;

In-depth interviews with staff representatives from five case-study organisations (n=11) engaging in detail with organisational background and ethos; practical theology/approaches; capacity and ways-of-working; rules and expectations; funding and governance; and perspectives on national policy and practice;

In-depth interviews with service users from five case-study organisations (n=22) individual and group interviews were conducted with current service users to provide: biographical information; perspectives and experiences of treatment programmes, including views on structure, ethos, effectiveness and support; changing relationship to religion and personal spirituality; practical theology of addiction, and understandings of, and relationship to, alcohol;

Participant observation (3-5 days in each case-study organisation involving approximately 40 service users and 10 service providers) gathering data on staff and residents' interaction as well as experiences and participation in day-to-day rhythms of the treatment programmes. During this time, the research generated a deeper understanding of the ways service users from different religions/faiths, with diverse socio-economic backgrounds, experience treatment.

The case study organisations were purposefully sampled and recruited from our national survey, chosen as representative of the diversity of faith-based alcohol treatment in England and Wales. They include a large 'mainstream' Christian faith-based alcohol treatment organisation as well as those focused on working with minority groups often deemed to be hard-to-reach and under-researched (Valentine et al 2009; Antin and Hunt 2013).

The case-study organisations are:

The Siloam Pool - an evangelical organisation located in the English Midlands who believe that addiction can be tackled through 'faith in God'. The Siloam Pool provides abstinence-based long-term residential (+6 months) and short-term residential (0-6 months) programmes. These include individual and group counselling, vocational and 'life skills' training and support; non-medicated detoxification and mandatory religious involvement. In the last 10 years, Siloam Pool has grown from twelve bedrooms to a current capacity for 57, and staff have grown from four to over 30. Research predominantly took place in a long-term residential house that has around 30 residents.

The Sanctuary - is a residential 'harm-reduction' programme run by a Christian charity located in the North East of England that provides supported accommodation for men who are alcohol dependent. Residents are permitted to drink alcohol in communal areas under supervision in order to create a safe environment to drink in moderation. Staff are present 24 hours a day and aim to support residents to reduce their alcohol intake. Tailored support plans encourage residents to move to find homes and employment. The Sanctuary's other services include a homeless day centre, emergency accommodation, abstinence-based residential units (16 beds across several houses) and a 15-month long recovery programme based on

Cognitive Behavioural Therapy and Twelve-Step principles. A peer-led structured programme consists of three days a week of therapeutic group work and two days volunteering in housekeeping, catering, retail, maintenance and gardening in order to build employability and life skills.

Open Circle - is a multi-faith, peer-led, abstinence-based alcohol recovery support service for vulnerable adults and families from Black, Asian and Minority Ethnic communities located in the English Midlands. Working collaboratively with GPs, local services and other appropriate healthcare providers, the programme offers education, training and volunteering, as well as help to access housing and employment seeking. Open Circle currently work with 60 service users.

Kimberly House (part of an international Christian social service organisation) - is located in the South West of England and offer specialist residential rehabilitation for people with substance misuse including both abstinence and harm reduction services. The residential abstinence based programme is short term (0-6 months) and includes counselling and a Twelve Step route to recovery. Religious involvement is not mandatory, however, 'a time of daily spiritual reflection from a variety of faiths, is expected.'

Restoration Course - is a Christian, Twelve Step, abstinence-based programme for people struggling with addiction. There is both online support and meetings at venues nationwide. At local meetings, service users are given a hot meal followed by presentations and small group conversations. The programme is wholly staffed by volunteers who are 'in recovery' rather than professionals or trained counsellors (although some volunteer leaders are trained counsellors) who also provide links to local debt charities and other services such as mental health, GPs, etc.

Beyond evidence collated for the database of faith-based alcohol treatment organisations, all individuals and organisations taking part in the national survey and case study research have been given a pseudonym (summary details of individual interview respondents can be found in the appendices). The names of other individuals and organisations have also been changed, where necessary, in order to ensure the anonymity of the respondents taking part in this study.[5] This research project follows robust social science ethical guidelines and procedures relating to issues such as anonymity, informed consent, data security and protection, etc. The project has been scrutinised by the Cardiff University Ethics Committee. The research team will undertake on-going monitoring and implementation of ethical practices regarding publication, dissemination of the research findings as well as with regards to the gathering of data and information relating to the impact of the research on policy and practice following the publication of this report.

Structure of the report

Following this introduction, the report has four substantive sections. Section two presents evidence from the 'mapping' of faith-based alcohol treatment services regarding: religious affiliation, funding and registration, service capacity and staffing, referral routes and in-programme medication and testing. Section three then examines in more detail the institutional context of faith-based alcohol treatment by discussing: austerity, institutional change and policy, faith-based alcohol treatment

service provision 'filling gaps', relationships between secular and faith-based organisations, transparency of theology and practice, professionalism and voluntarism, and diversity and equality. Section four considers practices of faith and spirituality by examining the different ways 'faith' is positioned inside different organisations; highlighting issues such as culturally appropriate support for 'hard-to-access' groups; the dilemmas of mandatory religious participation; and the ethics of evangelism and religious conversion when working with 'vulnerable' people. Section five considers faith in recovery with a focus on the diverse meanings and experiences associated with prayer, worship and religious instruction. The report concludes by reflecting on the implications of the research for faith-based alcohol treatment.

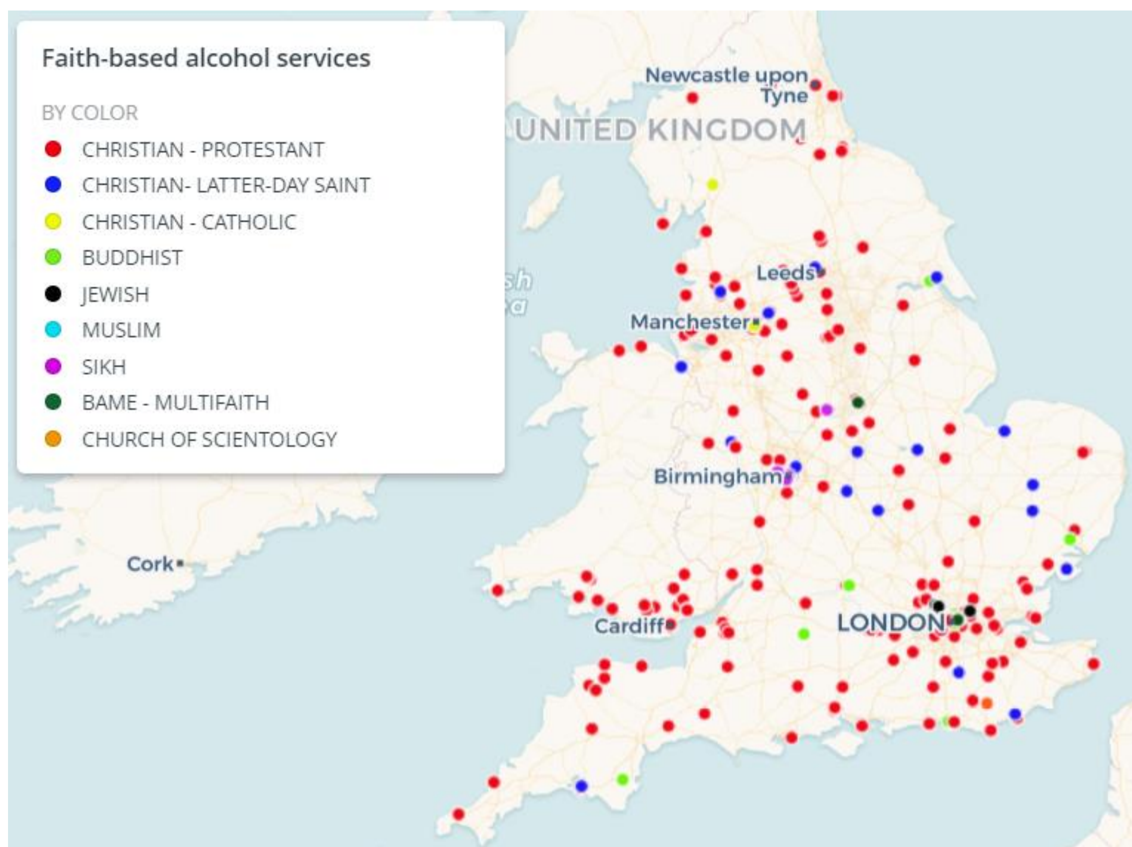
2 Mapping faith-based alcohol treatment

Faith-based alcohol treatment services play an important role in the landscape of contemporary policy and practice despite the size, scope and significance of activities being unclear. This section addresses that gap in knowledge and 'maps' location, religious affiliation, funding and registration, service capacity and staffing, referral routes, and in-programme medication and testing of faith-based alcohol treatment service providers in England and Wales.

Geographies of faith-based alcohol treatment services

Our survey of faith-based alcohol treatment service providers in England and Wales was undertaken by using existing databases, web-based searches, social media connections, advisory group advice and snowballing techniques. The survey revealed 135 organisations representing over 300 groups/projects/initiatives/courses.

Maps 1 and 2 show that there is clustering of faith-based treatment organisations in larger urban areas and small towns with rural services tending to be dominated by residential rehab programmes.



Map 1: Faith-based alcohol treatment services in England and Wales (Source: Faith in recovery survey).

Map 2: Faith-based residential alcohol treatment services in England and Wales (Source: Faith in recovery survey).

The maps contain contact information which people can use to find and contact facilities. Maps 1 and 2 are publicly available here and here.

The qualitative findings from our case study research also point to complex national, regional and local geographies:

> I live in South East England … most of the programmes I know of are within the largest city boundary, so there's very sparse services. There are no alcohol or drug services in the next biggest town. They've got a hub and spoke approach, and our nearest hub is further away, which is actually further away in a different county … So people have to go to that further away destination to get help, or once a week someone will come to the nearest town and provide a little satellite service for a couple of hours, or you go to your GP. When you end up getting into the heart of a drug and alcohol service, you can get prescribing of drugs, you can get substitute prescribing, opiate substitution therapy, a range of interventions, at a clinical level. The starting point for alcohol is a drink diary. So there's not much clinical work that you get, unless you start to talk about moving into physical problems or needing a detox. I was talking to a colleague today, very rarely do they do liver functions anymore, or look at Hep C, or look at anything in relation to alcohol and the effect that it might have on the liver or on other parts of the body. I think that's reflected across the country ... I'm sure there are highs and lows, where it's truer in some areas that alcohol services are even worse than others, but I think as a baseline, alcohol services really need some help in this country because the money has drifted towards drugs, and that's in relation to reducing crime as well.

(Hai Dede, Founder, Forward Restoration, Drug and Alcohol Addiction Recovery Programme, Community Interest Company, South East England).

While some respondents pointed to 'recovery hotspots' with good service provision, others lamented the uneven national, regional and local geographies of faith-based alcohol treatment which is well known across the sector.

However, as Whiteford et al (2015) highlight in their paper 'Two buses and a short walk: the place of geography in recovery', general accounts of the spatialities of alcohol treatment often fail to capture how location effects the commissioning of services, and the access, management and barriers to recovery. For example, for some marginalised groups, distance to service provision plays a vital role in enabling access to treatment with less fear of surrendering anonymity but is also a barrier itself to accessing services (Valentine et al 2009).

> Well, I suppose it's because a lot of rehabs, as I said, are very diverse in what they offer. So, if you had a local connection with your local commissioner, for your programme in rehab, is that fair that someone would have to go to that rehab, just because they live there, rather than picking a philosophy or a concept, or an approach that would work better for them, which may be elsewhere? Also, a lot of people see rehab as leaving, going away. You don't necessarily want something up the road. I think they're seen much more as a national resource, rehabs, than a local resource now.
>
> (Rosanne Whitehouse, Senior Commissioning Manager for Substance Misuse for Adults, County Council, English Midlands).

There were also differing views expressed regarding the location of residential rehabs. For some service users, rurality and isolation were an asset which benefited treatment:

> We are stuck out here really, in between two sides of motorways in the middle of nowhere, there's no shops for miles. Who wants to do that to themselves? You have to be committed if you come here, you understand what I'm saying? … If you are not then you are going to go or you are going to get chucked out because you don't want to abide by the rules and I've seen it now enough times.
>
> (Keith Brown, Aged 45-55, The Siloam Pool).

In contrast, service users in an urban residential rehab - Kimberly House – were able to walk around the town freely and were not 'artificially' removed from everyday spaces and practices of alcohol consumption:

> Obviously, there are a few pubs around here, so, on a Friday and Saturday night, we can hear them all out the front. We can hear them next door. You can hear them. No, it's a bit of a joke, really, because there's a rehab next door to a pub. It's seen as a bit of a joke. It's like, 'Oh, it's unbelievable, there's a pub next door and we're in rehab.' But I don't think anyone has ever actually gone in there, either, out of here.

(Will Cooper, Aged 25-35, Kimberly House - part of an international Christian social service organisation).

Alongside geographical mapping, our survey offered valuable insights into the theological and organisational structures of the sector. In the remainder of this section, we offer a critical interrogation, exploration and analysis of the heterogeneity and complexity of faith-based alcohol treatment service providers.

Religious Affiliation

Respondents were asked to identify which religious or spiritual traditions they most closely associate with - 49 out of 55 indicated that they were affiliated with only one religious affiliation. As Figure 1 shows, 76% of respondents described their organisation as 'Christian - Other' (non-Catholic), 15% of respondents affiliated with a Higher Power/12 Step tradition, and 7% of respondents affiliated with a Catholic Christian tradition.

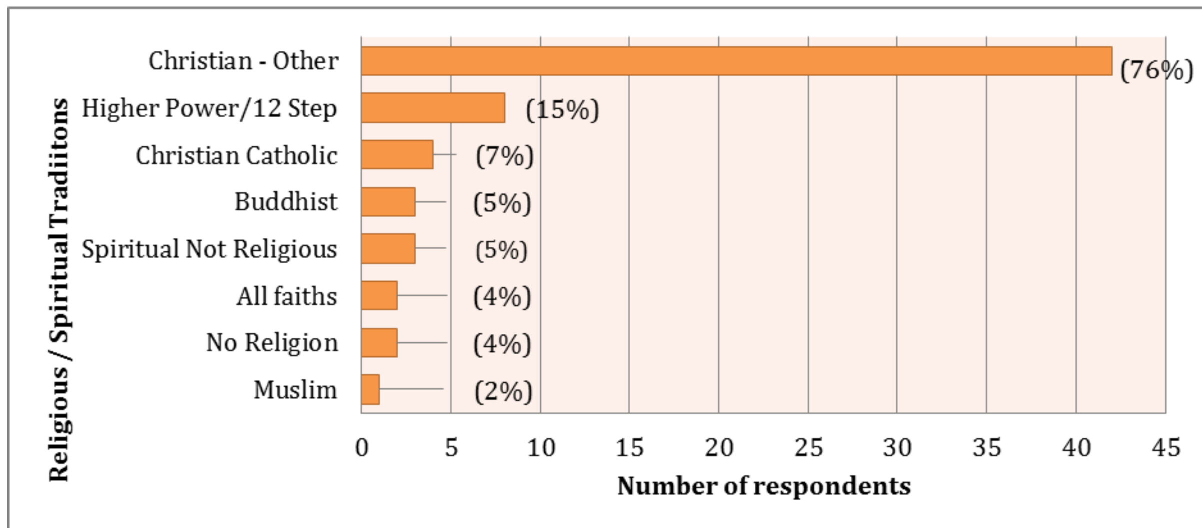


Figure 1: Self-identification of faith-based alcohol treatment services (Source: Faith in recovery questionnaire survey).

Unfortunately, the response rate from other faith groups was proportionally lower; one survey response was provided by a Muslim alcohol treatment service organisation and a further one response was from a BAME group that had a sub-project orientated for Muslim service users. We received responses from three Buddhist organisations, who employed various forms of meditation or mindfulness related to Triratna, Theravada and non-denominational/secular traditions.[2]

Of the 42 groups who self-identified as being Christian (non-Catholic), 22 described themselves as Evangelical. 20 groups aligned themselves with a range of Protestant traditions including Church of England (Anglican), Baptist, Pentecostal, and non-denominational (Figure 2). Five groups identified as 'Christian' - without specifying a tradition or denomination. Respondents who described themselves as being part of the 'Christian-Other' category included the Church of the Latter-Day Saints' (Mormon) 'Addiction Recovery' branch whose website suggests that they run a number of Twelve-Step recovery courses around the UK.

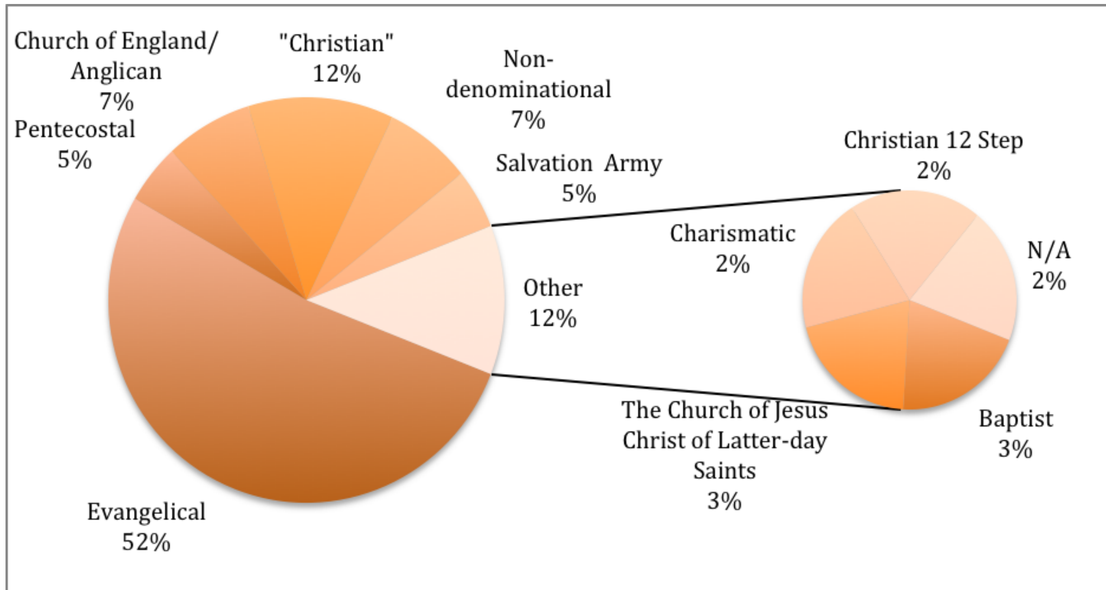


Figure 2: Denominational identification of faith-based alcohol treatment service providers (Source: Faith in recovery questionnaire survey).

Funding and registration

Around two thirds of our respondents indicated that they receive funding from 'umbrella' religious organisations or partner churches (Figure 3). A similar number rely on charitable foundations, and/or public donations to finance their activities. Income generated by collecting the housing benefit of service users, charging service user fees or taking on social enterprise status were the next most prevalent ways that faith-based alcohol treatment is funded. Only a small proportion of our respondents were funded through local authorities. Almost a quarter of respondents self-funded through charity shops and social enterprises such as gardening and furniture restoration. Other funding sources (11%) included personal financial contributions by respondents and gifts-in-kind (e.g. free premises provided by church).

