



# Faith-based alcohol treatment in England and Wales: New evidence for policy and practice

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## ABSTRACT

While the historical importance of religion in alcohol treatment is well known, the size, scope and significance of contemporary activities remain unclear. Here we begin to address this gap in knowledge by presenting results from a mixed methods study of faith-based alcohol treatment in England and Wales. The paper begins by mapping location, religious affiliation, organisational structure and service provision. We then discuss evidence regarding challenges, opportunities and tensions bound up with faith-based organisations ‘filling gaps’ left by long term restructuring of alcohol service provision, recent ‘austerity’ funding cuts and relationships between secular and faith-based organisations. In the final substantive section, we engage with questions of ethics and care by focusing on the internal workings of a subset of faith-based programs that make requirements for religious participation. Drawing on the variegated experiences of service-users, we reflect on the ethics of religious conversion in faith-based alcohol treatment. The conclusion offers policy and practice relevant insights and outlines areas for future research on religion, austerity, and alcohol treatment.

## 1. Introduction

Geographers have made significant contributions to advancing understanding of alcohol, drinking, and drunkenness. Critical research and writing over the past decade has focused on public, commercial, domestic spaces; legislation, policy, policing; masculinity/femininity; ethnicity/religion; intergenerational transmission of drinking cultures; mobilities; temperance; emotions, embodiment, affect; assemblages of (non)human actors etc (for reviews see Jayne et al., 2006, 2008, 2010, 2011a, 2011b; Jayne and Valentine, 2016; Wilton and Moreno, 2012). Within this body of work, attention has been drawn to the spatialities of alcohol treatment and recovery (Nicholls and Kneale, 2015; DeVerteuil and Wilton, 2009; Wilton et al., 2007; Thomas et al., 2008; Duff, 2010, 2012; Whiteford et al., 2015; Shortt et al., 2017; Mills, 2018), the ‘disciplinary-therapeutic’ nexus at work in formal and informal treatment settings (Wilton and DeVerteuil, 2006; Wilton et al., 2007; Fairbanks, 2009; Evans et al., 2015), and the political, racialised, gendered discourses bound up in ‘recovery’ (Love et al., 2012; Wilton et al., 2014; Evans, 2012). Much less attention has been given to the place of religion and alcohol treatment and recovery, despite historically having significant influence on alcohol treatment and recovery provision (Valverde,

1998; Kneale, 2001; Beckingham, 2010) and continuing to shape local policy regimes, the governance and ethos of service providers, and the meanings and identities constructed and experienced by service-users across the world (Hansen, 2005, 2012; Brandes, 2002; Sanchez and Nappo, 2008).

Indeed, the place of religion in alcohol treatment and recovery has received growing attention across the social sciences in recent years, ranging from studies of ‘effectiveness’ and ‘distinctiveness’ of faith-based alcohol treatment (Neff et al., 2006); religious framings of ‘addiction’ (Cook and Dossett, 2015; Dossett and Metcalf-White, 2020); lived religion, embodiment and conversion (Sremac, 2014; Sremac and Ganzevoort, 2013; Williams, 2016); the blurring of ‘secular’ and ‘religious’ spirituality (Dossett, 2013; Williams, 2015); and religious power, control and ‘indoctrination’ (Mikeshin, 2016; Zigon, 2010; O’Neill, 2014; Williams, 2017). Evidence to inform this debate however is largely limited by the lack of comprehensive data on the size, scope and significance of contemporary activities of faith-based treatment and recovery. This paper addresses this research lacunae by discussing empirical findings from the first geographic study of faith-based alcohol treatment service provision in England and Wales. In doing so we also respond to calls for a “critical” [understanding of] ... addiction

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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). By undertaking research which captures, interrogates and offers resources to address the diverse and often ambivalent nature of faith-based alcohol treatment, this paper seeks to offer new insights on a long debated but poorly understood sector as well as foreground the varied experiences of service-users.

To that end, the paper begins with an introduction to research design and methodology followed by presentation of empirical evidence which maps the location, religious affiliation, funding and registration, service capacity, staffing, referral routes, and in-programme medication and testing of faith-based alcohol treatment service providers in England and Wales. We then discuss the challenges, opportunities and tensions bound up with faith-based organisations increasingly 'filling gaps' left by long term restructuring of alcohol service provision, austerity-driven funding cuts, and changing relationships between secular and faith-based

organisations. More specifically we focus on issues of transparency of theology and practice, professionalism, voluntarism, and diversity and equality. The final substantive section of the paper critically engages with questions of ethics and care through consideration of treatment provision and services; expectations and rules; and mandatory religious practice. We conclude with policy and practice relevant insights and highlight areas for future research on religion, austerity, and alcohol treatment.

## 2. Research design and methodology

Our study applied quantitative and qualitative mixed methods in order to achieve a comprehensive study of faith-based alcohol treatment services. The project had two distinct elements: firstly, national surveys of England and Wales began with a systematic web-based search to capture the name, location and contact details of faith-based alcohol treatment services. This was followed by telephone and online

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*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). The programme includes individual and group counselling, vocational and 'life skills' training and support; non-medicated detoxification and mandatory religious involvement. In the last ten years, Siloam Pool has grown from twelve bedrooms to a current capacity for fifty-seven, and staff has grown from four to over thirty. Research predominantly took place in 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 which include a homeless day centre, emergency accommodation, abstinence-based residential units (sixteen beds across several houses) and a fifteen-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 Table* - 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 GP's, local services and other appropriate healthcare providers the programme offers education, training, volunteering, seeking employment as well as offer help to access housing. Currently working with sixty 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 on-line 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 a links to local debt charities and other services such as mental health, GPs etc.

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Fig. 1. Faith in Recovery? Case study organisations.

questionnaire surveys which collected, firstly, non-anonymised data regarding size, capacity, longevity of service provision, theological/practical approaches, religious ethos and affiliation, approaches/types to treatment, demographic and staffing structures, funding sources, referral routes, treatment requirements, religious expectations, and professional registration. A second anonymised section gathered detailed information on referral routes; conditions/expectations for service-users accessing treatment, mandatory drug testing and service-users use of medication, religious participation, funding, outcomes of treatment, and partnership working. The survey received 71 (53%) responses, with 55 (41%) full completions.

Secondly, ethnographic research with key stakeholders including, local authority and county council commissioning managers and service-user development officers; representatives of national and international faith-based networks; a Christian research and lobby group; and an independent healthcare consultant and inspector. During nine in-depth interviews we collected data regarding knowledge and experience of working practices of faith-based alcohol treatment organisations and potential strategies/plans barriers to increasing/improved partnership working. A further eleven in-depth interviews were undertaken with service providers from five case-study organisations gathering information on 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 (Fig. 1). This was complimented by twenty-two individual and group in-depth interviews with service-users providing biographical information; perspectives and experiences of treatment; views on structure, ethos, effectiveness, support; changing relationship to religion and personal spirituality; practical theology of addiction and understandings of, and relationship to alcohol. Finally, participant observation included three to five days in each case-study organisation involving approximately forty service-users and ten service providers gathering data on staff and residents' interaction as well as experiences and participation in day-to-day rhythms of the treatment programmes. The participant observation generated a detailed understanding of the ways service-users from different religions/faiths, with diverse socio-economic backgrounds experience treatment (see Jayne et al., 2019)<sup>1</sup>.

