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ORIGINAL PAPER

Programming Provided by Religious Congregations in the United States to Address Mental Illness and Substance Use Disorder

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Abstract

Mental health conditions, including substance use disorders, are one of the most commonly occurring yet least commonly treated health ailments in the United States. Religious congregations serve as important providers of mental health services, as they can fill this gap with accessible care. This study provides an up-to-date accounting of mental health service provision by religious congregations, using a nationally representative survey of U.S. congregations collected in 2012 and 2018–19. Half of all congregations in the U.S. provided a program or service targeting mental illness or substance use disorder in 2018-19, and rates of provision increased among Christian congregations between 2012 and 2018–19.

Keywords Mental health · Substance use disorder · Congregations · Religion

Introduction

Mental health conditions are one of the most commonly occurring health ailments in the United States. In 2020, 21% of American adults experienced a mental health disorder (52.9 million individuals), and 14.5% of American adults experienced a substance use disorder specifically (40.3 million individuals) (Substance Abuse & Mental Health Services Administration, 2021).[1] Nearly half of American adults will develop a mental health disorder at some point during their lifetime (Kessler et al.,

[1] Mental health disorders and substance use disorders are not exclusive categorizations of diagnoses. Because *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* (American Psychiatric Association (2013)) includes substance use disorders as a mental health disorder, this manuscript refers to "mental health disorders" to encompass both substance use disorders and other mental health disorders, unless specified explicitly.

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2005). However, these conditions are some of the most commonly untreated health ailments, as 62% of individuals who experience mental health conditions do not receive the professional treatment that they need (Walker et al., 2015).

Individuals who do not seek needed treatment for their mental disorders most commonly cite structural barriers, specifically high costs and insufficient insurance coverage, as the reason they are unable to access care (Walker et al., 2015). Although the primary goal of religious congregations is to offer worship services and spiritual guidance to their parishioners, religious congregations in the United States serve a crucial role as providers of services for mental illness and substance use disorders (Tsitsos, 2003; Blank et al., 2002; Frenk, 2014; Wong et al., 2018a; Wong et al., 2018b; Grim & Grim, 2019; Torres et al., 2022). Further, congregations often fill this gap with free and accessible care to parishioners and non-parishioners alike, overcoming barriers to access (Hidalgo et al., 2019).

Approximately 25% of individuals who seek treatment for mental health disorders turn to clergy and congregations for assistance (Wang et al., 2003), with about half of those individuals relying solely on these religious leaders and organizations for help with their mental health conditions (Wang et al., 2005). Given this important role that religious congregations play in the lives of individuals with mental disorders, it is important to better understand the prevalence of this care, as well as the qualities and markers of congregations that offer mental health services. The most recent estimations, based on data collected in 2012, found that 23% of U.S. congregations provide groups or classes focused on supporting individuals with mental illness (not including substance use disorders), and 38% of U.S. congregations provide groups or classes focused on supporting individuals with substance use disorder (Torres et al., 2022; Wong et al., 2018b).

Past research has identified several traits of religious congregations that are most likely to provide mental health resources. First, congregations with abundant resources, such as having large congregations with more attenders (Torres et al., 2022; Wong et al., 2018a, 2018b) and having more parishioners with high socioeconomic status (Wong et al., 2018b) are more likely to provide mental health programming. Additionally, congregations that mobilize these resources for service, such as having directed efforts to assess community needs (Torres et al., 2022; Wong et al., 2018b), having a staff member working on congregational social services (Torres et al., 2022; Wong et al., 2018b), starting its own nonprofit (Torres et al., 2022), and hosting a speaker from a social service provider (Torres et al., 2022; Wong et al., 2018b) are more likely to offer mental health services.

Second, congregations that are led by an older clergyperson (Wong et al., 2018b), led by a clergyperson with a master's degree (Wong et al., 2018a), or led by a clergyperson born in the U.S. (Torres et al., 2022) are also more likely to offer mental health services, as these religious leaders are hypothesized to have had more experience with offering mental health services in the U.S. context over their vocational and educational careers. Third, congregations that are geographically located in areas with a higher concentration of Black residents are also more likely to offer mental health services (Wong et al., 2018b). As past research has shown that Black individuals seek and receive mental health care less frequently compared to other

racial groups (McGuire & Miranda, 2008), this may illustrate that religious congregations are particularly likely to provide these resources if they are located in under-resourced communities and aware of the need immediately around the congregation.