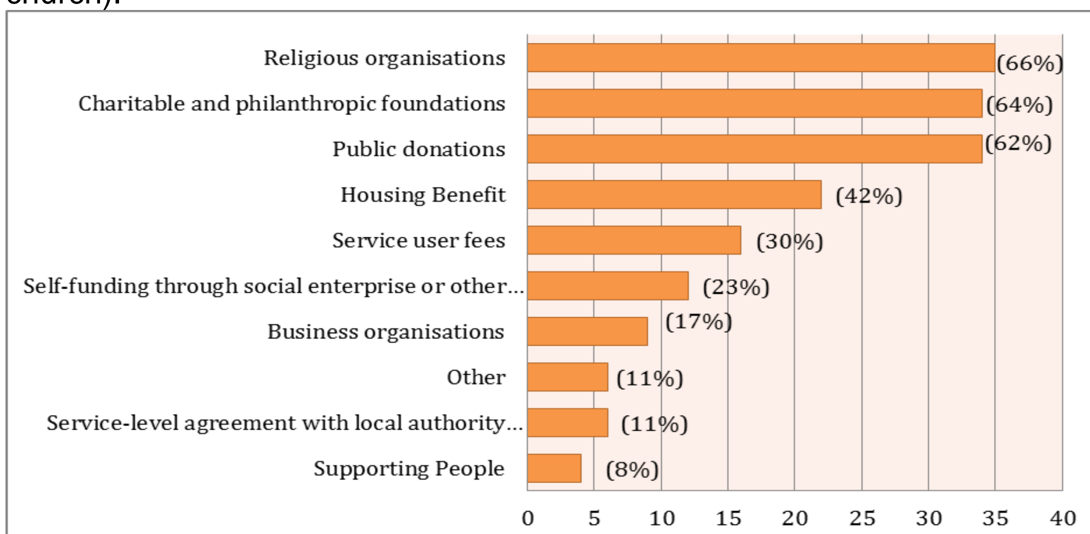


Figure 3: Funding of faith-based alcohol treatment service providers (Source: Faith in recovery questionnaire survey).

Around three quarters of our respondents were registered with the Charities Commission, thereby deriving benefits such as tax relief, public recognition, and access to certain funding streams. Those faith-based alcohol treatment service providers not registered with the Charity Commission tended to be smaller organisations with more limited resources; most were run by individuals, or as informal voluntary support groups.

Our research also revealed that across the sector there is a lack of external regulation - beyond responsibilities related to charitable status - allowing faith-based alcohol treatment service providers to exercise relative autonomy outside of financial and regulatory frameworks. For example, while 40% of respondents indicated residential elements to their service, only a quarter of those (5 respondents) were registered with and regulated by the Care Quality Commission (CQC) - which ensures standards of quality and safety within health and social care services. The low level of registration by faith-based alcohol treatment service providers is undertaken against a backdrop where the CQC can only enforce registration for organisations with a residential or community-based component where a medical practitioner, nurse or social worker are constituent of treatment programmes. Our survey also found that only 11% of respondents were registered with National Drug Treatment Monitoring System (NDTMS). The ‘other’ category (Figure 4) includes respondents not registered to any other body as well as those registered to voluntary support groups or by affiliation with a religious organisation are covered by their insurance, policies and procedures.

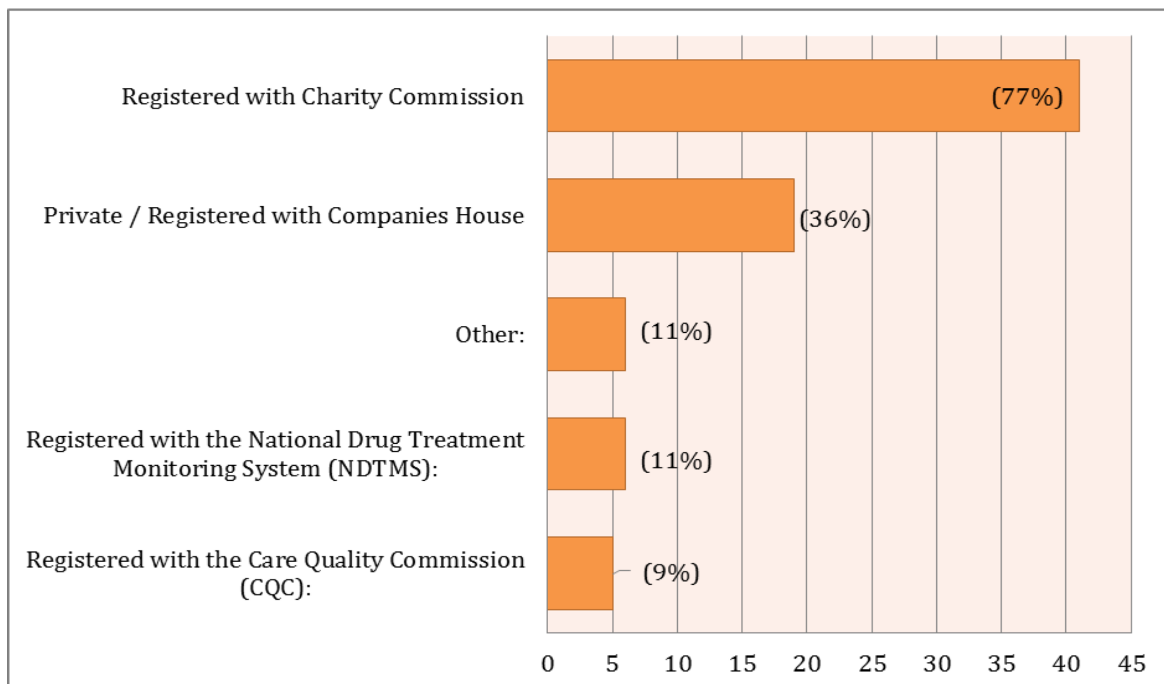


Figure 4: Registration status of faith-based alcohol treatment service providers (Source: Faith in recovery questionnaire survey).

Service capacity and staffing

Across the faith-based alcohol treatment providers who took part in our survey, service capacity varied depending on the type and duration of service offered. Non-

residential service providers offered programmes for service users in groups from 6 to 30 people. The largest residential provider could accommodate 83 service users, with smaller organisations tending to have less than 20 beds located across different sites.

In terms of staffing, as Figures 5 and 6 show, just under half (47%) of respondents to our survey only employed staff and volunteers who were of the same faith. While Evangelical service providers had a much higher proportion of staff and volunteers who were of the same faith, Muslim organisations indicated that their staff and volunteers were 'a mix of people of different faiths.' The 'other' category (4%) included a 'Buddhist recovery group who did not identify as a faith-based practice' and a group who self-identified as '1x Christian & 4 x 12 step fellowship attenders'.

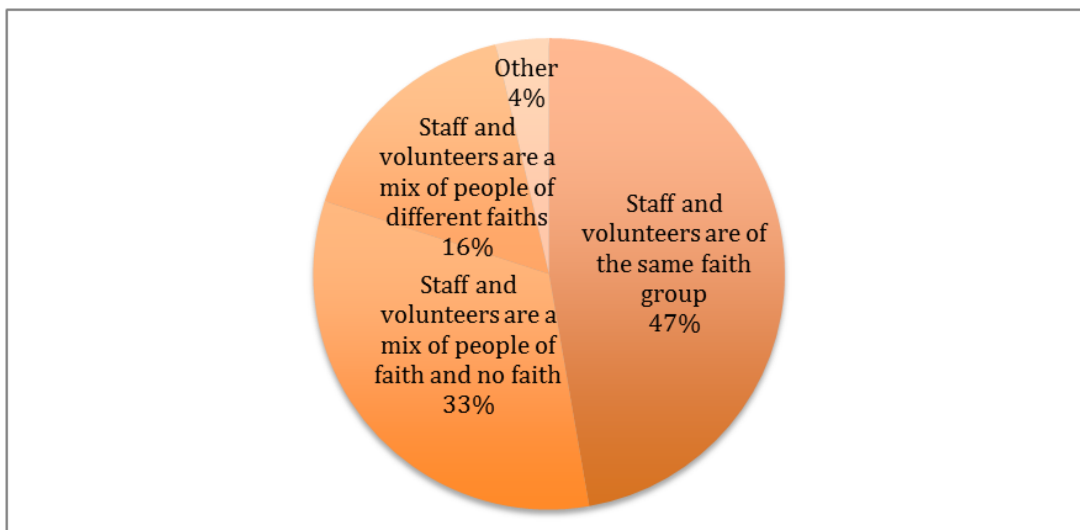


Figure 5: Staff structure of faith-based alcohol treatment service providers (Source: Faith in recovery questionnaire survey).

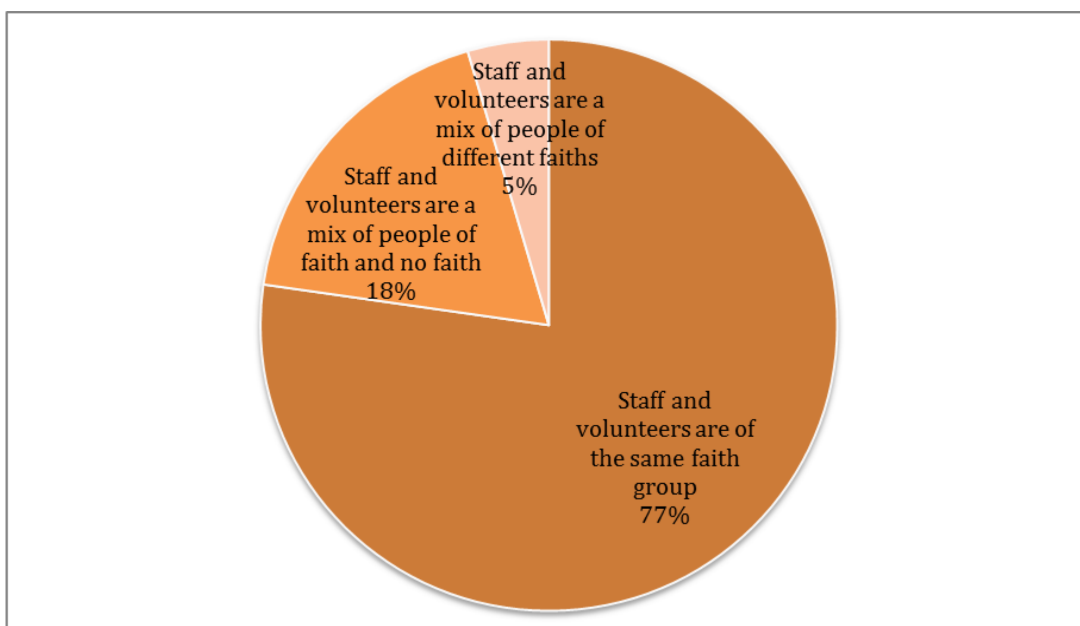


Figure 6: Staff structure of Evangelical Christian faith-based alcohol treatment service providers (Source: Faith in recovery questionnaire survey).

Referral routes

Respondents to our survey were also asked to indicate the three most common routes that service users pursued to access their service (Figure 7). After self-referral, friends and family or religious congregations, the most significant ways that service users access faith-based alcohol treatment is through a range of health, criminal justice and social care contexts. Respondents also identified 'other' referral routes (9%) including AA and NA fellowships.

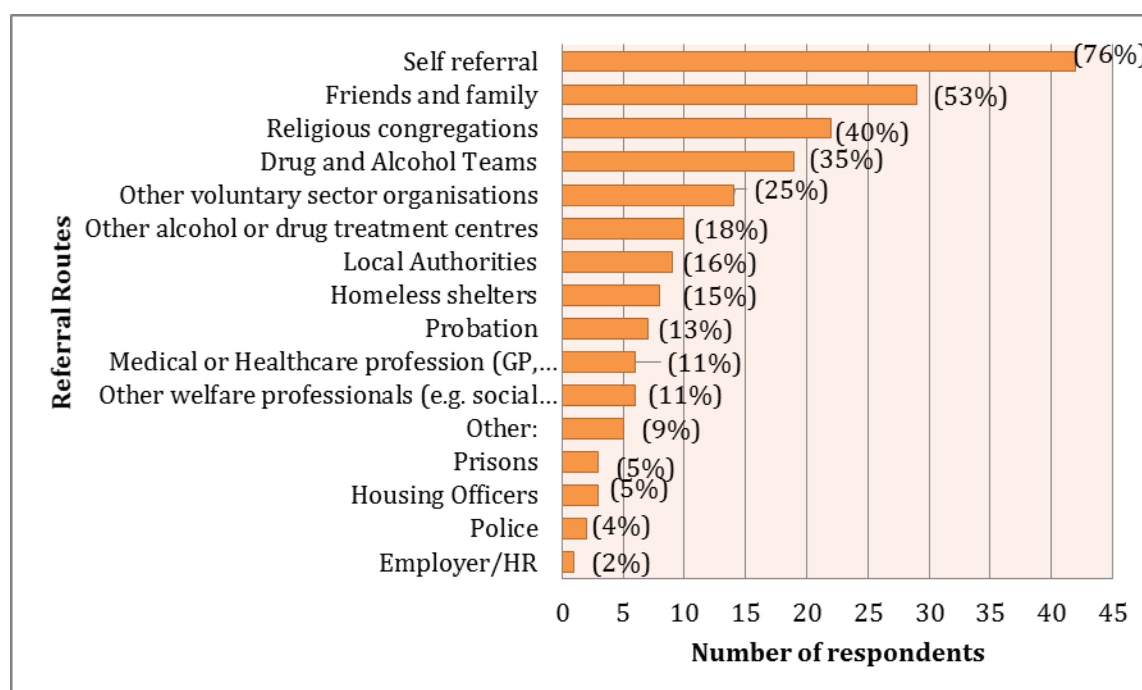


Figure 7: Most common referral routes to faith-based alcohol treatment service providers (Source: Faith in recovery questionnaire survey).

In-programme medication and testing

Three quarters of our respondents indicated that they permitted the use of prescribed medication. The remaining quarter was comprised of 9% who did not, and 16% who attached specific conditions to their in-programme use (anti-depressants only; non-addictive; no anti-psychotics; doctor supervision). 53% employed mandatory alcohol testing within their programmes.

Given the prevalence of abstinence-based approaches among the survey's respondents (see section four), it is perhaps not surprising that 'regulatory architectures of surveillance' (Williams 2015:197) were being pursued through mandatory testing (Figure 8). For example, in residential rehabs, 76% of organisations that responded to our survey undertook mandatory alcohol testing. However, as one respondent from a non-residential programme suggested, despite applying an abstinence-based approach, 'we would only test where we believed the client was not being honest'. Another respondent suggested that random testing was applied if agreed with the service user on entry. This evidence points away from the idea of a treatment space underpinned by totalised regulation and discipline, towards an emergent service ethic predicated on notions of reciprocal trust and honesty.

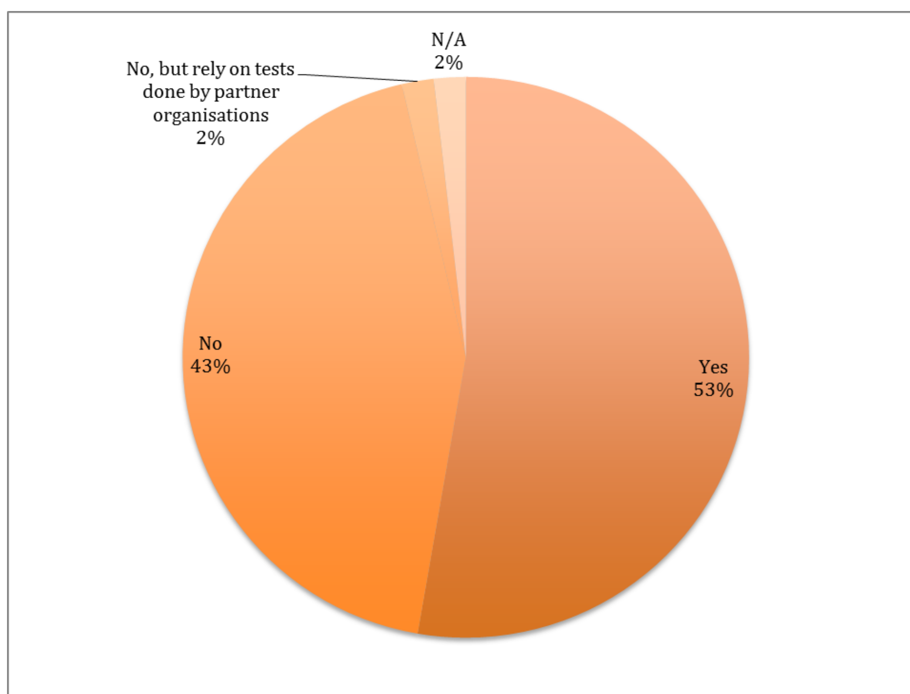


Figure 8: Mandatory alcohol testing undertaken by faith-based alcohol treatment service providers (Source: Faith in recovery questionnaire survey).

Summary

Evidence generated from our research shows that:

- There are 135 faith-based alcohol treatment service providers representing over 300 groups/projects/initiatives/courses in England and Wales;
- There is clustering of organisations in larger urban areas and small towns with rural services tending to be dominated by residential rehab programmes;
- 76% of respondents to our survey defined themselves as 'Christian – other' (non-Catholic), with 52% of those being 'Evangelical'.
- 66% of respondents indicated that they receive funding from 'umbrella' religious organisations or partner churches; 64% were funded through charitable/philanthropic donations; 62% through public donations; 42% by generating income by collecting the housing benefit of service users; 30% by collecting fees from service users; 23% by adopting social enterprise status; 17% by donations from businesses; and only 11% via local authority funding;
- 77% of our respondents were registered with the Charity Commission but only 11% were registered with the National Drug Treatment Monitoring System (NDTMS); and 9% registered with the Care Quality Commission (CQC);
- Non-residential service providers in our survey offered programmes for service users in groups from 6 to 30 people. Residential service providers tended to have less than 20 beds but the largest had 83;
- 47% of respondents to our survey only employed staff and volunteers who were of the same faith. 77% of Evangelical service providers only employed

staff and volunteers who were of the same faith. All of the Muslim organisations who took part in our survey indicated that their staff and volunteers were ‘a mix of people of different faiths’;

- Self-referral (76%), friends and family (53%) and religious congregations (40%) are the most significant routes that service users access treatment. Others include a range of health, criminal justice and social care contexts such as referral from other treatment services (25%); local authorities (16%); homeless shelters (15%); probation agencies (13%); healthcare (11%) and welfare professionals (11%); prison (5%) and police (4%) officers;
- 75% of respondents permitted the use of prescribed medication with 53% employing mandatory alcohol testing within their programmes. 9% of respondents prohibited the use of prescribed medication.

While this empirical evidence highlights how faith-based alcohol treatment services in England and Wales are heterogeneous with regard to religious affiliation, staffing/volunteering, affiliation and funding and so on, such findings only ‘scratch the surface’ of the complexity of the sector (Sider and Unruh 2004; Dossett 2013; Williams 2012). Subsequent sections of this report thus provide detailed findings and analysis.