The case study organisations were purposefully sampled and

recruited from our national surveys, chosen as representative of the diversity of faith-based alcohol treatment in England and Wales. They include a large government-funded Christian alcohol treatment organisation, an evangelical therapeutic community, as well as those focused on working with minority groups often deemed to be hard-to-reach and under-researched (Valentine et al 2010; Antin and Hunt, 2013). The research design and methods were scrutinised through Cardiff University's ethics procedures. To ensure anonymity respondents and organisations have been allocated pseudonyms. Interviews were recorded, transcribed, translated and were analysed using conventional qualitative techniques. The quotes used in the text are verbatim and editing is highlighted.

### 3. Mapping faith-based alcohol treatment in England and Wales

Our national surveys of England and Wales revealed 135 organisations representing over 300 groups/project/initiatives/courses clustered in larger urban areas and small towns with rural services dominated by residential rehab programmes. The interactive maps (Figs. 2 and 3) contain contact information which people can use to explore facilities in their area<sup>2</sup>. The density of faith-based alcohol service provision varies considerably by region, and by religious affiliation, as shown in Table 1. The location of some service providers partly reflects the presence of population (for example, Jewish alcohol services are all located in London and Sikh services mostly in West Midlands) whereas Buddhist and Christian services are not linked to a specific population, suggesting different locational factors at work. The sector is predominantly made up of Christian service providers in all regions, with the North West, South East, South West, and Yorkshire and the Humber having the highest numbers of Christian service providers. Dedicated services for Black, Asian and Minority Ethnic populations are sparse, as are Muslim alcohol services, and in some regions such as Wales and the North East, the only option for people seeking faith-based alcohol treatment in their area are Christian programmes. The qualitative findings also highlighted national, regional and local geographies:

most of the programmes I know of are within the largest city boundary ... there are no alcohol or drug services in the next biggest

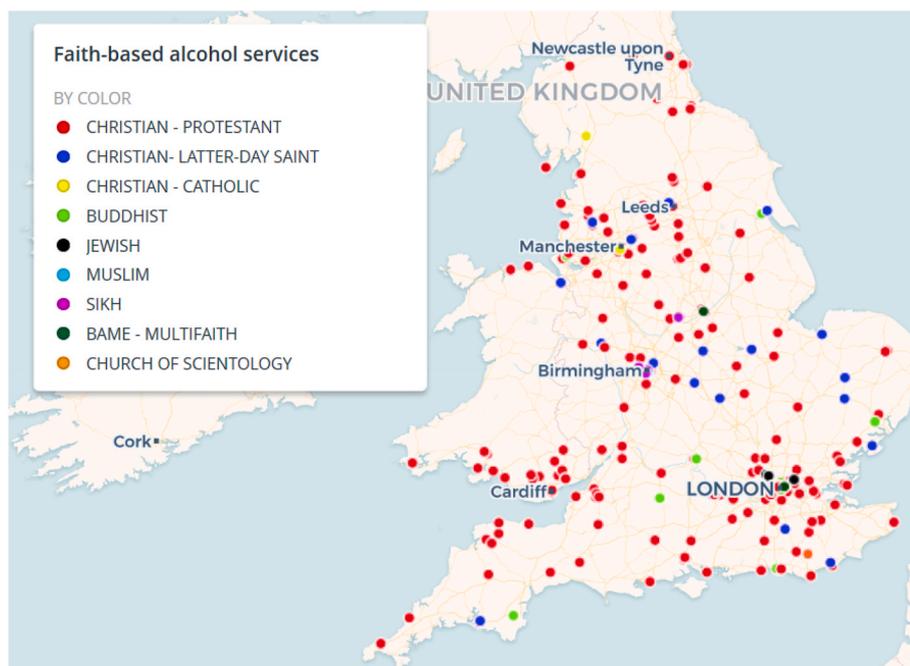


Fig. 2. Faith-based alcohol treatment services in England and Wales (Source: Faith in recovery survey). An interactive version is publicly available here [<https://webbojnr.carto.com/builder/aa710197-ce2b-4937-b0d4-47113ff02046/embed>].



Fig. 3. Faith-based residential alcohol treatment services in England and Wales (Source: Faith in recovery survey). An interactive version is publicly available here [<https://webbojnr.carto.com/builder/3a15ea3e-ac58-41b5-bcda-1370601d7d4b/embed>].

Table 1  
Regional distribution of faith-based alcohol services in England and Wales [2].

	Christian -Protestant	Christian - Catholic	Christian – Latter-Day Saints	Jewish	Muslim	BAME - Multifaith	Sikh	Church of Scientology	Buddhist	Total
North East	10									10
North West	32	3	2						2	39
Yorkshire and the Humber	28		2						1	31
East Midlands	17	1	3			1				22
West Midlands	16		3		1	1	3			24
East of England	22		4		1		1		1	29
London	17	1		3		1			4	26
South East	31		3					1	3	38
South West	31		1						2	34
Wales	21		1							22
<b>Total</b>	<b>225</b>	<b>5</b>	<b>19</b>	<b>3</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>1</b>	<b>13</b>	

town. They’ve got a hub and spoke approach, and our nearest hub is further away ... in a different county ... So people have to go to further away ... 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 ... 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 ... very rarely do they do liver functions anymore, or look at Hep C ... 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

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

As this quote highlights, respondents pointed to ‘recovery hotspots’ with good service provision, while others lamented the uneven national, regional and local geographies of faith-based alcohol treatment. However, as Whiteford et al. (2015) highlight in ‘Two buses and a short walk: the place of geography in recovery’, general accounts of spatialities of alcohol treatment often fail to capture how location affects acquisition, management, and barriers to recovery. For some marginalised groups distance to service provision plays a vital role in both enabling access to treatment with less fear of surrendering anonymity but can also be a barrier to accessing services (Valentine et al 2010).

Indeed, there were also differing views expressed regarding the location of residential rehabs. For some service-users, rural isolation was considered ‘beneficial’ as a disincentive to leave:

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 ...

(Keith, Aged 45–55, The Siloam Pool).

In contrast, service-users in an urban residential rehab - Kimberly House - are not ‘artificially’ removed from everyday spaces of alcohol consumption:

there are a few pubs around here ... on a Friday and Saturday night, we can hear them a ... It’s seen as a bit of a joke ... ‘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 ...