3 Institutional context: challenges, opportunities, tensions

This section engages in more detail with important challenges, opportunities, and tensions that have been identified by the research respondents as key to understanding the role of faith-based alcohol treatment in the context of broader landscapes of policy and practice. Subsequent discussion of quantitative and qualitative findings focuses on austerity, institutional change and policy; how faith-based organisations 'fill the gaps' in service provision; we consider the often 'difficult' relationships between secular and faith-based organisations; and reflect on issues of transparency of theology and practice; professionalism and voluntarism, and diversity and equality.

Austerity, institutional change and policy

Over the past few years, a growing number of popular and academic articles have discussed the impact of 'austerity' on alcohol treatment (Arie 2013; Roy and Buchanan 2016), with media stories including headlines such as 'drug and alcohol treatment services cut by £162 million … Residential rehabs budgets slashed by 25% in 4 years … One council has cut detox budget 90% since 2013' (Bulman 2017) with quotes including 'Paul Hayes, the chief executive of an umbrella group of leading UK addiction charities, highlighting that spending on drug and alcohol services has been cut by 25% since 2013, when the National Treatment Agency for Substance Misuse was abolished and responsibility for those services was placed in the hands of local authorities' (Siddique 2018). In this section we discuss not only the impacts of austerity on faith-based alcohol treatment but also focus on the longer-term effects of institutional and policy change, or as the majority of our key stakeholder and service provider respondents suggested, the current 'lack' of government policy (also see Alcohol Change UK 2018).

All the key stakeholder and service providers who took part in in-depth interviews pointed to the profound effects of austerity on landscapes of alcohol treatment. Recent and longstanding shifts in policy and funding priorities, including a decreasing importance of alcohol in comparison with crime reduction goals associated with drug treatment were also described as having significant impact on funding of alcohol related service provision as well as the problematic influence of changes in the benefits system affecting the lives of service users:

> I spoke to a commissioner just a few weeks ago, one of the local authorities from the area that she's commissioner for, drugs and alcohol services, passionate about recovery, passionate about rehab as well, passionate about her town. And she said 'I had just got the system working and I'd been told I need to cut 10% this year, 10% next year and 10% the year after. I'm just going to be sitting here watching the system fall apart.' And you really feel for somebody in that situation where they strive to get a system that is really working for the people who are often quite vulnerable, most in need, and then through just blunt cuts, saying 'Well what do I stop doing?' And she's saying 'I have no money for residential rehab' so they're trying to work out what they can do and we're saying 'Well how can we partner with you whilst recognising that

there's no money to do anything?’ So it’s having a huge impact and it’s having an impact on what they can hope to achieve with the people that are coming in.

(Trevor Robbins, Chief Executive, Levington Grange, Christian Drug and Alcohol Rehabilitation Centre, South East England and Member of INCSAO - International Network of Christian Substance Abuse Organisations).

Yes, absolutely. It’s so noticeable, in a way that I really didn’t expect. In the last few years, you see much more homelessness and the increase in drug and alcohol use that goes with that and affecting people that it wouldn’t have before, people that are working and stuff like that … Our budget has been cut by about 40% in the last three years, so what happens when the complex service that is meant to deal with really complicated people only have half the places they used to and we are expected to do more with less staff? The complexity of the clients that we are seeing now are people, now, my team see somebody that two years ago, three years ago, four years ago, would have been seen by a psychiatrist or a consultant and now we are doing that work because they are seeing the tiny, tiny percent. So that has had a huge effect.

It is huge. Yes, so apart from affecting the lives of the clients, which it does massively, seeing lots… There was a period of time where just on the ground seeing lots of relapses caused by the stress of benefits being taken away. On a more macro level, just things like we used to assess everyone that came in for an hour to an hour and a half, in person. We now have 20 to 30 minutes to do a telephone assessment and to do more than that you have to break the rules a little bit. The wages are much lower so when I first came into this job – not as a manager, as a practitioner, probably about 20 grand a year, 21 maybe, with increases - has now gone down to about 18 to 19, which means that we are attracting a much, much less skilled workforce, which impacts what we are doing. Less training budgets so people have less of an opportunity to develop their skills, which impacts the efficacy of what we are actually delivering; people get set in their ways rather than delivering what is actually effective.

(Leslie Denmark, Team Leader, Local Authority Commissioned Drugs and Alcohol Project, and Vitality Project, Trustee, Faith-based Recovery Support Group, South of England).

Respondents were keen to locate austerity policies as part of problematic longer-term restructuring, including increasing marketisation of health and social care services (also see Powers and Hall 2018). However, in response to austerity cuts, interviewees discussed how faith-based alcohol treatment services were seeking (although not always successfully) to diversify their funding models; such as a movement to use Social Impact Bonds (see McHugh 2013 for a critique) or converting to social enterprise models (with gardening, recycling business, cafés) and increased use of volunteering as ways to fund recovery programmes and generate income; becoming increasingly reliant on financial, food and other donations; as well as a move to drawing on the housing benefit of clients to fund residential rehabs:

Let's go back a little bit …1986 … there was no infrastructure then. You went to rehab, rehab was all that was available apart from a few community prescribing units, and some community alcohol services. Generally, rehabs were the only thing that people looked to for help ... Levington Grange was a big pile of bricks in the country that was run by a faith group or a new age group or do-gooders effectively, who weren't necessarily professionally qualified. It was like a cottage industry. The reason money has gone into services is because we've seen that drug treatment can effect, so the argument goes, crime reduction. So money followed. One was we need to work together, so the whole alcohol and drugs action team approach, was a start, and then as we started to work together, in terms of statutory services, and align priorities, that led to more arguments about giving money to local partnerships to deliver a national strategy locally. We saw money move from a cottage industry to at its height £1bn a year.

We are now on the other side of that mountain and we are down to about £700m a year. A good part of that goes on supply reduction, so on police-related work, customs-related work, and about £500m on drug and alcohol services. When we look at how is that £500m spent? About 5% of that is spent on infrastructure, so on the commissioning function, broadly. About 90% is spent on tier 2 and 3 services in the community. Then the remaining 5% roughly goes on rehab. Within that structure of services, we have charities that have massive overheads, 15-20% overheads. You look at Live Life: I think they have something like 100 staff on around the £100-130k pay mark. So these are big corporate organisations. So when you look at how that is cut up, what we find is before you start to see money on the pitch, there's a lot soaked up by the infrastructure itself. When it then gets on to the pitch, there are some seriously qualified people, who also need to be paid in terms of doctors and psychiatrists and people who command that kind of top money in terms of being able to provide evidence-based services … So we have got an infrastructure that grew in a time of prosperity, and we are trying to maintain that infrastructure through austerity, and I think that is negatively impacting frontline services. I can go into a local authority and save them £300,000-400,000 on a £2m contract, but what I would try to do is I would try and cut out the overhead, cut out the fat in the system and not cut out the frontline services. But those gains and those abilities to make those salami slice savings are diminished now, and we are at a stage where I think services are on the verge, I don't think they're in crisis at the moment, but I think they are on the verge of crisis.

(Hai Dede, Founder, Forward Restoration, Drug and Alcohol Addiction Recovery Programme, Community Interest Company, South East England).

So our funding, we get enhanced housing benefit for each of the residents that is here. That covers approximately 55 to 60%? So that covers a portion of the costs of them being here. They then have their benefits paid into our account and we give them £10 per week pocket money, up to a certain limit. If they get more money than that in from benefits, like one of the guys is at the moment, because he's on PIP as well as on ESA, so we're keeping that aside for him and when he does move on he'll have a nice little nest egg. Most of our food is donated from Costco. So are our meat products. We don't buy any meat

products whatsoever, so that's a real heavy expense that's gone. Most of the furniture is donated and stuff like that. So that helps to keep our costs down.

(Jenny Squires, Founder and Director, The Siloam Pool, English Midlands).

Changing trajectories of UK government funding priorities were also a concern for many of the respondents in our survey due to a lack of clearly formulated and articulated policy:

There's a disconnect between the central government's strategy which you read and say yes, it's fine, it makes sense, it talks about recovery. It doesn't say a lot as well, it's quite high level, but then it's very much well it's pushed down to the local authority to deliver and the local authority have removed any ring fence for drugs and alcohol. So drugs and alcohol just competes with everything else in the local authority's budget, it's not seen as a priority, or it's like well actually do we care for the elderly or for the people with alcohol problems? It's very difficult to make the case for why it's worth investing in it. So I think having a strategy that doesn't have teeth to be delivered locally is very, very difficult to get anything. So we've seen huge changes … So, a policy can be fine but it's how does it get implemented. And things like the Social Impact Bonds, it's novel, I could see it working really well for drugs and alcohol residential recovery centres because it is about that transformation and it's something that you could measure, and there are benefits for the person, their family, for society. We talk about some of the cashable savings not really being cashable, but there might be savings for a local authority, but they have to take the chance they're looking at something novel that's not been proven but until somebody gives it a go, you're not going to get the evidence base to show whether or not it works. And at the moment when money is tight, I would say that's the time to look at innovation. But they're always saying 'No, we're having another restructure, we haven't got the money and so we won't look at anything that might save us considerable money', which seems a bit back to front.

(Trevor Robbins, Chief Executive, Levington Grange, Christian Drug and Alcohol Rehabilitation Centre, South East England and Member of INCSAO - International Network of Christian Substance Abuse Organisations).

While there was significant confusion with regards to the content and direction of national government alcohol strategy, key stakeholder and service providers were also acutely concerned about ongoing cuts in funding and future restructuring of service provision:

So, in 2012 the Health and Social Care Act put community drug and alcohol treatment into the remit of the local authorities. And there was money from Public Health England for them and there was a certain amount for each local authority. But from next April, there is no money from central government and local authorities are supposed to find it from things like retained business taxes, business rates, so because drug and alcohol treatment is not a mandatory service they have to provide, and we all know what happens in local authorities: they cannot provide most things, let alone drug and alcohol … So, there is

going to be a huge crisis from April [2019], but nobody is saying much about it. That is a big fear really for me.

(Jon Brown, GP, Clinical Lead for Drug and Alcohol Treatment in a Criminal Justice Context, Local Authority, and Kingdom Release, Co-founder of Christian Research and Lobby Organisation, North East England).

'Filling the gaps' … the place of faith-based alcohol treatment services

It was clear from the in-depth interviews with key stakeholders and faith-based alcohol treatment service providers that austerity, along with longer trajectories of changing funding and policy priorities had led to a highly competitive sector whereby a number of national charities and private sector organisations compete with one another to win contracts. However, where there was little profit to be made for those companies, and where there was a lack of statutory funding, faith-based alcohol treatment services have been filling 'gaps' in local contexts:

The Community Care Act had changed everything in terms of the treatment landscape, and so suddenly there were opportunities; although I didn't have any qualifications, I had some experience … I set up five or six schemes and three offices and recruited staff, and it felt like the Wild West. We were running ahead of any guidance or good practice notes. It felt like we were inventing what we were doing while we were doing it. Gradually, that world started to consolidate and rules came in and studies were done on what constituted best practice, and I really enjoyed that.

In terms of my understanding of the world of alcohol recovery treatment, most of the treatment that is provided is provided by specialist organisations. Or most of the money for treatment goes to specialist organisations. They might be big organisations like Live Life, - or Change Time, or ActOnAddiction, or something similar … The NHS is mixed in with that, because sometimes these organisations are working in partnership with NHS organisations, and sometimes they are working with private elements of clinical work within them. So Live Life have a clinical arm to their work that is integrated with their psychosocial work, and increasingly these big organisations represent the mainstay of treatment in the UK. Behind that, are GPs, but GPs effectively are farming out anything complicated in relation to addiction to specialist organisations. Whether that's alcohol treatment, addiction treatments more generally, as a person going to a specialist agency, a tier 3 prescribing service or a service that can provide clinical responses to alcohol addiction; they have to have a GP. So everyone is registered with a GP or pretty much most people are, unless you're homeless or in difficult circumstances. But the GP doesn't provide the care. They farm that out to this other organisation.

(Hai Dede, Founder, Forward Restoration, Drug and Alcohol Addiction Recovery Programme, Community Interest Company, South East England).

The bigger organisations are people such as Live Life, ActionCare, ActOnAddication, but now they are broader than that, RECOVER, I think they have got a reputation for that. Not being so sensitive to local conditions … But I

think it is the corporate nature of it because things are up for tender about every five years or so, there tends to… it is a competitive landscape and the smaller ones tend to be pushed out of business because they have not got the infrastructure that can supply the hundreds of policies and procedures that the bidding process requires or the financial backing that bidding requires as well, so I think it has become concentrated in these larger providers.

(Daniel Found, Independent Healthcare Consultant and Inspector, South West England).

The pendulum tends to swing towards one organisation and then another. So, at the minute, there is an organisation called Live Life. It is a big provider of community drug and alcohol services. There is also Change Time. There is ActOnAddiction. And all of these are charities or community interest companies. And there are others as well. But with more contracts, they get bigger and then they lose contracts and get smaller, and some of them disappear. It is quite… and contracts are three years often, which is really short, plus a year or so, which is one of the huge commissioning issues at the minute. Apart from the other commissioning issue is that there is not going to be hardly any money from next April because of the way community drug and alcohol services are commissioned. It is not so bad in the prisons because that is NHS England commissioned, but in the community, there is going to be a huge issue of alcohol and drug treatment.

(Jon Brown, GP, Clinical Lead for Drug and Alcohol Treatment in a Criminal Justice Context, Local Authority, and Kingdom Release, Co-founder of Christian Research and Lobby Organisation, North East England).

With a few national not-for-profit charities dominating the alcohol treatment service provision sector, all our respondents recognised the important ways that faith-based organisations were 'filling the gaps' to offer services and activities not provided by government-contracted treatment providers, private sector, or resource-limited local authority related provision:

It's all well and good to slag off the churches. Who feeds all the homeless in the city? Not us. Not anyone here. The clothing, the housing: there's a lot of stuff done by faith-based groups. Public Health has got a lot to answer for in this. I really feel they have.

(Peter Moon, Alcohol and Drugs Service User Development Officer, Local Authority, South West England).

We finish work at 5pm or 8pm or whatever time we finish and we don't open on Saturdays and, again, this is before austerity we used to open on Saturday and we used to work until 8pm, but church organisations, church, faith-based organisations, exist around the clock and that is something that works really, really well, that they can add a more informal, less boundaried, way of supporting people. And they can also be people's friends, and that is something that we try to get people going with, because we can't be people's support networks and their friends, but faith-based organisations can. And they work

well in that yes, they provide that kind of holistic support. I think areas where could do better is just more training and more awareness on what organisations there are out there for providers and how to work with people about that and what potential benefits there are.

(Leslie Denmark, Team Leader, Local Authority Commissioned Drugs and Alcohol Project, and Vitality Project, Trustee, Faith-based Recovery Support Group, South West England).

Relationships between secular and faith-based organisations

With a diverse patchwork of actors involved in alcohol treatment service provision at national, regional and local levels, while there were opportunities for increased partnership working, there were also tensions between secular and faith-based approaches bound up with issues such as evidence-based practice, transparency of theology and practice, often exacerbated by the competitive nature of funding opportunities:

I think its faith-based versus secular. Where everyone understands the ground rules, and they meet the requirements of working in that particular sector, whether it's providing addiction services or whether it's some other social issue, allied to that or totally separate … I think the tensions arise when we have different aims and objectives and we are working in the same space, because then it's almost as if we are creating tension just by working with the same groups …The challenges come when there is competition, for instance, for resources, so if a faith-based organisation is working in the same area as a secular provider, either the faith-based organisation will say, 'It's not fair, because they get all the money. Because we've got faith-based credentials, the council does not want to deal with us and they won't give us a contract, but they'll give it to a secular organisation.' Or the secular organisation will say, 'they are getting in our way. Why are they getting a grant when we get a contract? We have to meet the performance standards and they get to just do what they want.' So I think it's when difference is accentuated and when our aims are different … So if a faith-based group comes in and their aim is to proselytise and evangelise, and they have less truck with the social issue, I think it can be difficult. When faith-based organisations are seen as judgmental and not willing to bear with people as people, and meet them where they are, I think that can be difficult. Similarly, where faith-based organisations are genuinely trying to help and they get batted away because they're faith-based organisations, and for no other reason necessarily.

One of the services we are looking to start is in our local church, and it's because our local church is a fantastic asset. It's got rooms, a cafe, it's got a family centre out the back, and it's got a great pool of willing volunteers that want to help. I think the main opportunities going forward for faith-based organisations are to realise that they have an asset and a network. A lot of faith-based organisations come out of churches or communities of one sort or another, and, within those communities, there are often some physical assets that are prominent in a town, or in a city, or even in a village. Often, secular providers don't have access to those assets per se, they have to go out and

> rent commercially and they have to get planning permission and all of those things. I think trying to marry together common interest and common purpose around some of the knowhow that the secular organisations have and some of the assets and some of the goodwill that faith-based organisations have is a really positive match, and it's something that can work to improve the community.
>
> (Hai Dede, Founder, Forward Restoration, Drug and Alcohol Addiction Recovery Programme, Community Interest Company, South East England).

One further factor in generating suspicion between secular and faith-based organisations was transparency regarding theology and practice and the extent to which competition for funding has led some faith-based organisations to adopt a more 'secular' public face to emphasise that their services and jobs are open to all:

> I think they have softened their edges. I think they have probably voiced their faith basis less to become more appealing to funders, I think. That's definitely true, I think, for local authority or DAT-based treatment services, definitely. Those have become the main contracts, so where there was a time when you had, as we were talking about before, little pockets of everything everywhere, they could afford to be that niche organisation that delivered X, Y and Z because somebody else was delivering A, B and C. But now, they've had to all pull together, I think their distinctiveness has maybe reduced. I think maybe they're less distinctive to their secular counterparts, certainly within the community. In resi-rehab, I think resi-rehab is a tough call. It's a decent sector to be in if you can keep your bed occupancy up. If you can't, you're in trouble, because it's a very expensive provision. So, in order to keep your bed occupancy up, you may soften your stance on certain things to get more people through the door. I think that's a different marketing approach. Or, maybe you don't even mention it. I was looking through one rehab recently and they never mention it, and I know they're a Christian, faith-based rehab. I know they are, I've been to see them, they're brilliant. They're great. Never mention it; you would never know. You would never know from their information that they provided.
>
> (Rosanne Whitehouse, Senior Commissioning Manager for Substance Misuse for Adults, County Council, English Midlands).

This correlates with wider trends among faith-based welfare providers to eschew 'conversion-driven' agendas that make service users engage in religious activities, and instead adopt more unconditional modes of service provision where the faith (engagement) of the service users is irrelevant (Cloke et al 2012). However, for other organisations motivated by an explicit desire to make converts, the downplaying of religion might serve to 'hide' or 'disguise' the real nature of their work.

Transparency of theology and practice

Concerns regarding challenges, opportunities and tensions between secular and faith-based organisations presented above were also particularly sensitive with regards to claims to 'evidence-based approaches', problematic moral and

judgmental views about alcohol; lack of expert knowledge and experience; lack of registration with governance bodies (see section one); clarity over the ethics, theology and practice; and lack of safeguarding, and equality and diversity knowledges and training (this will be returned to later):

> That there's lots of drug and alcohol treatment that is based on moral panic or judgement about drug and alcohol use. I don't personally view drug use or alcohol use as morally wrong or bad, I just would like people to have the tools to do it safely. And there is some really outdated drug and alcohol treatment that is based on ideas like being in denial, alcoholics being morally wrong, people that pathologically lie or things like that, that aren't based on any evidence and are actually really harmful for people. So that winds me up [laughs] basically, yes.
>
> (Leslie Denmark, Team Leader, Local Authority Commissioned Drugs and Alcohol Project and Vitality Project, Trustee, Faith-based Recovery Support Group, South West England).
>
> But then even within government you hear… I was talking to somebody yesterday about how one of the officials in the Department of Health was referring to the recovery, the people sorting that out, 'Is that that God-bothering spiritual lot?' That kind of language is not really helpful. It says a lot about the person saying. I was again hearing another Department of Health official talking in quite an open group, Public Health England, Home Office, and they were talking about a new official and they're a Christian, but it's alright, they're open to dealing with the ethical dilemmas of their role. And you're thinking drop in other faiths, you probably wouldn't describe it that way …
>
> (Trevor Robbins, Chief Executive, Levington Grange, Christian Drug and Alcohol Rehabilitation Centre, South East England and Member of INCSAO - International Network of Christian Substance Abuse Organisations).
>
> They don't need to be registered with CQC if they're not providing clinical services … So, resi-rehabs do, now then they're not going to get publicly funded clients, or they shouldn't. We wouldn't. We wouldn't send anybody from our county if they weren't CQC-registered. So, they're either relying on … They can still go there, but they're not going to be paid for by the council, or they shouldn't be. If that's one of your criteria, and I would suggest most councils would want that to be. But obviously, people can be self-funding, people can be privately-funding. It could be one where it's mainly housing benefit, so it's not necessarily council-funded, which a lot of the faith-based rehabs are; Hebron and Crucible UK, so you don't need to have council funding for that. So, I suppose you wouldn't need to be CQC-registered. But again, why wouldn't you want to be? It's not a hugely onerous thing, and it shows that you're as good as everybody else. Well, that's worth doing, isn't it?
>
> (Rosanne Whitehouse, Senior Commissioning Manager for Substance Misuse for Adults, County Council, English Midlands).

> Hebron, which I do have some concerns about, because they are so separate from even the mainstream Christian bodies. Well, on the one hand, they say that they offer treatment and rehabilitation for people, but on the other hand, they say to the statutory bodies, 'No, we do not' because otherwise, they would have to be inspected. They say, 'We are just support. It is just somewhere to live. We are just forming a community.' And I think do people know why they are going there? Do they really know? I am concerned that they are somehow being drawn into something that they do not know what it is until they get into it and then it is more of a closed community rather than an open community and people are expected to stay there and belong for a long time. Yeah. Because they do not fit into the statutory inspection thing, you do not know what standards are. Because they are a closed community, again, you do not know what the standards are. So, I am just suspicious without knowing.
>
> (Daniel Found, Independent Healthcare Consultant and Inspector, South West England).

Professionalism and voluntarism

One key tension between secular and faith-based alcohol treatment was the balance between professional knowledge and experience and a reliance on volunteers amongst faith-based alcohol treatment service providers:

> that came around this Big Society that David Cameron talked about, the third sector becoming much more important, and I just wonder if that is what is going to happen anyway with social welfare. For example, my church is opposite what was a Sure Start centre. Funding got cut for the Sure Start, so mothers, parents, carers migrated across the road to our church. We set up a soft play centre. We did not have professionals running it, but we just were open house and we just offered a place for people who felt a need for Sure Start before to come and join us. And we could probably do it more professionally really, but it has worked and people have joined. And you think, 'I wonder if there is space not just for the under-fives.' We run a lunch club for the elderly. Maybe governments used to fund services like that before and do not now. There must be so many ways in which churches as communities can say 'Tell you what. We can be really central to this community and be an integral part of meeting the needs of people who clearly have needs, who are marginalised in some way.' And you have got to include people with addiction problems in that. It is a bit specialised in the treatment and I would not say anybody can do that.
>
> (Daniel Found, Independent Healthcare Consultant and Inspector, South West England).

Despite such concerns, amongst the faith-based alcohol treatment service providers we interviewed there was a celebration that many of their volunteers were previous clients and 'experts by experience', but also an explicit acknowledgement of the limits to such knowledge despite an increasing reliance on volunteers to provide services due to budgetary constraints:

> I hate professionalism. I hate mundane attitudes. I hate passionless people, I want them out. I want people who are passionately in love with this work. We hire for passion, we train for skill and I want to see the life and I want to give that life to others here. I want to show them what it's really like … Because they want to be here. I think we're different on a number of fronts. We have had people apply to us for jobs and they have come from secular groups and the one thing that I have noticed is that there is such a level of professionalism amongst them that it's … There's a definite - professional barrier, a wall … I want guys who are going to take the job home with them. Who are going to be praying at night and are going to be thinking about the people. Who come in and work because they really want to. The biggest issue that I've got here is to tell the staff not to work too hard, to take time off. And so they are passionate about their work. So there's the relational side here and I think it's important. People need to be loved. People need to be in relationship with others. And if we can show them what friendship can do and how, when I'm genuinely interested in you and how I really want to help you… You can get books with formulae in but nothing ever comes close to the real thing …
>
> I would like to work on 50%, 50/50 or something like that [volunteers and employees with professional qualifications]. It keeps us on the right track. If they were all ex-users on staff we would have lockdown here every night. There is nothing so suspicious and paranoid, whatever you want to take it – as an ex-user. But if they were all clean guys, we would have silver service here. Everything would be swimmingly on the service and underneath it would be absolute mayhem. And I need the staff members who have always been clean to get street-wise. And they don't learn it out of a book. And as well, the guys who have been users are going to learn from the chaps who have been clean. We need a balance.
>
> (Bill Symmonds, Founder and Director, The Siloam Pool, English Midlands).

Equality and diversity

As well as the lack of social diversity of staff and volunteers working in faith-based treatment noted in section one, further tensions related to: differential opportunities for social groups to access treatment; and concerns over knowledges, training and moral values and attitudes of staff and volunteers with regards to equality and diversity, safeguarding etc.

For example, while 60% of respondents to our national surveys in England and Wales indicated a mixed sex care provision, it was clear from interviews with key stakeholders and faith-based alcohol treatment service providers, and in the participant observation, that female provision is lacking when compared to male-only faith-based programmes.

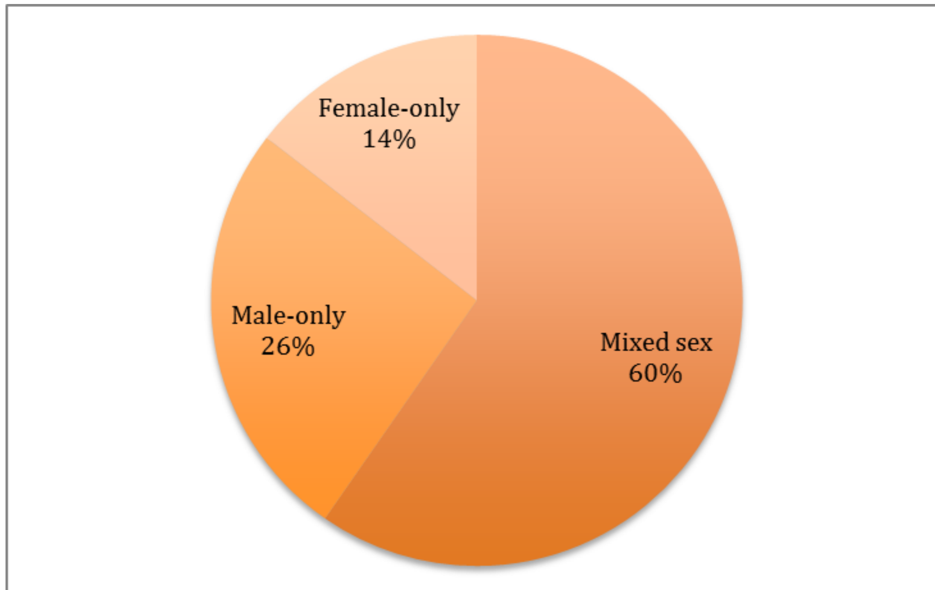


Figure 9: Accessibility of faith-based alcohol treatment services by gender (Source: Faith in recovery questionnaire survey).

As respondents elaborated, it wasn't just women who were underrepresented in faith-based alcohol treatment service provision, but also homeless people, travellers, ethnic minorities and those living in rural areas:

> Women are very much underrepresented in every stage of the treatment … Certainly say in residential rehab, the women's centres are the first ones to close and there aren't many of them anyway. I just heard one in London, 22-bed women's centre, closed. The issues with childcare… It's something I've been really convinced of, that we need to develop a women's service, because there are a lot of people we hear about in our local community, very much… Maybe single parents with children, but with a huge alcohol problem. There is nothing for them. So I'm trying to gather together a group of women to really start looking creatively at that issue. The rehab model doesn't seem to work. It's just not viable for whatever reason, there's only one women and babies unit in the country. It's really difficult to get that to work, but maybe structured day recovery around the school day, a 9:30 till 2:30 project with a shared meal and a babysitting service so that people can access the groups… Who knows? But just some very different model, and I think too often there hasn't been gender-specific designed responses. It's very much well this works for men or it's a men and women's service and that will have to do. And even a lot of the specific centres for women don't look that different from the men's centres for me, and I think maybe it just needs a total rethink.
>
> (Trevor Robbins, Chief Executive, Levington Grange, Christian Drug and Alcohol Rehabilitation Centre, South East England and Member of INCSAO - International Network of Christian Substance Abuse Organisations).
>
> Obviously, homeless people. That is just a huge… they are full of alcohol and drug problems, psychotic illnesses, neglect, lack of healthcare overall. I think that is a big deal … I think women probably get a raw deal as well … Rural areas, anecdotally, there is a lot of alcohol abuse, especially among farmers

> and isolated people. Yeah. And again, rural areas are much more difficult to access treatment because you have got to travel to a treatment centre, then you have got treatment and then it is very difficult. It is much better urban.
>
> (Jon Brown, GP, Clinical Lead for Drug and Alcohol Treatment in a Criminal Justice Context, Local Authority, and Kingdom Release, Co-founder of Christian Research and Lobby Organisation, North East England).

However, a handful of respondents did point to significant concerns regarding knowledges, training and (at times) moral values and attitudes of staff and volunteers with regards to equality and diversity, and whether all faith-based organisations have the resources to ensure safeguarding etc. Indeed, mirroring Wilton, DeVerteuil and Evans (2014) in our study there were a number of examples of ways in which faith-based alcohol treatment providers expressed problematic views on sexuality, gender, ethnicity and so on:

> I think, increasingly, in the modern church world, there is more of the kind of 'how do we do it at least to the world's standards and then add more to it?' than there is of the older... I worked with a group in a large city in the North West, a Christian organisation, whose head main office, is right in the middle of the gay village, literally, and the guy who has just retired from there... I'll mention the organisation but I would rather they weren't mentioned in this. It's a homeless charity ... The guy that started it was a Christian, a real pioneering man. A man of faith, a man of God, did it for 25 years, but he used to regularly say, 'I am operating from the devil's kitchen.' It just annoyed all the gay people and services around him.
>
> (Leslie Denmark, Team Leader, Local Authority Commissioned Drugs and Alcohol Project, and Vitality Project, Trustee, Faith-based Recovery Support Group, South West England).
>
> There will be a nursery there, so obviously we have got two agencies that we would be working with [Ofsted and CQC] Now we have got two people working two days a week and they have been doing this for some months now. They are doing the research for this so that when we do it, we do it properly. Setting up the nursery is quite something. I want to see a place, let's just say like this one here, where we can segment a number of rooms so we can have a family area. So mum – and she could have a baby, she could have children six, eight, ten, twelve, whatever – and so separate rooms for them but for it to be a family unit. For us to be able to teach the woman… I'd like to have a hairdressing area, part of it, so that… These women get androgynous after a while; I'd like to see them have nice hairstyles, become a lady, for them to see how to look after their children properly … Cooking lessons, health and how to manage their children properly so, again, bring in this woman that we've to teach them how to parent their children properly.
>
> (Bill Symmonds, Founder and Director, The Siloam Pool, English Midlands).

Summary

This section has focused on the institutional context of faith-based alcohol treatment by considering challenges, opportunities and tensions, highlighting that:

- unsurprisingly, the combined impact of austerity, long standing restructuring including marketisation of health services in England, and changes in UK government policy, has led to significant problems in the provision of alcohol treatment service provision;
- with that backdrop, faith-based alcohol treatment is ‘filling the gaps’ not covered by national charities, private sector companies, or statutory funding;
- despite stated desire for both secular and faith-based alcohol treatment service providers to work together, there remains significant suspicion with regards to evidence-based policy, transparency of theology and practice, often exacerbated by the competitive nature of funding opportunities;
- more specifically, key stakeholders and some faith-based alcohol treatment providers expressed concern about moral and judgmental views on alcohol; lack of expert knowledge and experience; lack of registration with regulatory bodies; clarity over ethics, theology and practice; and lack of safeguarding, equality and diversity knowledges and training.

In order to explore these last issues in more detail, the reminder of the report focuses on faith and spirituality in practice and experiences of service users.

4 Organisational ethos and practices

This section discusses organisational ethos and philosophy among faith-based alcohol treatment providers. In particular we focus on treatment provision and services; expectations and rules; mandatory religious practice; and ethics.

Organisational ethos and philosophy: the role of 'faith' and spirituality

Our survey asked faith-based alcohol treatment service providers to summarise their ethos and philosophy, with most responses focused on describing treatment modalities such as 'Twelve Steps', 'peer led', 'therapeutic', 'abstinence-based', and 'physical, spiritual and emotional'. Others, however, responded by stating religious or spiritual terms such as:

> Transformation through faith in Christ alone.
>
> Relationship with Christ equips us to face problems and addictions. Strengthens us to see addiction is a symptom of a deeper problem. Enables us to tackle the root problem. It is recovery - mental, physical, spiritual - through Christ.
>
> Our organisation exists to educate, equip and empower individuals and churches in their relationship with Jesus and, through discipleship and pastoral support, facilitate healing at the root causes of life-controlling issues through our range of support services.
>
> Treatment is great but we advise and go through ourselves the Twelve Steps of recovery with the help of Jesus Christ as our higher power.
>
> Twelve steps and Bible-based.
>
> That the roots of addiction are ultimately best dealt with through a relationship with God (although numerous factors may need to be addressed).

Developing Smith's (2002) and Sider and Unruh's (2004) typology of Faith Based Organisations (FBOs), alongside research on the degree to which service users are expected to engage in religious activities as a condition of service (Johnsen and Fitzpatrick, 2009), our research findings highlight a diversity of organisational ethos and philosophies claimed by faith-based alcohol treatment providers that can be best characterised as:

- Faith-saturated / faith *is* the programme. Staff share the organisation's faith commitments; programmes involve *explicit, extensive, and mandatory* religious content integrated throughout the programme;
- Spirituality *is* the programme. Religious/spiritual components are compulsory but non-exclusive to any one religion; instead there is explicit and extensive direction towards notions of spirituality as defined by service users themselves;

- Faith-centred. Including *explicit religious messages* and activities designed so that participants can *readily opt out* of these activities and still achieve positive outcomes;
- Faith-related. Founded by religious people and displaying religious symbols but not requiring staff to affirm any religious belief or practice, with the possible exception of executive leadership. Faith-related programs have *no explicit religious messages or activities*, although *religious dialogue may be available* to participants who seek it;
- Faith-background. Looking and acting secular, even though they may have a historical tie to a faith tradition. No explicit religious content or materials and *faith is considered as a motivational force and there are no expectations that service users should or will engage in religious activities.*

(see Smith 2002)

Treatment provision and services

Our research shows that 67% of organisations that completed our survey indicated that their primary mode of care provision was abstinence-based (see Figure 10). In most cases, abstinence-based programmes were predicated on theological understandings of addiction (as sin or spiritual void) and recovery (as divine deliverance or restoration). Hence, in these cases, anything short of total abstinence casts doubt on the soteriological power of the deity to deliver someone from their addiction. Non-abstinence can be taken to indicate failure of the individual to submit to God's will. 24% of respondents identified 'other' care approaches including weekly Bible study groups, 8-step recovery, clinical assessment and treatment, and an advice line and remote pastoral support.

Figure 11 points to the importance of the Twelve Step programme for faith-based alcohol treatment service provision, but this approach is still being used slightly less than 'advice and guidance', signposting and other 'group counselling' provision and services.

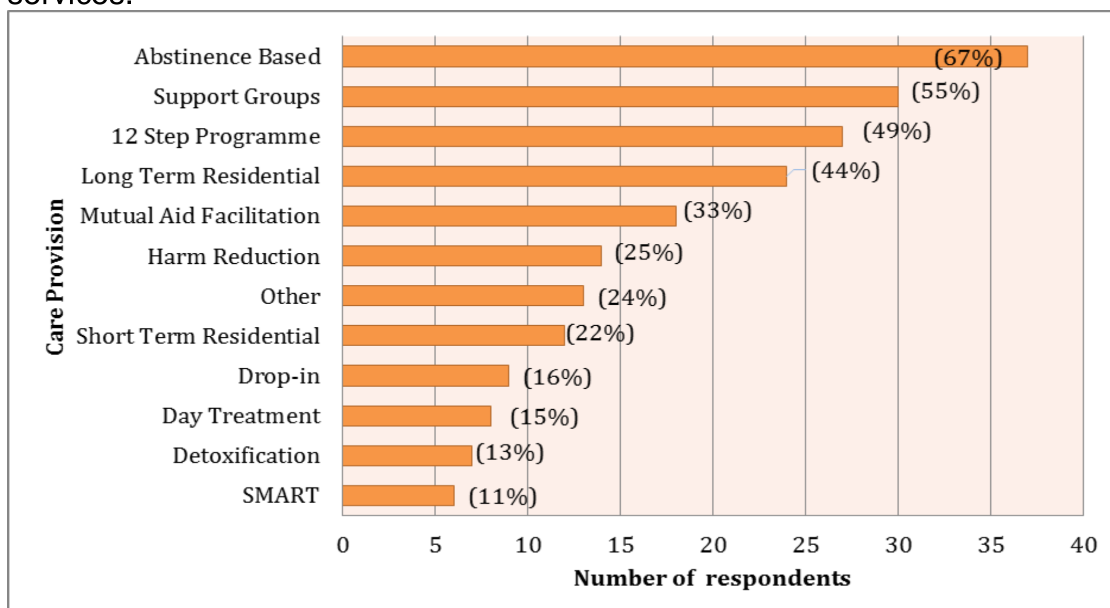


Figure 10: Care approaches of faith-based alcohol treatment service providers (Source: Faith in recovery questionnaire survey).