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

Alongside highlighting spatialities of faith-based alcohol treatment our research also offered valuable insights into theological and organisational structure of the sector. As Fig. 4 shows 76% of survey respondents defined themselves as ‘Christian - other’ (non-Catholic), with 52% of those being ‘Evangelical’. Unfortunately, the response rate from

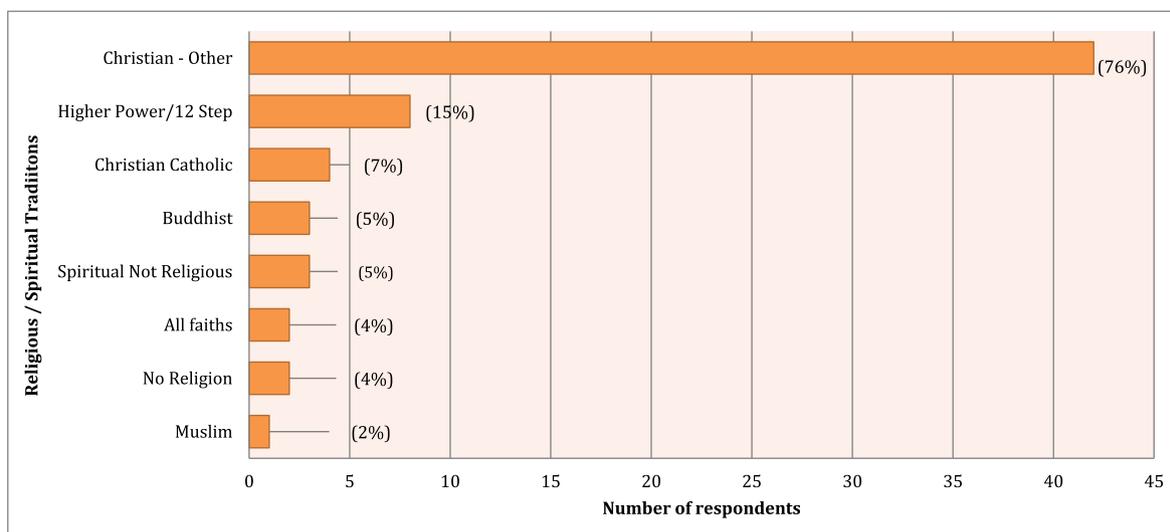


Fig. 4. Self-identification of faith-based alcohol treatment services (Source: Faith in recovery questionnaire survey).

other faith groups was proportionally lower; 1 survey response was provided by a Muslim alcohol treatment service organisation and 1 response from a BAME group that has a sub-project orientated for Muslims. We received responses from 3 Buddhist organisations that employed forms of meditation or mindfulness related to Triratna, Theravada and non-denominational/secular traditions. Of 42 groups who self-identified as Christian (non-Catholic) 22 described themselves as Evangelical, 20 groups aligned themselves with Protestant traditions, including Church of England (Anglican), Baptist, Pentecostal, and nondenominational, and 5 groups identified as 'Christian' - without specifying a tradition or denomination. Respondents who described themselves as being part of the 'Christian-Other' category included Church of the Latter-day Saints' (Mormon) 'Addiction Recovery' who run Twelve-Step recovery courses around the UK (Fig. 5).

Around two thirds of respondents indicated they receive funding from 'umbrella' religious organisations or partner churches (Fig. 6). A similar number rely on charitable foundations, and/or public donations. Income generated by collecting housing benefit from service-users, charging service-user fees or taking on social enterprise status were the next most prevalent ways faith-based alcohol treatment is funded. Only a small proportion of organisations were funded through local authorities.

Around three quarters of respondents were registered with the

Charity Commission, deriving benefits such as tax relief, public recognition, and access to certain funding streams. Faith-based alcohol treatment service providers not registered with the Charity Commission tended to be smaller organisations; most were run by individuals, or as voluntary support groups. Across the sector there is nonetheless a lack of external regulation - beyond responsibilities related to charitable status - allowing faith-based alcohol treatment service providers to exercise relative autonomy. 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 (Fig. 7). 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 (Fig. 7) 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.

Across the faith-based alcohol treatment providers who took part in

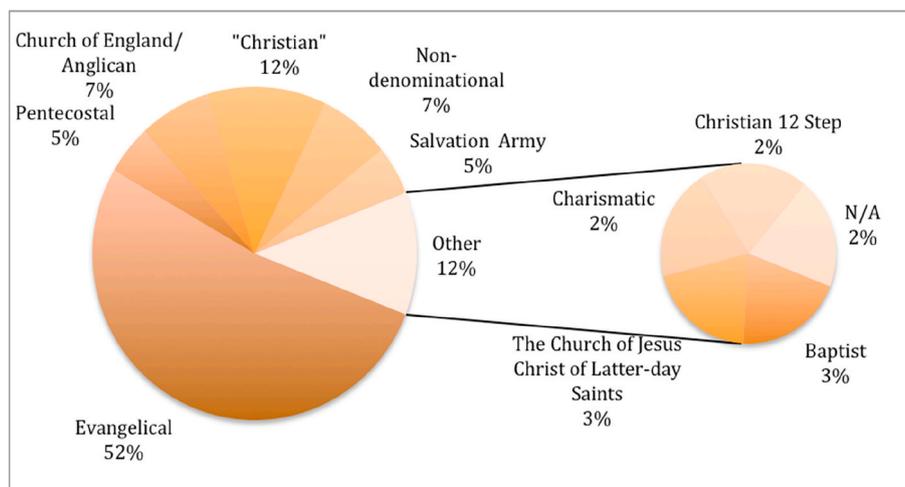


Fig. 5. Denominational identification of faith-based alcohol treatment service providers (Source: Faith in recovery questionnaire survey).

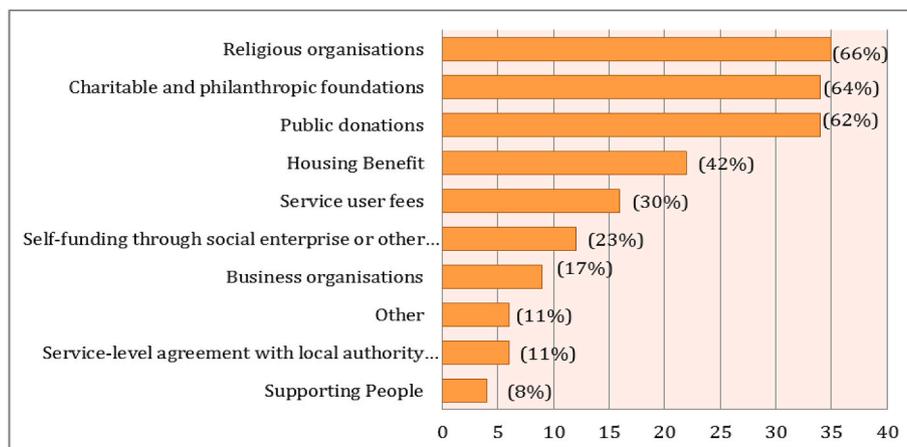


Fig. 6. Funding of faith-based alcohol treatment service providers (Source: Faith in recovery questionnaire survey).