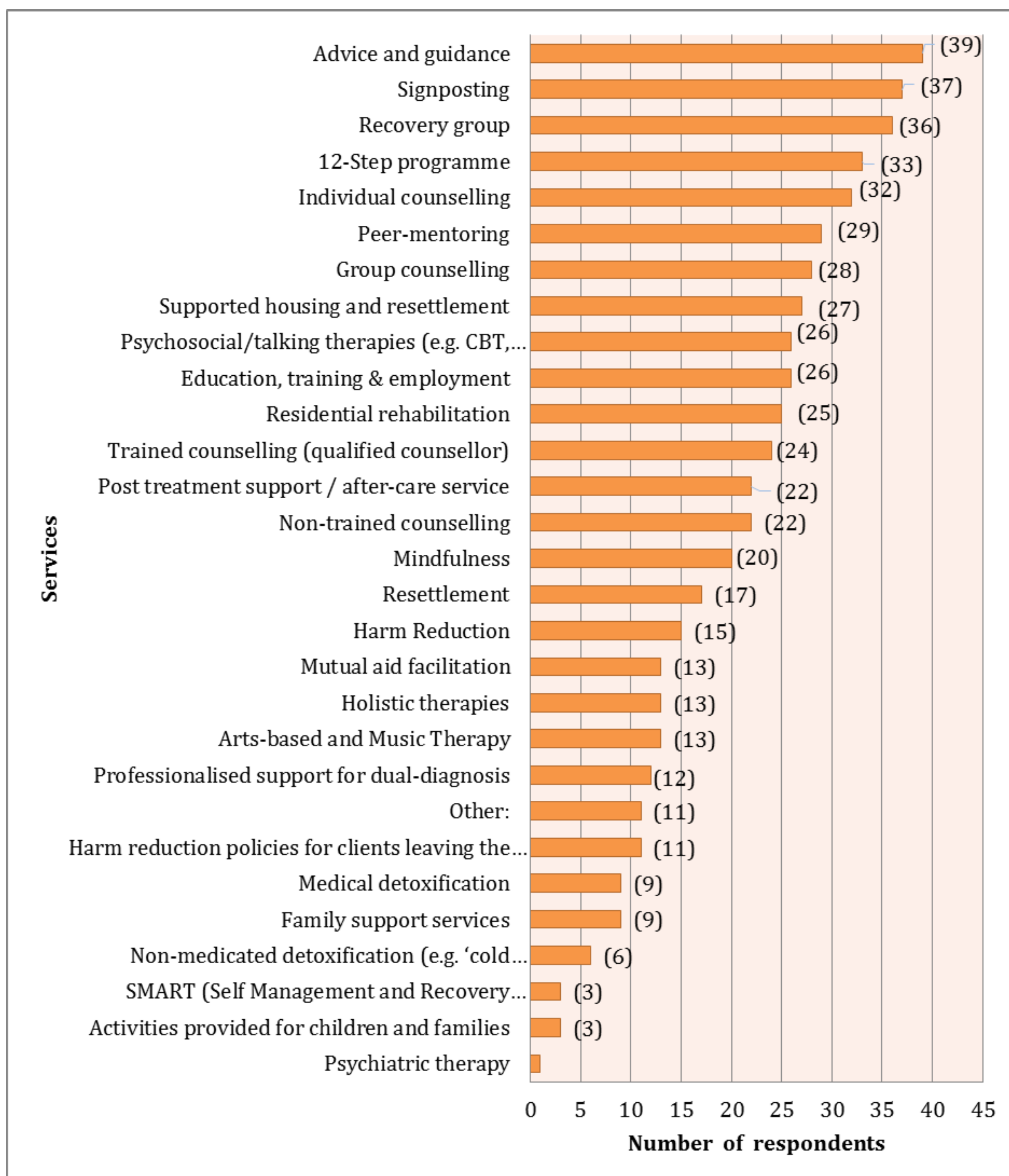


Figure 11: Services provided in faith-based alcohol treatment (Source: Faith in recovery questionnaire survey).

55% of all faith-based alcohol treatment providers and 81% of faith-based residential rehabilitation providers also suggested that their programmes entail work-based activities. Vocational activities were not only used as a psychosocial tool to aid treatment but as a way to increase the employability of service users (Platt 1995; South et al 2001). Activities included gardening, furniture restoration, art, drama, woodwork, IT, cooking, decorating, and working in charity shops and cafés.

Three of our case study organisations offered tailored treatment provision and services: Open Circle focused on Black, Asian and Minority Ethnic service users; The Sanctuary, a residential 'wet-house' for long term drinkers to learn to manage drinking in a safe environment; and the 'The Restoration Course', offered national franchised courses which provide online resources and face-to-face meetings in church venues.

Firstly, Open Circle provides a distinctive multi-faith approach catering for Black, Asian and Minority Ethnic groups in the English Midlands. Open Circle seeks to debunk misperceptions and misinformation among Black, Asian and Minority Ethnic communities, especially with regards to the 'Twelve Steps' approach that often has associations with 'surreptitious' Christianity (origins, belief system and meeting spaces). Instead, Open Circle offers spaces for ambient and eclectic spirituality. Religious iconography is scattered across each room, from disparate monotheistic, monist, pantheistic, dharmic and First Nation spiritualities. The 'twelve ' programme is utilised in an explicitly pluralist way and is respectful of diverse religious and spirituality traditions. Addiction is understood to have 'opened up' a channel for individuals to see different spiritual dimensions.

While occupying this important place in landscapes of treatment provision and service, Open Circle was critical of funding inequalities for Black, Asian and Minority Ethnic specialist alcohol treatment support services:

> 65% of the population in this city are white British … the service is designed for them ... But mainstream services are also taking the money for the 35% of BAME. If you divide the commissioned £25 million and ratio it 65/35 … that's a couple of million pound that should be for BAME services. The core service don't reflect this, not one iota, for culturally appropriate intervention. Yet we are doing it here, on a shoe-string budget.' 'We want a share of the equity within the city and county … where we can be bought back into the fold, and have honest, transparent relationships with mainstream partners. But partners must understand who we are, why we do what we do, and how we do it, and why it makes an impact. Rather than have a misinformed, prejudice perception.'
>
> (Mehak Tahim, Senior Recovery Worker, Open Circle, English Midlands)

Service users at the Open Circle highlighted their appreciation of culturally sensitive treatment provision and services, often in relation to other secular and religious treatment they had received:

> How is it different? The structure of it is the same. It's different because they understand my culture, they understand my background, they understand what I'm saying. Whereas in a Dependency Watch meeting, which I do go to those as well, I'd have to explain a little bit about… They're not used to my customs or my culture, whereas Open Circle have an idea of it.
>
> (Rahim Awan, Aged 25-35, Open Circle).
>
> I definitely felt more at home because there was so many more Asian guys there sharing their experiences and you could relate to them, their stories are

> very similar to my story about the family thing. I think it is a mixture of Sikhs and Muslims, Hindus, but very similar stories even though they're from different religious backgrounds … Yes, I think they could maybe do with some more staff. I think they're a service that is needed, definitely needed. There are not many places like this, I don't think there are. What I feel here I don't feel at any other place, not that I've accessed any other service because I haven't. I don't think I would want to.
>
> (Ahmed Abaza, Aged 35-45, Open Circle).

Secondly, The Sanctuary, a residential 'wet-house', offer a 'harm reduction' approach by managing drinking in a safe environment, with personal-centred goals towards abstinence:

> It's definitely a controversial idea. Like I say, our wet hostel in particular was just formed out of the need to house people who were physically addicted to alcohol. There wasn't a facility in our city for homeless alcoholics. It wasn't acceptable to leave them on the street, they needed somewhere to go, so that's why this was formed. We're really open, there's no taboo subject. We do have certain rules in place, residents aren't supposed to drink offsite, they're not supposed to drink over 5.3% stuff. This is me personally, I'd prefer honesty. If somebody's been out in the park and had a 4-pack or whatever, I'd rather just know about it and then we'd know what we're dealing with and we can work with it. So for me it is about just being open and honest and talking about stuff. But then again everybody in here has a different relationship with alcohol. We do have one resident at the moment who is abstinent completely, we've got a couple who more or less are, maybe have a can on an evening, we've got others who will have a drink at 7:30 in the morning and drink steadily throughout the day, we have others who get absolutely heavily intoxicated and then will sleep or whatever, peak and trough. And some people, like I say, consider it a problem, others don't. Some want to address it, others don't. We just act accordingly really depending on that person.
>
> (Dave Kilburn, House Support Worker, The Sanctuary, North East England).

Such approaches are rare among faith-based alcohol treatment providers, many of whom expressed scepticism of harm reduction approaches. Nevertheless, The Sanctuary provides valuable support for those unable and/or unwilling to meet the strict expectations of abstinence that characterise most faith-based residential programmes; meets the accommodation needs of people whose drinking practices would prevent them from retaining tenancy either in supported housing or private rental sector accommodation needs; and provides a supportive environment for long term drinkers to address other problems.

Thirdly, our national surveys identified a growth of franchised courses of faith-based recovery, such as The Restoration Course, which originated from prominent evangelical churches in the UK and USA and offers online resources and has face-to-face meetings in venues. Interestingly, these courses aggregate different 'addictions' so that alcohol, narcotics, gambling, sex and eating are discussed in peer-led group sessions modelled on Christian Twelve Step programmes. The

growth of the franchise model (similar to other Christian franchises such as Night Shelters, debt advice, Food Banks, Street Pastors) embody what Weir (2015) identifies as the new form of entrepreneurial Christianity shaping missional praxis. The Restoration Course has 39 groups across the UK:

> We have a vision for the Restoration Course to be offered in every major town or city in the UK within five years. I'm not sure whether that's God's ambition. If it is then we are in luck and we will do all we can to try and follow that… The thing about recovery communities is that some people here will probably be part of a Dependency Watch group as well and they might go along and say, 'It has not been working for us. Why don't we go and try this Restoration course down here? I've been and it's not a load of weird Christians. Actually, it's alright…treatment, was a really key word because for me, we're very careful not to use the word treatment. Some of the course leaders are trained counsellors … so we have got people who are qualified and trained, but we deliberately say, 'Actually this is about supporting each other in a real peer group way.' In terms of treatment, we will signpost people. People present themselves and it's quite obvious that they have maybe got a mental health issue, we will encourage them to go away and have a diagnosis and then come back when they have got medication. If people are carrying so much grief that they need professional counselling, we will link them in. We pay for counselling here. We've got links to the local counsellors. We've got links to Christian counselling. If they need prayer, we will signpost them off for that. We will do it all because we accept that we are not professionals in this, we are just people who are on the journey as well and we have a heart to take people with us.
>
> (James Booth, Director, Restoration Course, Online and nationwide venues).

As this quotation shows, the franchised programmes are not targeted as formal 'treatment' but instead focus on 'signposting' to mental health professionals and trained counselling, with group participants having the option of using Christian counsellors to receive prayer from trained volunteers in separate prayer rooms.

The rapid growth of these franchised groups has been accompanied by very localised partnerships with drug and alcohol teams. In terms of scale, the Living Change franchise currently has 24 venues nationwide, while there are 61 'Freedom Groups' - a modified Christian twelve step programme and church-based befriending scheme, created by Christian Social Action, a national Evangelical debt advice charity.

Expectations and rules

We saw in the previous section that significant tensions regarding the work of faith-based alcohol treatment service providers have emerged regarding concerns over control and religious indoctrination, particularly related to expectations and rules. This is especially true of residential programmes where service users are encouraged to 'break' from past lifestyles and habits.

Survey responses highlighted a wide range of expectations governing programmes. For example, abstinence-based programmes made prior abstinence (often from all

substances including nicotine) a pre-condition to entry. Residential programmes made obeying 'house rules' and contribution of 'daily housekeeping tasks' a key element of commitment to communal living in order to prohibit, or limit, disruptive or divisive attitudes, activities, etc. Most organisations required service users to adhere to religious/spiritual expectations *or* to adopt a sympathetic attitude of 'openness' or 'respect' towards religious or spiritual beliefs. Others indicated that there were no preconditions to accessing treatment and services other than: 'a desire to change'; 'desire to get and sustain a recovery'; 'willingness, honesty'; being 'motivated to change'; 'a desire to move away from suffering'; 'a willingness to actively seek recovery'; 'real desire for change' etc.

It is important to note that most secular treatment centres often have similar rules and expectations, for example, in placing conditions on residents to engage in 'secular' ideas of social citizenship, meaningful work, looking after each other, routine, responsibility, developing new skills etc. It is not only faith-based programmes that attempt to impose a worldview explicitly and/or implicitly. Ethical principles regarding proselytisation are not limited to religious groups but should be equally applied across 'secular' philosophies of recovery.

In section five we will discuss in more detail how theologies underpinning treatment and service provision are interpreted, applied and experienced by service users during daily life in faith-based alcohol treatment.

Mandatory religious participation and ethics

34% of organisations indicated that their programme contained elements of mandatory religious/spiritual participation. Mandatory religious participation in residential faith-based alcohol treatment was higher, at 52%.

28% of all responses to our survey suggested that religious participation was optional, highlighting how definition, meaning and practices related to 'mandatory religious participation' were ambiguous, although at the very least attendance at 'religious/spiritual sessions' by service users was expected. For those who elaborated on their optional 'religious participation', comments included: 'Recommended but not compulsory'; 'Preferred'; 'We encourage clients to seek out a church to participate in religious activities, but we do open with prayer and close in prayer'; 'On the whole no - but some sessions involve spiritual teaching and open up discussion'; 'Our group is based on religious worship. Clients are expected to not disrupt others but do not have to take part'; 'No, but a time of daily spiritual reflection from a variety of presenters, including Christian ministers is expected'.

Assertions by faith-based alcohol treatment service providers that religious participation is 'optional' does not always align with daily practice (see section five). Indeed, as the following participants' observations note and interview quotations indicate, programme goals, structure and experience for service users can remain conversion-oriented and, to varying degrees, coercive. Our research highlights the issue of transferred gratitude and reciprocity in which positive psychological, physiological and emotional experience of alcohol recovery is accredited to God and/or the organisation, which in turn sparks engagement with religious faith and explicit exhortation to engage in conversion conversations with keyworkers:

> Why have 50%... you can have 100% with God. Why sell yourselves short… Don't bury it. Talk about it with your keyworker.

Not to discount the important place of thankfulness in many faith traditions or imply *any* positive experience of recovery accredited to God is inherently a problem. Rather, there is evidence in the research findings of some groups applying a politics of gratitude during treatment. While the gift – of residence/recovery/friendship - might elicit an intuitive wish to reciprocate to the organisation. At the Siloam Pool, for example, staff outlined explicit instruction to residents to express 'gratitude'.

> Those who have been given much, should love much too... If you really appreciate what Jesus has done for you, the outworking is gratitude and you will love much … we aren't going to be a waiting room for hell. Salvation is the name of the game here … we are a ministry
>
> (Participant observation notes)

In this case there was a significant difference between everyday religious practices and ethics and the espoused public voice that emphasised voluntary participation, and the choice of residents to engage – or not – with the religious elements of the programme:

> Nobody is ever… We don't ever say to anybody, "If you don't become a Christian you're out." That doesn't come into it whatsoever. We've had people go right through the programme not a Christian … Yes and it's not… But we've had people right through phase three and out the other side and not a Christian and it doesn't… We don't allow that to influence our relationship with the individual … But their peer-led session in the morning is meant to have a Christian basis. The staff-led devotional after that, in both phase one and phase two, is biblically based. The next lot of teaching we do is not always biblically based. The guys always say grace before meals, they go to church on a Sunday. If somebody is of another faith we can allow them to go to their, wherever they need to go, on a different day. But Sundays they will still go to church with the others.
>
> (Jenny Squires, Founder and Director, The Siloam Pool, English Midlands).
>
> At least they will know they've been cared for by Christian love and that's… It's part of the discipline of the daily routine … The Christianity will come through here in the way that we treat people. No-one is forced to become a Christian but it permeates through this place … Yes, no-one is forced to read out the bible or to pray and all we ask is they respect the Christian ethos of the place. So if somebody is blaspheming here and mocking the word, it's not the place for them. And on the application form they will sign that they will respect the Christian ethos. So if somebody says, "I don't want to read out the bible, I don't want to pray," that's fine. That's their prerogative.
>
> (Bill Symmonds, Founder and Director, The Siloam Pool, English Midlands).

These research findings highlight the need for a more elaborate understanding of proselytisation beyond the conscious intentions of those doing the caring; instead, practitioners need to reflect on the power dynamics within faith-based alcohol treatment. We suggest recent debates over proselytism in faith-based service provision are limited by one-dimensional definitions of proselytisation as 'dishonest or coercive methods to win adherents' (Bickley 2015: 11), rather than appreciating more subtle forms of power at work in treatment through social incentives, probation-related requirements, and familial encouragements to 'work the programme'.

Our findings point to the need to revise current best practice based on a more sophisticated understanding of proselytisation. While the All-Party Parliamentary Group Faith and Society's "Faith Covenant" offers broad principles for engagement and joint working between local councils and faith groups in their area. This entails a requirement on FBOs to commit to "serving equally all local residents seeking to access the public services they offer, without proselytising, irrespective of their religion, gender, class, marital status, ethnic origin, age, sexual orientation, mental capability, long term condition or disability" (https://www.faithandsociety.org/covenant/full/).

Evidence presented here suggests staff and service user perspectives and experiences of 'proselytising' differ greatly, signifying that any assessment of the ethics of faith-based involvement should be ascertained by the voices of current and past service users. Failure to do so risks 'reading off' the sincere intentions of staff as synonymous with actual service user experience.

Summary

- 34% of all faith-based alcohol treatment providers make religious participation mandatory for service users, a figure that rises to 52% when residential faith-based alcohol treatment providers are considered;
- Vocational work-based activities (gardening, furniture restoration, manual work, cooking) featured heavily in faith-based alcohol treatment, with 55% of all faith-based alcohol treatment providers, and 81% of faith-based residential rehabilitation programmes entail work-based activities;
- Recent years have seen a growth in 'franchised' Christian Twelve Step recovery courses across the UK offering online resources and face-to-face meetings;
- Ethical questions regarding faith-based involvement in public services should not be limited to whether service provision is made conditional on expressing, or participating in, religious beliefs and activities. Nor should assessment of proselytisation be limited to the conscious intentions of those doing the caring. To do so risk overlooking the overt and more subtle power dynamics within faith-based alcohol treatment.

This section has ended with questions regarding the 'voluntary' framing of treatment as 'free entry and exit' and questions regarding overtly regimented exhortation of religious belief and discipleship (Williams, 2013). In the final substantive section of the report 'Faith in recovery: experiences', we foreground the voices of service users to explore these and other issues in more detail.

5 Faith in recovery: experiences

In this final substantive section, we foreground service user voices in order to explore their experiences of faith-based alcohol treatment. The biographies of service users who took part in our research highlight the diversity of social backgrounds and life stories of people who access faith-based alcohol treatment (see Appendix 3). Experiences of that treatment are equally diverse with a significant range of positive and negative opinions and experiences recounted by respondents during interviews and during the participant observation research with regard to: religious and theological ethos; everyday practices of treatment; challenges of professional and personal engagement with service providers, staff, volunteers and other service users etc. In order to capture this complexity we present research findings focused on: prayer, worship and singing; faith and spirituality as 'active ingredients' of treatment; we highlight strategies and techniques individuals developed to 'play the faith game'; as well as considering service users' pathways through treatment, their views on, and experiences of rules, 'strictness', as well as their right/ability to 'complain' about treatment regimes and practices.