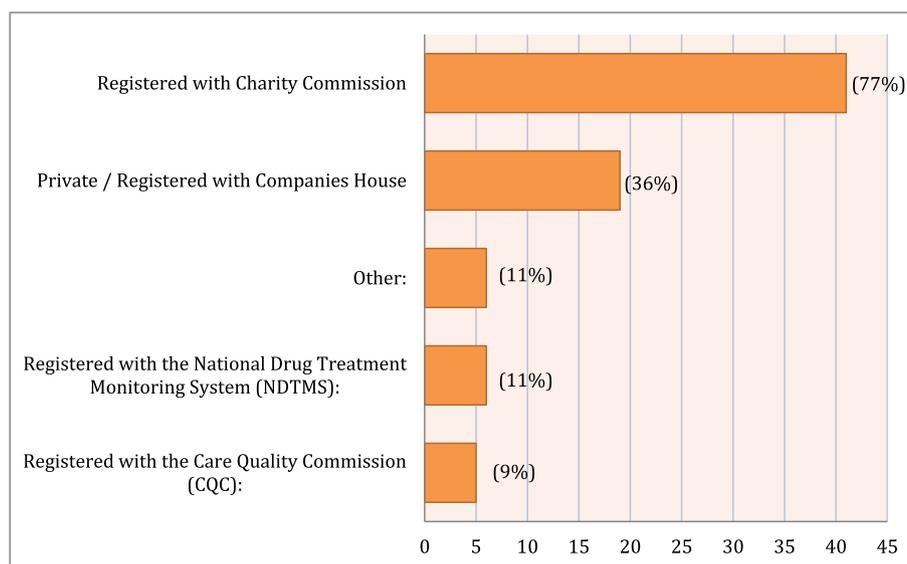


Fig. 7. Registration status of faith-based alcohol treatment service providers (Source: Faith in recovery questionnaire survey).

our survey, service capacity varied depending on the type and duration of service offered. Non-residential service providers offered programmes from 6 to 30 people. The survey also identified a notable growth in church-based franchises running Christian twelve step courses, some of which had developed referral partnerships with Local authorities. Of the 66 residential centres provided by faith-based groups, the largest can accommodate 83 service-users, with smaller organisations tending to have less than 20 beds located across different sites. Unsurprisingly given religious teachings on sobriety and self-control (Cook, 2006), the vast majority of faith-based alcohol services are geared towards long-term abstinence, with primary care provision comprising an amalgam of mutual aid facilitation, harm reduction, weekly Bible study groups, Self-Management and Recovery Training (SMART) recovery, 8-step recovery, clinical assessment and treatment, and an advice line and remote pastoral support. It is a diverse sector that defies neat characterisation. Some evangelical residential services retain the hierarchical structure of peer-support and other elements of the Therapeutic Community model which fell out of favour in the 1980s (Yates, 2003), while simultaneously sharing many of the modalities of eighteenth century ‘rescue missions’ where addiction was characterised as a sin or spiritual void to which religious conversion was the cure (White, 1998; see White and Whithers, 2005 on histories of faith-based recovery). Others, including the Social Services arm of The Salvation Army UK,

take a more ‘professionalised’ approach working closely with local authorities to offer harm reduction and abstinence-based programmes, and deliberately eschew any approach in which religion becomes a barrier to recovery and service access (Williams, 2015).

This schism in the sector is reflected in its staff composition with just under half (47%) of respondents employed staff and volunteers who were of the same faith. Evangelical service providers had a much higher proportion of staff and volunteers who were of the same faith, while the majority of respondents, including Muslim, Sikh and BAME organisations, indicated that their staff and volunteers were ‘a mix of people of different faiths.’ Several BAME respondents interviewed highlighted the importance of ‘culturally appropriate’ services following negative experiences in both faith-based and secular alcohol treatment, and the view that the ‘Twelve Step’ approach is associated with ‘surreptitious’ Christianity in its origins, belief system, and meeting spaces:

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.

(Mehak, Senior Recovery Worker, 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

(Ahmed, Aged 35–45, Open Circle)

Respondents to our survey were also asked to indicate three routes to accessing services (Fig. 8). After self-referral, friends, family or religious congregations, the most significant ways that service-users access faith-based alcohol treatment is through health, criminal justice, and social care contexts. Respondents also identified 'other' referral routes (9%) including Alcoholics Anonymous and Narcotic Anonymous fellowships. Three quarters of our respondents indicated that they permitted 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). Prohibitions of prescribed medication were often made on grounds of resource capacity and organisational ethos. For instance, some peer-led evangelical residential centres running on limited budgets insisted on medicated detox prior to entry or 'cold turkey' on arrival and disallowed any psychoactive medication (including anti-depressants). This not only creates barriers to treatment, but risks misdiagnosis of mental ill health. If suitability of the recovery programme and risk assessments on entry are absent, or not thoroughly adhered to, prohibition of medication presents dangers for acute alcohol withdrawal (NICE, 2020). Cameron and Ant, two former service-users at one such programme explain:

When I left Hebron they all tried to stop me getting in the car, saying I was going to die, and all that – bit 'culty' – I wouldn't send no clients there. Its hardcore. Working every day. You give up all your money. They made me cut all my hair off. No counselling. Just you and God. Its okay for some people – but people with mental health problems – they need treatment.

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

It wasn't the religion, it was the fact that they didn't want you to take anything to help you through those first few days when you get there. No paracetamols for your leg ache, no buscopan for your stomach cramps, and it's the thought that prayer will fix everything and they wouldn't even let you smoke and I cannot do everything all at once, you've got to do it gradually in stages otherwise you'll just fail and that's exactly what I think. I ran out the door. I couldn't do it

(Ant, Aged 25–35, Sanctuary)

Given the prevalence of abstinence-based approaches among the survey's respondents, it is not surprising that such regulatory technologies were being pursued through mandatory testing (DeVerteuil and Wilton, 2009). For example, 53% respondents employed mandatory alcohol testing, a figure that rose to 76% in residential rehabs. However, as one service provider 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'.

Harm reduction services such as controlled drinking projects were less common among faith-based providers yet one of our case-studies stressed the importance of meeting the accommodation needs of people whose drinking practices would prevent them from retaining tenancy either in supported housing or private rental sector accommodation, or would be unable or unwilling to meet the strict expectations of abstinence that characterise most faith-based residential programmes. Such practices embody elements of containment, care and responsabilisation for street drinkers (DeVerteuil and Wilton, 2009; Evans, 2015); however, we also wish to highlight a small but obstinate streak of radical faith-based activism (see Williams, 2013; Prior and Croft, 2016) which deploys notions of sanctuary as a theo-ethical and subversive practice of harm reduction that seeks to challenge the structural forces that produce and perpetuate harm for people who use drugs and alcohol (Roe, 2005 cited Smith, 2015).