Prayer, worship, singing, faith and spirituality … or replacing one addiction for another

Service users frequently raised the importance of singing and prayer as a key part of treatment:

> If I had to say which was the most significant? The singing, the worship songs are tremendously moving. I do find that very moving and it's the psychology of being in a group, isn't it? It's that feeling of belonging, that feeling of fellowship and community that we all long for. It's automatically there when singing in tune with a group of people. That's it, you've got it, the vibrations are synchronised, one is there in the zone. It's much harder to achieve that in discussion, much, much more difficult to achieve that in discussion. Whereas literally singing off the same hymn sheet, you're there.
>
> (Martin Albright, Aged 45-55, The Siloam Pool).
>
> "Whenever I get the thought…[about having a drink]" … We have some rosary beads in Islam, a lot of people have some sort of way to, whether they meditate on the spot or whatever. But these beads that we have, there's a little prayer that we say each time, each bead, and it helps relieve that urge to want to use, that urge to go off and go on a mad one. It helps release that and that was through somebody in here as well. It's like a form of meditation, you get very relaxed, you get very eased. It's strange, those thoughts become distant again. Don't get me wrong, it does not come straight away, it took me two or three weeks for me to start getting into my prayers more and getting into my meditation more. Meditation is having those 10, 15 minutes in the morning to myself and asking God that going through this day, I don't use.
>
> (Rahim Awan, Aged 25-35, Open Circle).

While several of the service users we interviewed were sceptical about the value of worship beyond raising the spirits and 'breaking up' the boredom of being in residential treatment, for one service user, Martin, the charismatic tenets of worship was something he appreciated:

> Although they're not promoting it greatly, the brand of evangelical Christianity that the people behind the Siloam Pool come from I find very attractive in as much as they have an awareness of the supernatural. Some elements of the Church of England are very pedestrian, in order to make it totally uncontroversial and acceptable to everyone. Talks of other dimensions and such stuff would be frowned upon, whereas that is acknowledged here without being made any big deal of. We do touch upon topics like tele-transportation, prophesy, seeing into the future, stuff like that, God's gifts, speaking in tongues, things like this are touched upon just lightly, in case anybody would be interested. And I like that, I like that. There's more to God than could be put onto a sheet of A4 paper.
>
> (Martin Albright, Aged 45-55, The Siloam Pool).

There was nonetheless significant difference of opinion amongst service users regarding the role of faith and prayer in treatment, but, in contrast, all of the respondents we interviewed highlighted how greater awareness of spirituality was now central to their lives. For example, in the following quotations, Rahim and Will discuss a reinvigoration of faith:

> So I was leaving for the rehab and my mum had my bags and everything packed ready for rehab, and I went to say bye to my mum and stuff. Obviously I'm still really, really off my rocker at the moment and I remember her giving my prayer mat and my Quran to me and saying, "Just while you're there." I thought, "OK…" But I never did, until a week, two weeks passed and it was in the rooms where I kept hearing this higher power thing, and I thought, "Hold on, man. I'm going to touch out. What has my God given me?" Now you've got to think about, it's two weeks into my rehab so I'm now with a bit more of a focused mind, my diet's changed, everything's clean for me at the moment. And I wrote down all the opportunities that my God has given me, meaning he's given me the opportunity to come to rehab, he's given me the opportunity to meet people in recovery, he's given me the opportunity to come to Open Circle. And this is my God working for me because he's not going to come down a flight of stairs and say, Look, mate. I'm going to hold your hand and we're going to sort you out. As much as it happens in a cartoon, it's not going to happen in real life. My god works through people and this is the nice fact about, he's working through people.
>
> (Rahim Awan, Aged 25-35, Open Circle).
>
> My higher power is doing the next right thing; the bond you have between family and friends, the love; synchronicities, déjà vu, dreams; the bigger picture, the bigger world. Like, not being so defined in yourself, looking at the bigger picture in life. Pretty much, I've linked it to a higher power, yes, to something. I don't know what it is, but it's something. When I pray in the mornings, I pray to

> God, not to a higher power. So, I've got… I believe there's a God, but my higher power is other things as well. I just use the word 'God.' I just believe there's one thing out there, and everyone might have an interpretation of it differently … I quite like mindfulness, but that's just meditation. Mine is my daily practice in the mornings; my praying, my 'Just for Today' book, reading my daily reflection. Have you seen the books? On every day, you've got a different reading; those and praying. I say the serenity prayer every morning, and off the back of that, I'll just freestyle how I'm feeling in the morning, anything I experienced the day before. I might ask God to remove any defects I might have had, or something I might have done. That sets me straight up. Then, throughout the day, we have reflections and things. But, there are little prayers being said in and out the day, so it keeps you plugged in. You're working on the twelve-step programme, so that keeps you plugged in to spirituality. It's all around you, in bits and bobs. All the time, yes, in little bits and bobs, but it's not thrown in your face. They do it in a clever way, where you're always around it and it's always there. If you choose to notice it, it's there.
>
> (Will Cooper, Aged 25-35, Kimberly House - part of an international Christian social service organisation).

Whereas some service users highlighted the importance of faith and spirituality in treatment, others were more sceptical:

> A lot of people I know are religious, and they pray to God. When I go to the meetings, they tell me to say the prayer and say the word 'God' because they want to hear it: 'God.' "Grant me serenity to take the things I cannot change and courage to change the things I can, and wisdom to know the difference." I always say 'God' … Because it's what they believe. I am in an environment... This is a catholic country; maybe catholic, maybe protestant, but God. You have to say it. Yes, because if I don't say it, I am going to be the bad one in there. I don't want to be the bad one. I want people to look at me. Talk to me. Not say, 'This is the prick who doesn't believe in God.' I don't mind to say 'God'. Maybe he comes one day and proves to me that he exists. At the moment, I see that much shit on the street, a mother with a teenage daughter, prostituting themselves. Things you don't believe. A person killing another lad? It's horrendous. God is not there. My father beating me up from 7 to 12, and beating up my mother. Where is God? Where? There's no God. I was a waiter for a long time. As a waiter, you say what the people think. You say it and you get tips. It's the same.
>
> (Juan Martinez, Aged 45-55, Kimberly House - part of an international Christian social service organisation).

Staff from one of our case study organisations nonetheless expressed concern that 'residents who appear most on fire [devoted and charismatic about their faith] are most likely to relapse'. Yet, it was noted during the participant observation research that those staff emphasised the need to accept Christ as a panacea for addiction, suggesting 'recovery without God is delaying the inevitable [death]'. Such comments point to concerns over 'cross addiction' (religious obsession and swapping one dependency for another), which was often mentioned by service users - and staff - in

the research. There is undoubtedly a problematic issue here if religious belief and practice becomes a behavioural/process addiction associated with negative symptoms, such as Obsessive Compulsive Disorder behaviours (for instance, the ritualistic release of guilt and low self-esteem), loss of contact with friends and family, rigid judgementalism, or giving money to religious organisations at the cost of basics for self and loved ones (Vanderheyden 1999; Taylor, 2002; Sussman and Black 2002). Equally, care is needed not to overlook healthier engagements with religion that brings positive effects to the lives of participants, and would not be classed as addiction:

> People say being into spiritual things is a crutch or it’s a cross-addiction, but so is eating fucking chocolate. You give up drugs and you start drinking copious amounts of coffee. So why then is it all ‘Ooh’ if people talk about spirituality or addiction or getting into God rather than using drugs? If God keeps me clean and I can live a good life without robbing people, stabbing people, hurting society, robbing off my parents, beating up my brother, the list is endless, I’d rather believe in God, thank you. [laughs] I can put up with that. You can call me the God squad, you can say this, that and the other. You can even say I've got a cross-addiction. Yes, thank you very much, at least it’s healthy for me. [laughs] At least it’s a healthy addiction.
>
> (Cameron Richardson, Aged 25-35, Kimberly House - part of an international Christian social service organisation).

Socialisation, ‘conversion’ … conform or leave?

American sociologists Rodney Stark and John Lofland suggest that conversion is determined not through individual assenting to particular propositional theologies, but by the strength of an individual’s interpersonal attachments to various in-group and out-group members (see Stark 1986). These theoretical insights help frame the experiences of religious conversion in faith-based residential alcohol treatment discussed by our service user respondents. For example, service users reflected on conversion through socialisation with peers during religious practices:

> It's a real sense of love, wholeness, connection; however, when I wasn't in that place, it exacerbated the anxiety. It made me feel really uncomfortable, like there was an expectation on me to be a certain way. And that only made me want to protect myself and become more subdued and inward … If I'm being honest with you, it’s only just started to change [laughter] over the last… I've just heard myself say that out loud. I would probably say I've had seasons where I’ve felt more open and connected to God, to people, and worship has been easier if you like. And I've had times when I’ve felt withdrawn and isolated in myself and my mind, quite disconnected, and worship has been painful almost, like ‘get me out of here.’ Like I said to you yesterday, when I was going to church, in the end I was just going through procedure, through loyalty to my wife, so I wouldn’t get earache. And during that time in worship, it was painful. It’s that thing, isn't it? You've signed up for this, so this is what you've got to do. Does that adhere to a quality? There are a lot of questions about that sort of stuff.

(David Street, Aged 25-35, The Siloam Pool).

David went onto describe his conversion as an 'event' and 'a process' through socialisation into a 'loving community' that gave him a sense of acceptance:

> It was the first spell. I used to sit in devotions, the teachings. I used to hear all these historical stories, and then someone introduced me to the New Testament, Romans, living by the spirit. After about two or three weeks I was reading 'Life by the Spirit' and I just had a total revelation. I truly believe the Holy Spirit filled me and I jumped off the chair and I was bouncing around the walls for weeks. I realised that Jesus did walk this earth. Jesus did die. Jesus was resurrected … So I guess I used to hang around with like-minded people and I was in a circle that was so like-minded that it never really grew mentally or emotionally, or somewhat physically. But when I came to The Siloam Pool, it broadened my horizons; it gave me a new perspective. All of a sudden I was around people who seemed very wise, very driven, very loving, very caring. There was a sense of peace there. And I remember thinking to myself, I don't know if this is what life is like without religion, or if this is religion in essence. It brings about a sense of peace. I wanted it. It was quite intriguing at the time.

'Longer serving' service users in peer-led programmes are required to give encouragement and service users gave positive accounts of socialisation and positive peer support:

> It has taken me a good number of weeks to sing with full voice. Without a doubt. Despite the fact that as a person I'm not shy and I've had some experience with speaking and singing in public. But it still took me quite a while, and some of the other blokes still find it difficult. But it's dealt with very well here. One isn't picked out for not singing. Some of the blokes sit down halfway through the song, perhaps their back is aching, perhaps they're just having a bad day and feel a bit cheesed off. They're not picked out for that, and I think because of the way that an individual's growth in faith is treated very tenderly here, it's promoted very well. Instead of getting people paying lip-service and jumping up and down and playing the part, it's genuine. What people are doing and saying and feeling is genuine.
>
> (Martin Albright, Aged 45-55, The Siloam Pool).

However, in peer-led faith-based programmes there was also evidence of blurred ethical ground of 'volitional agency' and the ways exhortation to 'follow the example of Christian discipleship as modelled by others' rubs against the intersections of social attachment, validation and imitation. New residents are encouraged to suspend suspicion and accept the 'need to surrender to God', often alongside depictions of 'tough love' and messages of 'take it or leave it':

> Basically I'd tell them my experience and how I wasn't a Christian in any way, I wasn't Bible orientated in any way and I'll explain to them… because that's all I can do, is show them what I've been through and how it's changed me and then it would be up to them how they want to take it because everybody takes a programme differently and sees it differently … Don't be suspicious, take it with

> open arms, because you start going in there suspicious and all this, you aren't going to get the programme and it's just going to stop you from improving …It's religion religion religion, Bible Bible Bible, devotion, reading your Bible, reading your… everything is based on that. I don't think the boss man would have it any other way … Everything you do here … Let's put it this way, there's a choice. You want to stay here then you adapt to your surroundings, yes? If you want to stay here and mess about then the front door is there. They are not holding you here, they are not keeping no one here. If you don't like it, see you later. Call a cab, pack your things. They'll even help you pack your things to go because they don't want you here upsetting the ambience they've got here, so that's what they will say to you.
>
> (Keith Brown, Aged 45-55, The Siloam Pool).

Notions of 'voluntary engagement' are further complicated by the reasons some service users have entered faith-based alcohol treatment:

> A couple of the people here are not wanting to be here, whether it's a condition of a parole licence or whether it's because they've exhausted the bank of mum and dad and they've got to come here to regain the faith of their parents. But there are a couple of blokes here who haven't themselves consciously made the decision. So there is some anger and resentment, and even amongst us who have made the decision to come here.
>
> (Martin Albright, Aged 45-55, The Siloam Pool).

Lack of alternative options available to service users means there are social, legal, and material enticements to work the programme, in addition to physical barriers highlighted by Keith below:

> We are stuck out here really, in between two sides of motorways in the middle of nowhere, there's no shops for miles. Who wants to do that to themselves?
>
> (Keith Brown, Aged 45-55, The Siloam Pool).

Service users also expressed concerns about 'favouritism', and the benefits of 'fitting in' in peer-led programmes often enabled by 'being seen to' engage in religious participation. Moreover, Dossett (2013) has highlighted that treatment practices can lead to service users internalising 'stigmatized identities' in faith-based treatment around narratives of 'sinful self' and 'restored self'. Indeed, our research found evidence of service users' 'failures' being put down to 'talking the talk, not walking the walk' as an explanation of 'faith relapse' or displays of 'non-Christian behaviour'. On one hand, such narratives can be read as intentional strategies to protect the alleged 'superiority' of conversion as a pathway to recovery, as it allows staff to both discount and outsource failure onto the individual who has allegedly not sufficiently followed the programme, or question the sincerity of the faith commitment in the first place. Alternatively, such narratives demand that service users question their own relationship to the programme, encouraging greater fervour and displays of 'surrender':

> Everybody sings, everybody likes to have a sing-song and they reckon that God reveals himself to you or talks to you or shows himself to you when you sing - and open up your heart [Pause] How could I put it, it's like guiding me. Sometimes a voice, sometimes a feeling. You would know because it's a voice you've never heard before and it will just come and tell you this is what you need to be doing, this is what I want you to do. Things like that. Because I used to ask the question "Oh God is talking to me and he's told me this". "Well he ain't talking to me, so what's going on? What am I doing wrong?" They just said, "Just open yourself up in the worship and sing and he'll come to you, he will come to you eventually". I can get in the groove of the singing. I can feel a lot more, singing. Things will hit me more because that's my mojo rather than I pass and sit up the front… excuse me, and talk for hours. I'll listen but eventually that volume will just get turned down.
>
> (Keith Brown, Aged 45-55, The Siloam Pool).

Indeed, participant observation research noted how 'sin' and 'addict' were often used interchangeably, which deliberately or inadvertently, produces a dualism of the divided self: one which is guilty yet open to the possibility of freedom. In response service users shared concerns in interviews that religious ethos and disciplinary practices included explicitly coercive attitudes, 'either conform or leave':

> Okay, during the application process, it clearly says that you have to respect the Christian ethos. Are you willing to do that? Yes or no. A lot of them say yes, and predominantly they do. We've had people who again… They probably don't look at it so much as you're trying to dismiss religion, but more you're bringing a negative kind of opinion that is opposed to religion, so you're having an impact on others. So for that reason you would probably have to go. In a nutshell it's either conform or leave. That's putting it bluntly. I think there is certainly a belief that your own ways of thinking, your own attitudes, didn't do you any good in the community, so your way of doing things is not working. So you're going to do things our way, and if not, it's not suitable for you here.
>
> (David Street, Aged 25-35, The Siloam Pool).
>
> Poor Dean got a **** [a warning] because he was sat next to me. Then he went out and he got told... See what I mean? They're listening in. He got told, off Bill's son, he got told you can't sit on the back rows. So he said, 'I'll sit down the side then.' Outside, it may as well be level with me, I'm in front row. They stripped them all out. Some people don't like singing. I didn't like singing when I first came. Some lads are bad on their legs. They've got to sit down. They moan about that … Holy. Apparently. Some of the lads sit down and pray. I told one of the lads, 'When you sit down, just bow your head, they'll think you're praying.'
>
> (Kelvin Pearce, Aged 25-35, The Siloam Pool).

‘Fake in recovery’? … ‘Playing the game’

In response to what they saw as overly oppressive regimes of surveillance, many of the residents we interviewed highlighted examples of transgression and resistance. For example, displays of disengagement (not standing up, not singing, arms folded, sly looks and eye rolls) were used to register disapproval. Other service users similarly developed coping strategies to ‘show they were working with [the] programme’, performing their ‘know how’ about how to use scripture to act ‘holy’ and to raise their arms during singing so that they were thought more ‘highly’ amongst the group. Indeed, on Sundays, there was more noticeable wearing of religious paraphernalia (wrist bands / crucifixes) which while these should not be dismissed as insincere per se, were talked about as a visible strategy to ‘get by’ in the most ‘hassle free’ way. One respondent coined the phrase ‘fake in recovery’ to refer to the ‘guys who claim to be Christian … when they leave the programme, they won’t stick to it’. When asked whether some people go through the motions with the singing and the praying, one service user replied:

> Yes. Listen, in everything, you’ve got guys who go over the top, you’ve got guys who don’t do a lot, you’ve got guys who do just enough. It’s all different. As long as you are doing what needs to be done here, you will be left alone. If you are not, then they’ll tell you, “Listen, we don’t think this is for you. Pack your kit and go” … I nearly got chucked out the other day. Same thing, this lack of sleep, in pain with my shoulder, behaviour started coming out sideways. Now, this programme is bigger than me and you, yeah, so they will not have one individual bring this programme down. They will get rid of you if they have to. They will get rid of the 30 guys here if they have to just to show that, you know what, it’s all about this programme, isn’t it? You either toe the line and do the programme or see you later. This is how they do it here. You either like it or you don’t, but they are not forcing you to stay here. There’s no forcing you here. I could go into the office right now and say, “Listen, I’m packing my bags, can you call a cab for me, I’m going?” “No problem.”
>
> (Keith Brown, Aged 45-55, The Siloam Pool).

Pathways through recovery … rules, ‘strictness’ and a ‘right to complain’

While some service users access faith-based alcohol treatment because of probation referrals or having just come out of prison, as noted in section one self-referral and friends and family was the most prevalent route. However, most of our respondents had previously tried other treatment programmes and were happy to share stories and advise other service users:

> I sit next to Peter and ask him how he ended up in Siloam. He tells me that he’s done 4 rehabs - 1 private, 1 NHS, Hebron and now Siloam I ask him to compare Siloam to Hebron. He tells me that there is much more free time at Siloam. At Hebron he had to do more work (mainly leafleting), and slept in a dorm. He enjoys having his own room at Siloam. I ask him about the religious aspect of both Hebron and Siloam. He tells me he’s a Catholic – so he doesn’t have a problem with it ‘as long as we’re all singing from the same hymn book’.