While the survey data offers important insights into faith-based alcohol treatment services in England and Wales, this empirical evidence only begins to 'scratch the surface' of the complexity of the sector (Dossett, 2013; Williams, 2012). Indeed, there is a risk of 'reading off'

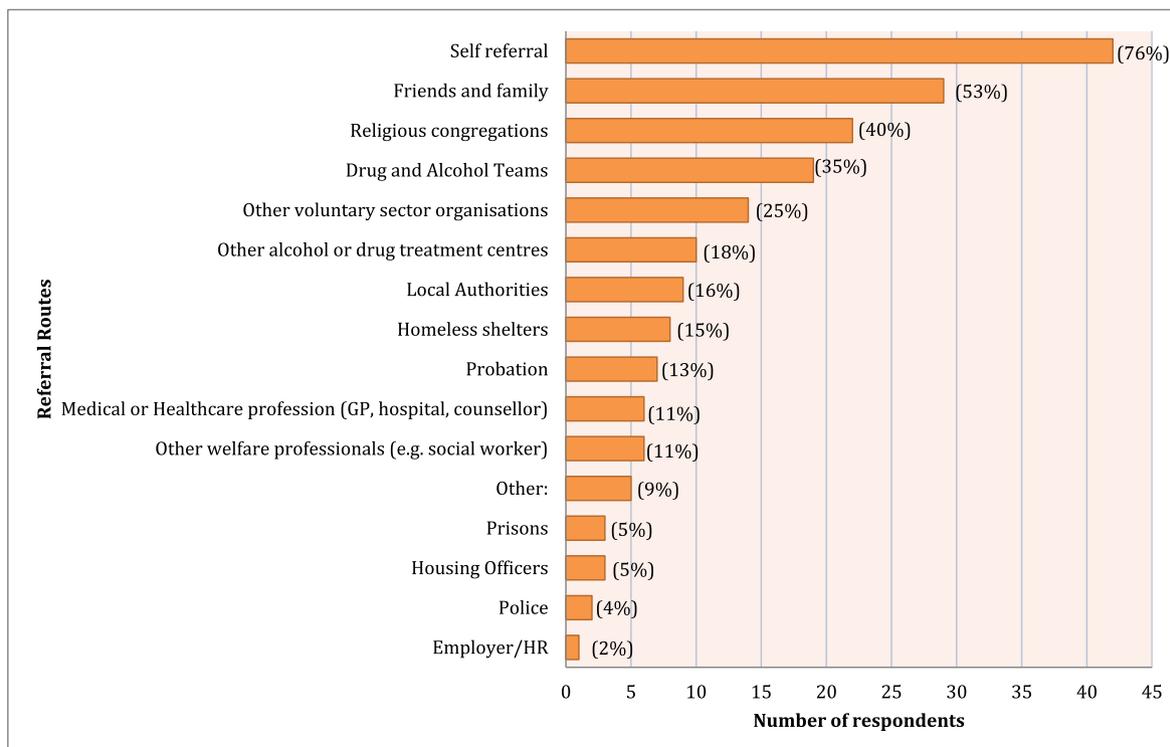


Fig. 8. Most common referral routes to faith-based alcohol treatment service providers (Source: Faith in recovery questionnaire survey).

service-user experiences from the denominational/theological profile of an organisation - a problem associated with typologies of faith-based organisations in the sector (Sider and Unruh, 2004). In order to develop a more sophisticated understanding of the place of faith-based alcohol treatment in England and Wales, in the next section we offer critical reflection on challenges, opportunities, tensions bound up with long term restructuring of alcohol service provision and more recent 'austerity' funding cuts.

#### 4. Institutional change, austerity and policy

The majority of key stakeholder and service providers taking part in our study emphasised a 'lack' of government policy and the negative effects of austerity on alcohol treatment (see Alcohol Change UK, 2018; Arie, 2013; Bulman, 2017; Siddique, 2018). 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 highlighted by our respondents 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:

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 [2015–2018], so what happens when the service that is meant to deal with really complicated people only have half the places they used to and are expected to do more with less staff? ... The complexity of clients that we are seeing ... two years ago ... would have been seen by a psychiatrist or a consultant and now we are doing that work because they are seeing a tiny per cent. So that has a huge effect ... apart from affecting the lives of the clients, which it does massively ... on the ground we're seeing lots of relapses caused by the stress of benefits being taken away ... We now have 20–30 minutes to do a telephone assessment ... to do more you have to break the rules ... The wages are much lower ... not as a manager, as a practitioner ... gone down to about 18–19 [thousand pounds per year], which means that we are attracting a much less skilled workforce ... Less training budgets so people have less of an opportunity to develop their skills, which impacts the efficacy of what we are actually delivering ...

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

Such findings can be contextualised against a backdrop of partial convergence of alcohol and drugs policy in the UK. In 2010 the Coalition government re-valourised 'abstinence based' approaches initiated by the previous New Labour government. This intensified under the current Conservative regime to include welfare and criminal justice sanctions as part of a 'recovery agenda' based on the 'responsibilisation' (Roy and Buchanan, 2016) of 'vulnerable subjects' (Brown and Wincup, 2019), underpinned by 'behavioural politics orientated towards actions and lifestyles of an apparently problematic subgroup of the population or "underclass"' (Monaghan and Yeomans, 2019: 122). Despite a partial policy convergence service providers and key stakeholders lamented the relatively reduced levels of funding for alcohol services in comparison with drug treatment, and while in our study we found no evidence of organisational restructuring related to policy convergence, or dedicated faith-based alcohol treatment organisations broadening their mandate in the context of shifting funding priorities to also encompass drug treatment, respondents did however note that the revalorising of abstinence politics/policy and its close fit with the philosophy and practices of faith-based organisations has contributed to the recent growing

prominence of the sector.

However, respondents were also keen to locate austerity policies as part of problematic longer-term restructuring, including rapid re-tendering cycles of service providers and increasing marketisation of health and social care services (Alcohol Change UK, 2018; Power and Hall, 2018). Indeed, in response to austerity cuts, interviewees suggested that faith-based alcohol treatment services often sought (although not always successfully) to diversify their funding models; using Social Impact Bonds (see McHugh, 2013 for a critique); converting to social enterprise models (gardening, recycling business, cafés); increased use of volunteering; reliance on financial, food and other donations; as well as drawing on clients' housing benefit to fund residential rehabs:

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 ... 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. ... I can go into a local authority and save them £300,000–400,000 on a £2m contract ... try and cut out the overheads ... and not cut out the frontline services. But those gains and those abilities to make those salami slice savings are diminished ... we are at a stage where I think services are on the verge ... of crisis.