> Curiously he can't remember much of the religious aspect of Hebron … Daryl says that in the first 5 weeks of Phase 1 of The Siloam Pool he thought he was in a Catholic rehab. One day, he suddenly realised it wasn't 'Catholic but Christian'. Some guys tell him that Catholics are Christians. He doesn't seem convinced … Den talking about all the rehabs he's been to. Others chip in listing them and sharing stories. Many have done stints in Hebron or Crucible UK. He seems to only go to faith-based rehabs. He got evicted from both – he says he cannot see how the heart of Jesus is at work in places like that.
>
> (Participant observation notes)

Indeed, respondents talked about 'cultish' practices; lack of clinical knowledge; availability of faith-based treatment compared to statutory or private rehabs; and experiences of racism and xenophobia:

> I think that statutory organisations and faith-based organisations, there's a problem with faith-based organisations, because usually a faith-based organisation has come from one religious ideology. That's more indoctrination. And a lot of the people go to these places… One of the guys went to Hebron, which is a Christian-based organisation and he went there, he's a white guy, and they were saying, 'we need to get rid of these goddamn Muslims.'
>
> (Herbert Bailey, Aged 45-55, Open Circle).

One particular way that service users traced their own and others' pathways through treatment was to consider and compare the 'rules' and 'strictness' of different secular and faith-based treatment:

> The programme is designed to get on your nerves. It's supposed to be like that because if it weren't a structured programme then it would be all over the place. Yes, you are going to get annoyed with it, you are going to say you don't like this and you don't like that but that's how it is. No one likes changes, no one likes to say this is what you do. No one likes being told what to do, especially me, being the kind of person coming from prison, no one can't speak to me the way they want to speak to me, but it's something that you've got to get used to because the programme works, it works, it's just that it's the people that go on the programme, they either want to do it or they don't want to do it but they'll go and relapse. So the programme is designed to work. And it works, it does work. You've just got people who try and buck the programme, who try and break the rules … You have to be committed if you come here, you understand what I'm saying? … If you are not then you are going to go or you are going to get chucked out because you don't want to abide by the rules and I've seen it now enough times.
>
> (Keith Brown, Aged 45-55, The Siloam Pool).

> Look at the rules. For example, they take the telephone from people. They don't realise it, I get my telephone to talk with friends. Not with drug addict friends, with friends who are in recovery and that, and they are helping me with my recovery. That's my higher power, the phone. They take my phone away. I

> cannot speak with nobody. All the phone calls are monitored. So what? I have to talk with my friends with you beside. I don't fancy it. I talk with my friends the way I talk with my friends. Maybe I swear, maybe I don't swear, but 'keep your voice... be careful about what you say.' It's mad. I learned English on the streets. I didn't go to school to learn English. I learned it in the fucking street. I swear a lot. I say bollocks, I say a lot of words, and they are trying to keep myself like a gentleman. I am not a gentleman. I am a person. I am a drug addict. I was for a long time a drug addict. I don't know what they want to get. I don't go to church. I don't do things.
>
> (Juan Martinez, Aged 45-55, Kimberly House -part of an international Christian social service organisation).

Service users from across our case study organisations expressed a wide range of concerns regarding: mobile phone prohibition; restrictions on music and TV; the timing and balance of the programme structure and activities; unreliable vocational training; repetition of activities; and lack of financial autonomy. In contrast, others celebrated the 'mundane rhythms' of daily life in residential treatment:

> For me personally the most important strategy is provide a safe place, to provide a safe place that's temptation-free, and to make it very plain to me that I cannot decide to have a sneaky one and get away with it. If we do go out, if we are unsupervised for any time, they'll test us for alcohol, tobacco and all the rest of it, so it's very apparent that there are no sneaky ones to be had, which I like. That suits me. I've got a straightforward choice: I can be here and be clean or I can leave and go and do whatever I like. That suits me. It would be very awkward for me if every now and then I got the whiff of cigarette smoke when I'm walking down an upstairs corridor, heard someone cracking a bottle from behind a closed door somewhere, that would be driving me absolutely bananas. So the strategy of complete and utter enforced abstinence, that strategy for me is crucial … So in the morning either there will be devotion and teaching or there will be first devotion and then a work party. So the work party might be weeding the garden or it might be giving the kitchen a deep clean as opposed to just the normal wipe-over it gets each day. Or it might be painting some windows, whatever needs doing around the place, hoovering the public areas, cleaning windows, the glass … You'll be given an extra washing-up duty for example. We're responsible for all of our own domestic chores. Like I say there's only one member of staff on at any one time so they don't cook, they don't wash up, they don't wield the hoover. Every part of the domestic routine is looked after by us. We're self-sufficient in that respect.
>
> (Martin Albright, Aged 45-55, The Siloam Pool).

Despite such positive comments, many of the service users we interviewed expressed serious concern about their ability to 'complain' when they felt there was problems with their treatment programme, and when they were allowed to offer 'feedback' they felt it was often ignored. Such evidence suggests that faith-based alcohol treatment providers need to respond to experiences of those making use of the services in ways that are meaningful to the service user in order to ensure dignity and opportunities for reciprocity.

Summary

- Service user experience of faith-based recovery are diverse, with significant positive and negative views and experiences recounted;
- Singing, prayer, faith, and spirituality featured heavy in service user accounts of recovery, although their role, meaning, and experience varied considerably, with different individuals accentuating the transformative power of religious ‘collective’ and ‘peer-led’ conversion;
- ‘Faking it’ and ‘playing the game’ were seen as a widespread and pragmatic engagement with group practices of prayer and worship;
- Ethical questions regarding faith-based involvement in public services should not be limited to whether service provision is made conditional on expressing or participating in religious beliefs and activities. The espoused voice by faith-based providers might insist their service is ‘welcome to all’ and non-discriminatory on grounds of identity, but this does not guarantee these values and principles are present ‘on the ground’;
- Care is needed to mitigate the risk of practices suggesting that ‘prayer is enough’. This is not to criticise the deeply held belief held of faith-based organisations and individuals concerning the sufficiency of God in ‘releasing people from addictions’; rather, it is to question the false dichotomy between the ‘spiritual’ and ‘scientific’ expertise constructed in such programmes, which can lead to misdiagnosis of mental health problems, the denial of psychoactive medication (including anti-depressants), and unethical forms of proselytising;
- Service users often have sophisticated knowledge regarding pathways to treatment and provision and services in both secular and faith-based alcohol treatment, and their voices should be foregrounded in reviews of practice and policy;
- Our research suggests the need for a more elaborate assessment of proselytisation beyond the conscious intentions of the service providers with more attention being paid to power dynamics within faith-based alcohol treatment.

6 Summary and recommendations

Mixed methods qualitative and qualitative research into faith-based alcohol treatment services in England and Wales highlighted that:

Mapping faith-based alcohol treatment

- There are 135 faith-based alcohol treatment service providers representing over 300 groups/projects/initiatives/courses in England and Wales;
- There is clustering of organisations in larger urban areas and small towns, with rural services tending to be dominated by residential rehab programmes;
- 76% of respondents to our survey defined themselves as 'Christian – other' (non-Catholic), with 52% of those being 'Evangelical';
- 66% of respondents indicated that they receive funding from 'umbrella' religious organisations or partner churches; 64% were funded through charitable/philanthropic donations; 62% through public donations; 42% by generating income by collecting the housing benefit of service users; 30% by collecting fees from service users; 23% by adopting social enterprise status; 17% by donations from businesses; and only 11% via local authority funding;
- 77% of our respondents were registered with the charity commissions but only 11% were registered with the National Drug Treatment Monitoring System (NDTMS), and 9% registered with the Care Quality Commission (CQC);
- Non-residential service providers in our survey offered programmes for service users in groups from 6 to 30 people. Residential service providers tended to have less than 20 beds but the largest had 83;
- 47% of respondents to our survey only employed staff and volunteers who were of the same faith. 77% of Evangelical service providers only employed staff and volunteers who were of the same faith. All of the Muslim organisations who took part in our survey indicated that their staff and volunteers were 'a mix of people of different faiths';
- Self-referral (76%), friends and family (53%), and religious congregations (40%) are the most significant routes that service users access treatment. Others include a range of health, criminal justice and social care contexts such as referral from other treatment services (25%); local authorities (16%); homeless shelters (15%); probation agencies (13%); healthcare (11%) and welfare professionals (11%); prison (5%) and police (4%) officers;
- 75% of respondents permitted the use of prescribed medication with 53% employing mandatory alcohol testing within their programmes. 9% prohibited the use of prescribed medicine.

Institutional context: challenges, opportunities, tensions

- Unsurprisingly, the combined impact of austerity, long standing restructuring including marketisation of health services in England, and changes in UK government policy, has led to significant problems in the provision of alcohol treatment service provision;

- with that backdrop, faith-based alcohol treatment is ‘filling the gaps’ not covered by national charities, private sector companies, or statutory funding;
- despite stated desire for both secular and faith-based alcohol treatment service providers to work together, there remains significant suspicion with regards to evidence-based policy, transparency of theology and practice, often exacerbated by the competitive nature of funding opportunities;
- more specifically key stakeholders and some faith-based alcohol treatment providers expressed concern about moral and judgmental views on alcohol; lack of expert knowledge and experience; lack of registration with regulatory bodies; clarity over ethics, theology and practice; and lack of safeguarding, and equality and diversity knowledges and training.

Organisational ethos and practices

- 34% of all faith-based alcohol treatment providers make religious participation mandatory for service users, a figure that rises to 52% when residential faith-based alcohol treatment providers are considered;
- Vocational work-based activities (gardening, furniture restoration, manual work, cooking) featured heavily in faith-based alcohol treatment, with 55% of all faith-based alcohol treatment providers, and 81% of faith-based residential rehabilitation providers entail work-based activities;
- Recent years have seen a growth in ‘franchised’ Christian Twelve Step treatment courses across the UK offering online resources and face-to-face meetings;
- Ethical questions regarding faith-based involvement in public services should not be limited to whether service provision is made conditional on expressing, or participating in, religious beliefs and activities. Nor should assessment of proselytisation be limited to the conscious intentions of those doing the caring;
- Rather, the voices of current and past service users are better indicators of ‘good practice’ and the ‘ethics’ of religious conversion within treatment.

Faith in recovery: experiences

- Service user experience of faith-based recovery are diverse, with significant positive and negative views and experiences recounted;
- Singing, prayer, faith and spirituality featured heavily in service user accounts of recovery, although its role, meaning, and experience varied considerably, with different individuals accentuating the transformative power of religious ‘collective’ and ‘peer-led’ conversion;
- ‘Faking it’ and ‘playing the game’ were seen as a widespread and pragmatic engagement with group practices of prayer and worship;
- The espoused voice by faith-based providers might insist their service is ‘welcome to all’ and non-discriminatory on grounds of identity, but this does not guarantee these values and principles are present ‘on the ground’;
- Care is needed to mitigate the risk of practices suggesting that ‘prayer is enough’ or presenting religious conversion as a panacea. This is not to criticise the deeply held belief held of faith-based organisations and individuals concerning the sufficiency of God in ‘releasing people from

addictions'; rather, it is to question the false dichotomy between the 'spiritual' and 'scientific' expertise constructed in such programmes, which can lead to misdiagnosis of mental health problems, the denial of psychoactive medication (including anti-depressants), and unethical forms of proselytising;
- Service users often have sophisticated knowledge regarding pathways to treatment and provision and services in both secular and faith-based alcohol treatment, and their voices should be foregrounded in reviews of practice and policy;
- Our research suggests the need for a more elaborate assessment of proselytisation beyond the conscious intentions with more attention being paid to power dynamics within faith-based alcohol treatment.

Recommendations

- **Transparency:** faith-based alcohol treatment service providers should make public and easily accessible: details of the ways in which theology informs the organisational ethos and day-to-day activities; clear guidance on the role of 'faith' and 'spirituality' as an active ingredient of treatment; clarify and define justification, processes and outcomes of 'disciplinary' processes; offer clear routes, and responses to service users to make 'complaints'; monitor the socio-economic backgrounds of service users and outcomes of treatment; offer details of expertise and training of staff and volunteers; ensure that all staff and volunteers undertake equality, diversity and safeguarding training;

- **Monitoring and regulation:** all faith-based alcohol treatment providers should provide data on their activities and outcomes to the National Drug Treatment Monitoring System (NDTMS). The Care Quality Commission (CQC) or Care Inspectorate Wales (CIW) should ensure that faith-based alcohol treatment service providers are fully informed about criteria for registration;

- **Ethics, care and theology:** faith-based alcohol treatment service providers need to develop a more sophisticated understanding of proselytisation beyond the conscious intentions with more attention being paid to power dynamics within faith-based alcohol treatment. Greater care should be given to spiritual autonomy of individuals in treatment in order to avoid religious coercion and spiritual abuse. Practitioners should receive professional training in alcohol dependency, addiction and mental health. The UK's All-Party Parliamentary Groups' Faith and Society 'Faith Covenant' must go further than a commitment on the side of faith-based organisations not to engage in proselytising; rather, the voices of current and past service users are better indicators of 'good practice' surrounding religious practices (including the 'ethics' of religious conversion);

- **Diverse and culturally appropriate services:** There is no typical service user. Individuals should be able to choose from a wide range of secular, theological and spiritual approaches in alcohol treatment and recovery, according to their preferential worldview. Religion and ethnicity do not straightforwardly map onto each other. Specialist services for Black, Asian

and Minority Ethnic backgrounds are important pathways for recovery for some individuals who disclosed stigmatising experiences in other treatment providers;

- **Pathways to treatment and recovery:** Public Health England and Public Health Wales should host information on faith-based alcohol treatment providers alongside information about organisational approach and what service users can expect. Guidance must be developed to support the effective referral routes to faith-based alcohol treatment programmes. An independent ‘myth busting’ guide should be written to aid the work of commissioners, local authorities, and referral pathways (for instance, probation officers) that details and explains different practices, expectations and philosophies of various faith-based organisations.

Notes

1. The National Drug Treatment Monitoring System (NDTMS) is hosted by Public Health England and collects data from publically funded substance use treatment services in England. It monitors trends and produces reports and statistics at a national and a local level. Local authority commissioners routinely draw on the NDTMS for indicators of the quality of services. The Care Quality Commission (CQC) and Care Inspectorate Wales (CIW) are independent organisations that monitor, inspect and regulate health and social care, including alcohol treatment.

2. The Faith Covenant is a joint commitment between faith communities and local authorities to a set of principles that guide engagement, aiming to remove some of the mistrust that exists and to promote open, practical working on all levels (https://www.faithandsociety.org/covenant/). It seeks to overcome the reluctance of some councils to engage with faith groups, partly perhaps out of fear that they will spend public money on proselytism (among other things). In the context in which the Covenant is usually signed, there are not any service users involved, because it is a high-level agreement to greater engagement, encouraging councils to treat faith groups on the same basis as the rest of the voluntary sector. The wording of the Covenant is adapted differently by local areas, and in some they have taken the reference to proselytising out altogether, by mutual agreement of the council and faith groups.

3. Examples of geographical writing on alcohol, drinking, drunkenness - urban and rural public and commercial spaces (Thomas and Bromley 2000; Chatterton and Hollands 2002, 2003; Hubbard 2005; Latham 2003; Latham and McCormack 2004; Jayne et al 2006, 2008a; Valentine et al 2007; Bell et al 2011; Jayne and Valentine 2017); legislation, policy and policing strategies (Kneale 1999; Beckingham 2008; Wilson 2005; Hubbard 2005; Leyshon, 2006; Shaw 2014; Waitt et al 2010; Jayne et al 2006, 2008b, 2012; Valentine et al 2007a, 2007b); pub life and identity (Edensor 2006; Kneale 1999, 2004; Leyshon 2005, Maye et al 2005); drinking at home (Holloway et al 2008; Liu 2018); masculinity and femininity (Holloway et al 2009; Brickell 2008); ethnicity and religion (Valentine et al 2009); young people (Valentine et al 2007); intergenerational transmission of drinking cultures (Valentine et al 2010); mobilities (Jayne et al 2012); children, childhood and family (Lowe et al 1993; Jayne et al 2012, 2013; Jayne and Valentine 2015, 2016c and 2017b; Valentine et al 2010 and 2013); temperance (Kneale 2001); health, alcohol treatment and recovery (Philo et al 2002; Twigg and Jones 2000); and assemblages of human and non-human actors bound up emotions, embodiment, affects of alcohol, drinking, drunkenness (Jayne et al 2010, 2011b, 2016a; Waitt et al 2011; Shaw 2014).

4. Searching for relevant FBOs involved in alcohol treatment and recovery was undertaken in a systematic and methodical manner. First, the Charity Commission website was searched for organisations containing the combinations of specific keywords such as ‘religious’, ‘faith’, ‘faith-based’, ‘spiritual’, along with ‘recovery’, ‘treatment’, ‘alcohol’, ‘addiction’, ‘life-controlling’, ‘substance misuse’. This process was repeated on both the Companies House and Care Quality Commission’s website, as well as the signposting websites of key drug/alcohol advice organisation such as Frank (http://www.talktofrank.com), NHS

(https://www.nhs.uk/ServiceSearch/Drug%20treatment%20services/LocationSearch/340), and Rehab Online (www.rehab-online.org.uk). The websites of relevant organisations were subsequently searched in order to find links and signposting to similar, associated and/or partner organisations. Second, the keyword combinations used above were entered into Google in conjunction with particular locational terms. We began with geographically broad searches, including 'faith-based recovery' and 'UK', working our way down to county and city specific searches. Third, we set up a Twitter account and followed relevant FBOs. Twitter also facilitated a form of organisational snowballing in that it allowed us to search the 'followers' of appropriate FBOs – some of whom we found to be similar, associated, and/or partner organisations. We also used Twitter to send out requests for relevant information that were - in turn - circulated beyond our network. Fourth, we used key contacts and stakeholders – including individuals on our advisory panel – to put us in contact with relevant organisations/individuals. This was especially helpful in gaining an understanding of – and contacts details for - for hard-to-reach, BAME organisations. This also included emailing meta-FBOs such as JubileePlus, The Muslim Council of Britain, the Sikh Awareness Society, and the Board of Deputies of British Jews. Fifth, we inserted a question into our survey that allowed respondents to suggest similar, associated, and/or partner organisations that they thought should be included in our survey. Indeed, the fourth and fifth stages were designed to help us find FBOs that may not have an online presence. Indeed, the survey question was particularly helpful in revealing a number of small FBOs that were not registered charities/companies and did not have any online presence.

We circulated our survey to the collated groups – often via multiple online platforms (email/Twitter) - in order to gather detailed information regarding organisational ethos and background, service capacity, and theological/practical approaches. Exact numbers of active groups - and related projects - are difficult to attain given that a number of FBOs contacted are umbrella organisations responsible for franchised recovery courses that run independently (and often unadvertised). In some cases, a single respondent covered a number of different types of projects. For example, one organisation might run a detoxification programme, a harm reduction programme, an abstinence-based programme, and a follow-on aftercare service. This would all be subsumed into one survey response.

Much work had to be done to gather responses – which were initially quite sparse. Repeat reminder emails and phone calls were made to the majority of contacted organisations. Discounting those groups who we subsequently discovered to have ceased running – or those we had mistakenly thought to be FB groups - we received 71 (53%) overall responses to the survey, with 55 (41%) full completions.

Some organisations declined to take part in the survey, for a variety of reasons. Some did not define themselves to be involved in alcohol treatment, instead viewing substance misuse work as just one element of their work on homelessness or sex-work. Others declined to take part as they did not self-identity as being faith-based. No questionnaire surveys were completed by Sikh, Jewish or Hindu faith-based alcohol treatment providers.

5. Beyond our case study organisations other pseudonym presented through the report are:

- *Dependency Watch* (International Twelve Step programme mutual aid sobriety fellowship);
- *Levington Grange* (Christian Drug and Alcohol Residential Rehabilitation Centre);
- *Crucible UK* (Christian drug and alcohol programme);
- *The Grange* (Provider of residential addiction services);
- *Recover* (Abstinence from addictive behaviours training);
- *Hebron* (Residential Christian responsibility and self care drug and alcohol approach);
- *ActOnAddiction* (Large UK wide drug and alcohol charity);
- *RESTIC* (Residential alcohol and drugs therapy unit for men on benefits based on abstinence and Twelve Step programme);
- *City Road Drop in* Christian drop in centre providing food, toiletries, clothing and services signposting);
- *Change Time* (National Health and Social Care provider);
- *Live Life* (Voluntary organisation specializing in substance abuse and criminal justice interventions);
- *ActionCare* (Charity providing alcohol and drugs services);
- *@help* (Online portal for drug and alcohol services);
- *Living Change* (National Online and Nationwide Venues 'franchise' Christian Twelve Step programme);
- *Christian Social Action* (A national debt advice charity and franchise working through churches, which also have launched befriending schemes and a modified Christian 12-step programme through its 'Freedom Groups')

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Appendix 1: Profile of key stakeholder interviewees

Professional details	Professional background	Personal background (where relevant)	Expertise/ training	Faith/Spirituality
Hai Dede, Founder, Forward Restoration, Drug and Alcohol Addiction Recovery Programme, Community Interest Company, South East England	Early career as builder and electrician. 'In recovery' and now with 30 years of experience in Drug and alcohol treatment; this began as a volunteer at centre where had accessed detoxification and rehabilitation programmes. Then employed in numerous drug and alcohol treatment roles including Arrest Referral Schemes; Commissioning for Drug and Alcohol Treatment Services; criminal justice and prison roles; freelance work with police forces, primary care trusts, government agencies; founder of drug and alcohol addiction recovery, community interest company (CiC)	'In recovery' from drug addiction. Spent 2 years at an abstinence-based Christian community which provided medical detoxification and rehabilitation programmes, including after-care and key-worker support. All staff and volunteers were Christian	Management, health and safety training; 'experience-led' expertise	Grew up in a Muslim family but identified as 'non-religious'; adopted Christianity during medical detox and rehabilitation
Ruth Garside, Policy Advisor, Belief Together, National Network of Multi-faith-based Organisations Involved in Delivery of	Market research		Masters in policy studies	Christian

Public Services, South East England				
Rosanne Whitehouse, Senior Commissioning Manager for Substance Misuse for Adults, County Council, English Midlands	Local and national probation service roles; Chief executive officer, Christian non-clinical drug and alcohol charity		Masters in Social Work; Masters in Public Health; management and leadership training	Christian - doesn't identify with a particular denomination Attends an Anglican church and involved; leading worship, coordinating home and youth groups
Peter Moon Alcohol and Drugs Service User Development Officer Local Authority, South West England	Early career as building labourer. Volunteering with young people's charities	'In recovery' from drug addiction. Attended numerous residential and non-residential medical detoxification and rehabilitation programmes including 2 years in a three year, Christian Twelve Step residential recovery	NVQ in Health and Social Care; NVQ in Drugs and Alcohol and Young People	Catholic
Trevor Robbins Chief Executive, Levington Grange*,* Christian Drug and Alcohol Rehabilitation Centre, South East England and Member of *INCSAO - International Network of Christian Substance*	Graduate volunteering led to 24 years at abstinence-based Christian community providing medical detoxification and rehabilitation programmes alongside roles at international Christian network which provides support for those in addiction work.	Family members and friends who experienced alcohol and drug addiction		Christian

Abuse Organisations				
Warren Henry, Commissioner of Substance Misuse Treatment Services, County Council, South of England	Post PhD post as Information and research officer, Drugs and Alcohol Team		PhD on Drinking and the night-time economy	
Leslie Denmark Team Leader, Local Authority Commissioned Drugs and Alcohol Project and Trustee, Vitality Project, Faith-based Recovery Support Group, South West England	Two years of working in commissioned community drug and alcohol services; also management of LGBT drug and alcohol service		Social Science undergraduate degree	Christian
Daniel Found Independent Healthcare Consultant and Inspector, South West England	20 years experience of inspecting and auditing substance misuse services – residential and community; National Policy lead on substance misuse; Representative on department of Health working group; Board member of the FDAP - Federation of Drug and Alcohol Professionals; trainer of substance misuse inspection		Masters in Social Administration and Social Work; Diplomas in Management, Health and Social Care; Postgraduate Certificate in theology	Christian

	staff for the Care Quality Commission			
Jon Brown, GP, Clinical Lead for Drug and Alcohol Treatment in a Criminal Justice Context, Local Authority, and Co-founder of Kingdom Release, Christian Research and Lobby Organisation, North East England	Professional work as Psychiatrist and GP; medical director of inpatient detoxification programme; community substance misuse programme; clinical lead for drug and alcohol treatment in criminal justice context		Degrees in Psychiatry and medicine; specialist training in general practice; and certificates in drug and alcohol	Christian

Appendix 2: Profile of service provider interviewees

Professional details	Professional background	Personal background (where relevant)	Expertise/ training	Faith/Spirituality
Jenny Squires, Founder and Director, The Siloam Pool, English Midlands	Trained as a radiographer and ultrasound, and manager of ambulance service Set up and ran a small rehabilitation centre Current responsibilities include management of 'phase 3' of the treatment programme – prior to independent living including a food bank project	Family member with alcohol dependency	'Experience-led' expertise	Christian
Bill Symmonds Founder and Director, The Siloam Pool, English Midlands	Manager of ambulance service Set up and ran a small rehabilitation centre Current responsibilities include management of 'phase 1 and 3' detoxification, counselling, vocational work and employment and life skills training		'Experience-led' expertise	Christian
Mehak Tahim,	Various positions working in	Recreational alcohol and	Undergraduate	Sikh

Senior Recovery Worker, Open Circle, English Midlands	mental health and social care Current responsibilities include client assessment and case management	drug use	degree in Health Studies; PGCE with specialism in Health Studies	
Neil George, Director, Open Circle, English Midlands	'A street lifestyle' of illegal activities Current responsibilities include client assessment and case management	'In recovery' from drug addiction. Experience of secular Christian and BME multi-faith treatment	Diploma in Counselling and psychotherapy ; NVQ adult health and social care	Muslim
Andrew Beatty, Chaplain, Kimberly House - part of an international Christian social service organisation, South West England	30 years of working in drug and alcohol; including roles such as principle project worker Main responsibility involves managing the programmes multi-faith/spiritual work with a 12-step programme	Family member with alcohol dependency	NVQ in Social Care and Management; NVQ in Pastoral Care; Diploma in Addictive Behaviour; training courses in counselling, diversity, health and safety	Christian
Derek Watson, Recovery Worker,	Career in financial services		Undergraduate degree in	Christian

The Sanctuary, North East England	Current responsibilities include case management		health and social care	
Dave Kilburn, House Support Worker, The Sanctuary, North East England	Current responsibilities include housekeeping, cleaning, cooking, laundry, and any additional support for residents regarding financial and life skills			Non-religious
Rich Goodman, Chaplain, The Sanctuary, North East England	Former chaplain to a public school Christian chaplain and pastoral support for service users			Christian
James Booth, Director, Restoration Course, Online and nationwide venues	Son of prominent evangelist and had a successful career both in the UK forces, and then working in the financial services sector	'In recovery' from gambling addiction		Christian
Leanne Holmes, Trustee, Restoration Course, Online and nationwide venues	Course leader and ministry head for the largest Restoration Course in the UK Also worked for Christian Charity	Started drinking heavy from the age of 11 and is 'in recovery'		Christian
Paul Knowles, Trustee,	Trustee responsible for marketing the Restoration			Christian

Restoration Course, Online and nationwide venues	Course to churches Freelance marketing and sales manager (Christian publishing)			

Appendix 3: Profile of service user interviewees

One-to-one interviews

Personal details	Personal background	Alcohol treatment history	Faith/spirituality
Keith Brown, Aged 45-55, The Siloam Pool	Born in the South East of England, from a Caribbean background with 7 brothers and sisters. Father worked in skilled building trade and mother worked in healthcare. Following sustained domestic violence Mother left the family home but the violence shifted towards the children. Expelled from school for hitting a woodwork teacher with mallet after being slapped for not paying attention in class. Taken into care because of increasing violent behaviour but experienced physical, mental and sexual abuse Left school at 17 to begin a manufacturing apprenticeship and during this time started taking recreational drugs and drinking alcohol after joining a gang. Began undertaking armed robberies and was eventually caught and sentenced to 20 years in prison. During custodial sentence became drinking more-and-more and also became addicted to heroin and prescription painkillers. Following a	Found support in prison generally inadequate but on release went straight into a secular residential rehabilitation course on the south coast of England. During the second custodial sentence a Drug and Alcohol support worker suggested attendance at The Siloam Pool Now at The Siloam Pool– in phase 3 of programme	Adopted Christianity 'in recovery'

	successful rehab programme, problems with finding accommodation let to re-arrest and a further 6-year prison sentence returning to addiction to heroin, alcohol and painkillers		
Kelvin Pearce, Aged 25-35, The Siloam Pool	Grew up in the English Midlands with a comfortable middle-class lifestyle. At the age of 14, Father died which led to recreational alcohol and drug taking and suicide attempts. At 18 had a son, found a manual job and for a while things went well living as a family Recreational drug and alcohol use became heavier and left new family and moved in with a new girlfriend who was an ‘alcoholic’. Lived together for around 8 years	Had accessed non-residential alcohol support which had mostly been ineffectual until a support worker recommended The Siloam Pool The Siloam Pool is first experience of residential rehab treatment - now in phase 3 of programme	Adopted Christianity ‘in recovery’
David Street, Aged 25-35, The Siloam Pool	Grew up in the West Midlands and became addicted to nicotine as a teenager, which led to smoking cannabis, amphetamines, ecstasy as a teenager. Became part of a ‘clubbing scene’ - alcohol consumed with cocaine, heroin and crack cocaine	Made contact with a drug and alcohol support worker who recommended The Siloam Pool The Siloam Pool is first experience of residential rehab treatment - now in phase 3 of programme	Adopted Christianity ‘in recovery’
Martin Allbright, Aged 45-55, The Siloam Pool	Started drinking ‘like an adult’ at aged 15, started working full-time as at 16 and recognized a problem with alcohol	Found out about the Siloam Pool through recommendation by a friend	Rediscovered Christianity while ‘in recovery’

	by 18. Working in the stressful role as a nurse and the financial and parental responsibilities of being a single parent to three young children. Used alcohol as a way to relax Following an accident at work and associated anxiety and depression became self-employed but the structure of the working day allowed drinking to begin in the afternoons. Following the recession the work dried up and was forced to claim benefits, and began living/caring for a friend suffering from depression and alcohol addiction. This situation led to further dependence on alcohol	The Siloam Pool is first experience of residential rehab treatment - now in phase 3 of programme	
Rahim Awan, Aged 25-35, Open Circle.	Grew up in the English Midlands in a middle-class family from Bangladesh. Expelled from 6th form for selling cannabis to other pupils and went on to qualify as an electrician and worked as an electrical engineer Had began smoking cannabis at the age of 13 and started dealing at 14, initially cannabis but then cocaine, which also began to consume significant amounts alongside work commitments. At this time also started selling crack cocaine and became a	Brief period in secular 12-step recovery programme that was ineffective and was recommended to visit Open Circle	Muslim

	user also. Alcohol was also a key factor in having a big night out with drugs His family became aware of his problem and sent back to Bangladesh, where he accessed cannabis and alcohol		
Ahmed Abaza, Aged 35-45, Open Circle	Grew up in the English Midlands to a middle-class family. At aged 11 the father left due to the mothers worsening illness. Became carer for his mother leading to his own isolation and depression Started smoking cannabis and drinking alcohol at aged 17 and left school with no qualifications. At aged 21 started smoking crack cocaine and after a visit to the doctors was recommended Open Circle	Open Circle is first experience of any formal treatment and recovery	Muslim
Daniel Hill, Aged 35-45, Open Circle	Grew up in Northern Ireland. Father from Africa and Mother from Ireland. Went to grammar school and joined armed forces after school but was discharged due to ill health but had also suffered racism and physical abuse in school and in the armed services After leaving the Navy started to drink heavily and became increasingly violent, spending time in a young	Drug and alcohol counselling and then time in alcoholics anonymous. Recommended to attend Open Circle as specialists in Black and Minority support	Christian

	offender institution. Worked in factories and became a supervisor but alcohol was a growing problem. Moved to North East England and worked in construction, became addicted to amphetamines Trained in business administration and was employed by a local government and became a team leader and restricted drinking to the weekends which were full of drinking and violence. Moved to the English midlands where worked on public transport and then in a call centre, drinking alcohol continued and became addicted to painkillers. This led to smoking crack cocaine and heroin Was referred to drug and alcohol services following drink-drive conviction		
Jon Campbell, Aged 55-65, Open Circle	Grew up in the English Midlands and left school aged 15 to work for successful family business. Had an unsuccessful arranged marriage at aged 18 and two further marriages with four children and four grandchildren. Father was an alcoholic and all male family members drank heavily Started drinking at aged 16 with school	Numerous attempts at private residential rehab and alcohol anonymous but they didn't work Was recommended to go to visit Open Circle	Sikh

	friends. During early 20s alcohol started to become a problem. Started taking cocaine in early 30s		
Vikash Patel, Aged 45-55, Open Circle	Grew up in the North East of England where various family members experienced alcohol and drug abuse Became addicted to heroin and alcohol	Thirteen years of various treatment including Twelve Steps in different formats alcoholics and narcotics anonymous; later attended residential secular and Christian rehabs Was recommended to try Open Circle	Hindu
Herbert Bailey, Aged 45-55, Open Circle	Grew up in a working-class neighbourhood in the English Midlands. Struggled at school because of dyslexia Addicted to drugs and alcohol during 'rave' period. Made a living through criminal behaviour and earnings of girlfriend who worked as a prostitute	Various treatment including Twelve Steps in different formats alcoholics and narcotics anonymous; later attended residential secular and Christian rehabs Was recommended to try Open Circle	Non-religious
Juan Martinez, Aged 45-55, Kimberly House - part of an international Christian social	Born in London to parents from southern Europe. At 15 years old, started to drink alcohol, smoke hash, marijuana, cocaine, ecstasy, trips. By 24 years old, problems with heroin and injecting cocaine	Tried various residential and community treatment and rehabs	Catholic

service organisation			
Will Cooper, Aged 25-35, Kimberly House - part of an international Christian social service organisation	Grew up in the South West of England in a working-class family, started drinking cheap ciders and smoking cannabis having left school. Joined the armed forces and suffered from post traumatic stress disorder, and a family suicide, and ended up in prison for serious assault. On release successfully completed an apprenticeship, found a girlfriend and had two children. The relationship broke down and a court case for access to the children ensued. During this time alcohol consumption increased with anxiety and depression and could be aggressive once drunk	Accessed drug and alcohol treatment, went to a rehab but didn't like the programme Was recommended to try Kimberly House	Adopted Christianity while 'in recovery'
Cameron Richardson, Aged 25-35, Kimberly House - part of an international Christian social service organisation	Grew up in Wales and began to travel the world employed as a cook and an engineer at the aged of 16. While in the Caribbean started drinking alcohol, smoking cannabis and crystal meth. Lost his job due to alcohol and drugs and then joined a Christian community and left after stealing money and later spend time in prison. Settled in and then moved around several cities in the UK, and then sold all possession to fund time travelling in North American, Asia and Europe. Returning home, the alcohol and drug consumption	Following release from prison asked to leave a Christian residential rehab because of breaking the rules. In prison chanced upon on leaflet for Kimberley House	Christian

	increased and began undertaking robbery and several prison terms		
Glenn Russell, Aged 25-35, Restoration Course	Started drinking everyday from the age of 20, at its height was as much as 20 bottles of cider everyday, while maintaining a full-time job	GP referral after black-outs and then time at alcoholics anonymous and was recommended the Restoration Course in a chance meeting with an old friend	Christian

Group interviews

Personal details	Personal background	Alcohol treatment history	Faith/spirituality
Max Collins, Aged 35-45, The Sanctuary	Grew up in North east of England, drugs of choice became cocaine and alcohol in late teenage years. Began to take cocaine in work and felt isolated in addiction. Started a family and moved away but later returned to consuming alcohol and/or cocaine every day	First tried 12-step fellowship meeting and then attended the Sanctuary. Since joining he has had several relapses but now '9 months clean'	Higher Power/God of my own understanding
Carl Sanders, Aged 35-45, The Sanctuary	Brought up in a violent family. Dad was an alcoholic. Was expelled from high school, and was abused when 'in care' Began 'glue sniffing' and then became caught up in crime to obtain alcohol and drugs Started using prescription and illegal drugs, which led to financial problems and a broken relationship and became homeless	Attended methadone detox. Joined The Sanctuary residential programme Abstinent for 18-months	Not disclosed

Gary Hayes, Aged 45-55, The Sanctuary	Recreational and mixed drug use in adulthood that led to a family break-up and period of homelessness and time in hospital	Referred to The Sanctuary on leaving hospital	Higher Power/God of my own understanding
Lesley Phillips, Aged 25-35, The Sanctuary	Gambling, drug and alcohol addiction	Not disclosed	Not disclosed
Myles Ward, Aged 35-45, The Sanctuary	Addiction of alcohol	Time in secular rehabs and then joined The Sanctuary	Higher Power/God of my own understanding
Jane Nelson, Age 35-45, The Sanctuary	Alcohol and drug addiction led to a period of homelessness and then prison	Unsuccessful periods in secular rehabs, followed by time at Crucible UK, Hebron and the Sanctuary	Christian
Simon Adams, Aged 45-55, The Sanctuary	Left an abusive home as a teenager and joined the armed services where became dependent on alcohol. After being discharged from the armed services worked in the transport industry while also ‘partying’ on the weekend with alcohol and other recreational drugs. Relationship break-ups led to periods of homelessness	Attended Twelve Step secular programme and detox in prison Was recommended to attend The Sanctuary following a period of homelessness	Not disclosed
Shaun Perry, Aged 34-45,	Grew up in small city in the English Midlands and had a functioning life	Attended several detox programmes	Roman Catholic

The Sanctuary.	drinking alcohol. After relationships had broken down sought help		