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

our funding, we get enhanced housing benefit for each of the residents ... that covers approximately 55–60% ... Most of our food is donated ... Most of the furniture is donated ...

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

Changing trajectories of UK government funding priorities were also a concern for most respondents. There was significant confusion with regards to content and direction of national government alcohol strategy with key stakeholder and service providers acutely concerned about ongoing cuts in funding and future restructuring:

in 2012 the Health and Social Care Act put community drug and alcohol treatment into the remit of local authorities. And there was money from Public Health England ... 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 ... 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, 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).

Indeed, facing significant reductions in local government service spending (Hastings et al., 2017), nearly 60% of local authorities in England and Wales cut funding for drug and alcohol treatment services in 2018 (Gabbatiss, 2019), while funding for residential rehabilitation and detox treatment in England has been reduced by 15% in the period 2013/14 to 2017/18 (Slawson, 2018). £162 million (16%) has been cut from budgets for drug and alcohol services in England since the abolition of the National Treatment Agency in 2013 (Rhodes, 2018). This has resulted in a highly uneven service provision landscape, with cuts to

public health budgets hitting the most deprived communities hardest (Thomas, 2019) alongside areas where drug and alcohol-related deaths is the highest (Slawson, 2018). Cuts to the Revenue Support Grant from central government to local authorities alongside the removal of protected drug and alcohol treatment budgets within public health grants means that local government funding for drug and alcohol treatment will be increasingly dependent on local business rate retention. This will further widen inequalities between local authorities where what is funded is determined not just by the preferences of local commissioners and needs of the community, but the ability to leverage financial support from Local Authority budgets (Recovery Partnership, 2017).

It was clear during in-depth interviews that key stakeholders and service providers lamented that austerity had significantly affected alcohol treatment and funding landscapes, in parallel with longer trajectories of changing funding, policy priorities and competitive bidding (between national charities and private sector organisations). Thus, with a lack of government funding, faith-based alcohol treatment services have been filling ‘gaps’. Moreover, funding for faith-based alcohol treatment services drawn from religious organisations, charitable and philanthropic organisations, public donations, housing benefit, service-user fees (whilst also being under pressure from austerity) has not been affected to the same degree as service providers reliant on statutory funding (see Fig. 6):

It's all well and good to slag off churches. Who feeds 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 ...

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

before austerity we used to open on Saturday and we used to work until 8pm, but faith-based organisations, exist around the clock ... they can add a more informal ... way of supporting people

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

With a patchwork of actors involved in alcohol treatment service provision at national, regional, and local levels, such quotes highlight the perceived necessity of partnership working between local authorities and faith-based alcohol treatment providers. Interviewees however highlighted tensions of partnership, including, evidence-based practice, transparency of theology and practice and the competitive nature of funding opportunities as fuelling conflict:

I think its faith-based versus secular ... The challenges come when there is competition ... 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 ...' 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 ...

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

Of particular importance in generating suspicion amongst secular organisations was a concern that competition for funding has led some faith-based organisations to adopt a ‘secular’ public face:

they have softened their edges ... voiced their faith less to become more appealing to funders ... That's definitely true ... I was looking through one rehab recently and they never mention it, and I know they're a Christian, faith-based rehab ... I've been to see them,

they're brilliant ... You would never know from their information that they provided.

(Rosanne, Senior Commissioning Manager for Substance Misuse for Adults, County Council, English Midlands).

Indeed, evidence from our study correlates with wider trends among faith-based welfare providers to eschew ‘conversion-driven’, and instead adopt ‘unconditional’ modes of service provision that does not require individuals to participate in religious activities and faith/spirituality is only discussed if requested by service-users (Cloke et al., 2012; Birdwell, 2013). Professionalisation does not necessarily result in ‘secularisation’, often feared by some faith-based organisations as a diluting of faith values; but rather embodies both a turn towards more participatory theologies where in-common practices of *caritas* allow a blurring of faith-secular identification (Cloke et al., 2019), and a more pluralist approach to recovery where the faith and spiritual understanding and preferences – or absence thereof – of the client are central (Williams, 2015). However, for organisations motivated by an explicit desire to convert, the downplaying of religion might be considered disingenuous.

Tensions between secular and faith-based organisations also circulated around ‘evidence-based approaches’, problematic moral and judgmental views; expert knowledge/experience; registration with governance bodies; safeguarding, and equality and diversity:

That there's lots of drug and alcohol treatment that is based on moral panic or judgement about drug and alcohol use ... some really out dated ... denial, alcoholics being morally wrong, people that pathologically lie or things like that ... really harmful

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

Despite these concerns, many faith-based alcohol treatment service providers interviewed tended to celebrate being ‘experts by experience’ albeit with concerns regarding increasing reliance on volunteers due to budgetary constraints:

I hate professionalism ... I want people who are passionately in love with this work. We hire for passion, we train for skill ... I would like to work ... 50/50 [volunteers and employees with professional qualifications] ... If they were all ex-users on staff we would have lockdown here every night ... I need the staff members who have always been clean to get street-wise. And they don't learn it out of a book ... We need a balance.

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

And finally, while 60% (14% female and 26% male only) of respondents to our national surveys in England and Wales offer mixed sex care provision, it was clear from interviews with key stakeholders and faith-based alcohol treatment service providers, that provision for women is lacking. Respondents elaborated that travellers, ethnic minorities and those living in rural areas are also underrepresented in faith-based alcohol treatment service provision. A handful of respondents also pointed 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 et al. (2014) in our study there were examples of faith-based alcohol treatment providers expressing problematic views on sexuality, gender, ethnicity and so on:

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

to teach the woman ... I'd like to have a hairdressing area ... 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 ...

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

## 5. Religious practices and experiences: ethics and care

In this final section, we discuss questions related to ethics and care in faith-based alcohol treatment. Scholarship has examined the role 'faith' and spirituality play in narratives and experiences of recovery (Sremac, 2014; Dossett, 2013; Williams, 2016), as well as theorised faith-based and other alcohol treatment spaces through the lens of governmentality (Mikeshin, 2016; Garmany, 2010; Evans, 2012; Williams, 2017) to analyse the discursive practices, architectures, and daily routines which coalesce to shape the disciplined body and delineate the conditions for (often gendered) 'technologies of the self' (Evans, 2012; Hansen, 2012). We wish to supplement these accounts by foregrounding the knowledges and experiences of current service-users to offer focused discussion on issues of power, agency and religious participation. Our intention is not to tarnish the work of 'faith-based alcohol treatment' per se; but instead draw attention to practices and experiences in the sector that require urgent critical discussion. While UK faith-based organisations have shifted towards non-interventionist and unconditional forms of service provision in the area of street homelessness (Cloke et al., 2005; Johnsen and Fitzpatrick, 2009); it is clear from previous sections a different set of philosophies and practices are evident among a subset of faith-based alcohol treatment providers. Given the onus on behavioural change and the positioning of religious practice as an integral part of some – but not all – recovery programmes, it is vital to consider the ethics and politics of religious conversion. Recent geographical work has highlighted the implication of political, economic, and socio-cultural processes in conversion practices, processes, and experiences – and how these processes differently operate across space, scale and tradition (Woods, 2013; Kong and Nair, 2014; Williams, 2020). We wish to respond to Wood's (2012) call for critical inquiry into the 'ameliorative, and potentially predatory, interconnections between social marginality, welfare provision, faith-motivated groups and religious conversion within the space of the city' (p.449), and foreground how conversion practices and processes intersect with 'individuals whose mobility is limited, restricted or otherwise dependent on another party' (p.450).

Our research generated important empirical evidence directly relevant to these academic debates. For example, 34% of respondents indicated that their programme contained elements of mandatory religious/spiritual participation, for example, requiring service-users to attend and/or actively participate in prayer, worship, and religious teaching. Mandatory religious participation in residential faith-based alcohol treatment was higher, at 52%. Other respondents stated there were no preconditions to accessing treatment and services other than: 'a desire to change'; being 'motivated to change'; 'a desire to move away from suffering'; 'a willingness to actively seek recovery'; 'real desire for change' etc. Of the 28% of respondents who stated religious participation was optional, some of their comments suggest a more ambiguous picture: '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'.

If the distinction between 'optional' and 'mandatory' religious participation is deeply ambiguous, academic and practitioner reflection on faith-based alcohol treatment must acknowledge the possible disconnect between the espoused ethos (what is claimed or believed by service providers), the operative ethos (the everyday rules and programme), and the lived experiences of service-users. Here we draw primarily on one of the case-studies – Siloam Pool, an evangelical residential rehabilitation provider – to examine the gap between claims made by service providers that religious participation is 'optional' and how these are perceived and experienced by different service-users. As the following evidence indicates, programme goals, structure and experiences of service-users can remain conversion-oriented and, to varying degrees, coercive. Indeed, our research highlighted the issue of transferred gratitude and reciprocity in which positive psychological, physiological, 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:

Ask yourself, 'why are you here'? People come on the programme and think 'I don't want the God bit. I just want the recovery.' That's ok. But why have 50% ... you can have 100% with God. Why sell yourselves short ... Don't bury it. Talk about it with your keyworker.

(Staff member leading morning devotion, participant observation notes)

While not discounting the importance of thankfulness in faith traditions or imply any positive experience of recovery accredited to God is inherently problematic, there was nonetheless evidence that some groups apply a politics of gratitude in which the gift - of residence, recovery, friendship - elicits an intuitive desire to reciprocate (Mauss, 2011). At the Siloam Pool, for example, staff outlined explicit instruction to residents to express 'gratitude'.

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/ethics and the organisation's emphasis on voluntary participation, and the choice of residents to engage - or not - with religious elements of the programme:

We don't ever say ... "If you don't become a Christian you're out." ... We've had people go right through the programme not a Christian ... 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 ... 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, Founder and Director, The Siloam Pool, English Midlands).

In such peer-led programmes there is direct encouragement to 'follow the example of Christian discipleship modelled by others'. 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, Aged 45–55, The Siloam Pool).

These findings highlight that current understanding of proselytism in faith-based service provision is 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 that work through social obligation, incentives, and familial encouragements to 'work the programme':

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.

(David, Aged 25–35, The Siloam Pool).

David continues to describe his experience of conversion:

When I wasn't in that place [feeling connected], it exacerbated the anxiety. It made me feel really uncomfortable, like there was an expectation on me to be a certain way ... You could say it was almost like an intravenous drip to get hydrated, if you like. I was just dripped the word of God and on that particular day, it just washed over me.

It is not surprising that service-users expressed both positive and negative opinions and experiences. While singing and prayer was positively discussed as a key part of recovery by several residents of Siloam Pool, others were sceptical about the value of worship beyond raising the spirits and 'breaking up' the boredom of residential treatment. Yet, David's account above reveals the ethical complexity surrounding his conversion experience which was entangled with initial feelings of indifference and alienation. Respondents also signposted concerns over 'cross addiction' (religious obsession and swapping one dependency for another), which was often mentioned by service-users - and staff - in the research. This is undoubtedly problematic if religious belief and practice develops into 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, 2008). However, 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:

[Prayer] helps relieve that urge to want to use, that urge to go off and go on a mad one ... 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.

(Rahim, Aged 25–35, Open Circle)

People say being into spiritual things is a crutch or it's a cross-addiction, but so is eating fucking chocolate ... So why then is it all 'Ooh' if people talk about spirituality or addiction or getting into God ... ? 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, Aged 25–35, Kimberly House - part of an international Christian social service organisation).

It is equally important to avoid a consequentialist ethic where the end goal of recovery justifies the means, thereby reinforcing stigmatising discourses of the 'addict' and legitimatising harmful practices (O'Neill, 2014). Any assessment of the ethics of religious conversion must recognise the relational agency of service-users beyond limited readings of volition and free choice. If the freedom of service-users to engage in religious practices is circumscribed by the desire to reciprocate, social incentives (favouritism/belonging), direct exhortation by staff workers, then, what is often claimed by an organisation to be 'optional' can be experienced by some service-users as unwanted, and to varying degrees coercive, proselytisation. These issues take added significance in austerity where resource rationing changing eligibility and reduction in residential treatment centres (Matthew-King, 2019; Alcohol Change UK, 2018) restrict the treatment options for people seeking support. Indeed, notions of 'voluntary engagement' were further complicated by probation-related requirements to participate:

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 ... there is some anger and resentment ... amongst us who have made the decision to come here.

(Martin, Aged 45–55, The Siloam Pool).

Existing scholarship has highlighted the expansion of faith-based substance abuse treatment in the USA where the combination of Charitable Choice Legislation and court-ordered referrals to evangelical rehabilitation centres is understood to constitute the bio-political underbelly of the 'war on drugs' and the carceral-industrial complex (Rodriguez, 2010; Bourgois and Hart, 2010). Little attention however has been given to similar dynamics in the UK wrought by austerity cuts to frontline services and available treatment options, and its implications on blurring the boundaries between mandatory and voluntary engagement in faith-based programmes.

In response to the regimented structure and intense surveillance of some faith-based programmes, it is important to recognise the 'ethics of engagement' of service-users themselves (Williams, 2016) which range from willing or tactical acquiescence to transgression and resistance, often changing over time and in relation to specific spaces depending on individual proclivities and circumstance. For example, displays of disengagement (not standing up, not singing, arms folded, sly looks, eye rolls) were used to register disapproval. Service-users also disclosed coping strategies to 'show they were working with [the] programme', performing their 'know how' - repeating 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 should not be dismissed as insincere but were nonetheless a visible

strategy to 'get by' in a 'hassle free' way. One respondent coined the phrase 'fake in recovery' to refer to 'guys who claim to be Christian ... [but] when they leave the programme, they won't stick to it'. When asked whether some people go through the motions with singing/-praying, one service-user replied:

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, Aged 45–55, The Siloam Pool).

Service-users highlighted other examples of sophisticated knowledge and experiences of navigating faith-based and secular alcohol treatment, for example, talking about 'cultish' practices; lack of clinical knowledge; availability of faith-based treatment in comparison to statutory or private rehabs; and experiences of racism and xenophobia:

there's a problem with faith-based organisations, because usually a faith-based ... 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, Aged 45–55, Open Circle).

Moreover, service-users traced their own and others' pathways through by comparing 'rules' and 'strictness' of different secular and faith-based treatment expressing 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 ... 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 .. We're self-sufficient in that respect.

(Martin, Aged 45–55, The Siloam Pool).

Despite such positive comments, many of the service-users we interviewed expressed concern about their ability to 'complain' when they felt there was problems with their treatment, and when they were allowed to offer 'feedback' they felt it was often ignored. Taken together, the shifting role of faith-based providers in the contemporary landscape of alcohol treatment and recovery has heightened the significance of longstanding questions about service access with regard to referral pathways, 'choice' of treatment provider, variegated experience of

service-users, and expectations over religious observance.

## 6. Conclusions

In this paper we have presented data that maps the size, scope and significance of contemporary faith-based alcohol treatment in England and Wales, as well as offering critical reflection on the opportunities, challenges and tensions bound up with faith-based alcohol treatment. Budget cuts and growing pressure on frontline workers (probation, GPs, alcohol workers) has led to faith-based alcohol treatment services becoming increasingly significant service providers in the sector, raising questions about the diverse approaches, practices and expectations in faith-based alcohol treatment, and crucially, how these are experienced by service-users. By presenting the most comprehensive dataset on the scale and make-up of faith-based alcohol treatment in England and Wales to date, our intention is to help those working in the sector avoid uncritical celebration or prejudicial generalisation of 'faith-based alcohol treatment', and instead focus on specific practices and experiences associated with a subset of faith-based providers which require attention.

As well as engaging with theoretical and empirical debates our research generated policy and practice relevant insights and recommendations. Indeed, all key stakeholder and service providers who took part in our study pointed to the 'lack' of government policy, ongoing budget cuts, restructuring and pressures of marketisation as factors likely to further embed faith-based organisations in landscape of treatment in the coming decades. In response our research evidence suggested that, firstly, transparency needs to be at the heart of faith-based alcohol treatment including public and easily accessible details of the ways in which theology informs the organisational ethos and day-to-day activities; to 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; and ensure that all staff and volunteers undertake equality, diversity and safeguarding training.

Secondly, 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.

Thirdly, service providers need to develop a more sophisticated understanding of proselytisation beyond the conscious intentions of the 'giver' and take into account the power dynamics in faith-based alcohol treatment, and in welfare provision more generally. To this end, greater care should be given to the spiritual autonomy of individuals to avoid subtle forms of coercion and spiritual abuse, and practitioners should receive professional training in alcohol dependency, addiction, and mental health. Currently the UK's All-Party Parliamentary Group Faith and Society's 'Faith Covenant' offers principles for joint working between local councils and faith groups based on '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' (APPG *Faith and Society*, 2020). We argue the '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 involvement in alcohol treatment, especially with regard to the 'ethics' of religious conversion.

Fourthly, faith-based alcohol service providers, along with government and secular organisations, need to do more to offer diverse and culturally appropriate services. People should be able to access a range of secular, theological and spiritual approaches to alcohol treatment and recovery, according to their preferential worldview. However, the

mapping of the sector reveals stark regional geographies in both the availability and cultural appropriateness of service provision. While 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 individuals who disclosed stigmatising experiences in other treatment providers.

Finally, Public Health England and 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.

In offering a comprehensive review of the key empirical evidence from our research into faith-based alcohol treatment in England and Wales, this paper has made clear links between shifting policy landscape and funding regimes which have led to faith-based alcohol treatment and organisations coming to 'the fore' because of service availability, inexpensive delivery, relative lack of reliance on statutory funding, and the government's revalorisation of abstinence - and the voluntary sector more widely - fits the therapeutic mandate of faith-based organisations. While this work makes an important start in understanding the ethical tensions that surface at the intersection of austerity, care and religion, there is clearly more work to be done to examine the blurred boundaries between state and faith-based welfare provision in austerity. Critical research is needed to address the variegated experiences of people recovering from alcohol dependency in different faith-based and secular treatment settings. This will involve theoretical, empirical and methodological research which investigates the emotional geographies of religious conversion, alongside tracing the ways faith-based alcohol treatment is configured in diverse cultural and political-economic contexts (see, for example, Hansen, 2012; Zigon, 2010; O'Neill, 2015). In addition to conceptualising alcohol treatment as a site of 'regulatory richness' (DeVerteul and Wilton, 2009), evidence of hybrid therapeutic cultures blurring dominant dichotomies of religion, spirituality and secularity also suggests alcohol treatment and recovery is a rich site to analyse contemporary permutations in landscapes of belief and unbelief across different state-religion-society configurations (Dossett, 2013; Dossett and Metcalf-White, 2020). Exploring the relational geographies of austerity in the daily life of people in recovery also is a critical area of research, one which takes heightened significance following the increase in alcohol and drug deaths since 2010 (Rhodes, 2018), relapses related to the stress of benefit changes/delays/sanctions, the 'hollowing out' of existing social infrastructures many people rely on for emotional sustenance (Shaw, 2019) and the highly contingent formation of new relationships of care (Hall, 2019).

## 7. Notes

1. A full version of the research report can be found at <https://alcoholchange.org.uk/publication/faith-in-recovery-service-user-evaluation-of-faith-based-alcohol-treatment>
2. Figs. 2 and 3 and Table 1 exclude organisations or services which did not have an available address or postcode required for mapping, such as online signposting and telephone support groups (e.g. [SikhHelpLine.com](http://SikhHelpLine.com)); homeless outreach activities of residential communities (E.g. 11 Teen Challenge Teams in towns and cities); 6 Church of Latter-Day Saints' Twelve Step Chapters (Staines, London, Colchester, Poole, Manchester, Liverpool); 6 Calix Society Mutual Aid Support Groups (Birmingham, Coventry, Oldham, Sheffield, Sussex, Liverpool); and 6 Christians Against Poverty Release Groups (Salisbury, Telford, Bexhill, Truro, Teignmouth, Manchester).

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## Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.healthplace.2020.102457>.

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