Fourth, recent research has found that congregations with a higher number of unemployed attenders and a higher number of younger attenders are more likely to offer programming for individuals with substance use disorders (Torres et al., 2022). It may be that these congregations are responding to the needs to their unemployed congregants. It may also be that congregations made up with a high proportion of younger individuals, who research has shown to have fewer stigmatizing views of substance use disorders (Adlfat et al. 2009), are more likely to offer these services.

Fifth, research has demonstrated that the religious tradition of the congregation matters for understanding which congregations are more likely to provide programming and support for individuals struggling with mental health disorders. However, research has produced mixed results regarding the relationship between religious tradition and the provision of these services. Tsitsos (2003) found that Black Protestant congregations were most likely to offer services targeting substance use disorders, and Frenk (2014) found that white mainline Protestant congregations were most likely to offer mental health services (including substance use disorder and broader mental health disorders) and Catholic congregations were least likely. Torres et al. (2022) found that white conservative Protestant congregations were the most likely to offer services targeting substance use disorders, and Wong et al., 2018b did not find any variation by religious tradition when determining the congregations most likely to offer services for individuals with mental illness. Additionally, both Wong et al., 2018b and Torres et al., 2022 found that congregations that have the practice of speaking in tongues during worship services are also more likely to provide these services. Thus, the impact of theological tradition and beliefs on providing these services remains unclear.

Finally, one congregational characteristic that has not been accounted for in past analyses of congregational provision of mental health services, but which may be important to account for, is a measure of congregational collaboration. Past research on health-focused programs offered by religious congregations to target physical health ailments has emphasized the role of collaborations between religious congregations and other organizations and institutions. This research found that congregations often collaborate with other organizations to provide these services, and that congregations that collaborate with other entities are more likely to offer health-focused programs (Werber et al., 2012; Williams et al., 2015).

The Current Study

The current study seeks to provide the most up-to-date accounting of the provision of mental health services (including services targeting substance use disorder) by religious congregations, using data from the 2012 and 2018–19 National Congregations Study (NCS). Notably, the 2018–19 NCS added new measures of mental health and substance use disorder service provision. Thus, this data offers the ability to assess change over time among repeated measures and to assess the overall

representation of mental health and substance use disorder service at a more accurate level because of these new measures.

In addition to this descriptive analysis, this paper also examines whether predictors of the congregational provision of mental health services found in past research continue to remain significant in the contemporary social context. By doing so, this analysis will offer a more holistic and complete understanding of both the rates of mental health service provision by religious congregations, as well as the types of congregations most likely to offer these services.

Data and Methods

The data for this analysis comes from the third and fourth waves of the National Congregations Study (Chaves et al. 2020), collected in 2012 and 2018–19. The National Congregations Study (NCS) is a nationally representative sample of religious congregations, collected in conjunction with the General Social Survey (Smith et al., 2019). If a GSS respondent reported attending religious services at least once a year, a follow-up question asked where the individual attended those religious services.

Those congregations named by the nationally representative sample of GSS respondents thus create a representative cross-section of religious congregations in the United States. The NCS then attempted to follow up with each of those congregations by interviewing a key informant, typically a clergy person, to gather a variety of information concerning congregational characteristics, activities, beliefs, and demographics. The response rates for the 2012 NCS was between 73 and 78%, and the response rate for the 2018 NCS was 69%.

For the descriptive analysis of service provision in 2018–19, I included all religious congregations (Christian and non-Christian). However, to assess change over time between 2012 and 2018–19 and to examine correlates of the provision of mental health and substance use disorder services in 2018–19, I included only Christian congregations. This is for two reasons. First, non-Christian congregations are a small yet heterogeneous group, and it is difficult to distinguish if patterns among this group are substantive realities or simply random variation as a result of the small sample size. Second, some of the key variables of interest as possible correlates of mental health and substance use disorder service provision were only asked of Christian congregations.

Limiting my sample to Christian congregations allowed for greater clarity in my analysis regarding the theological measures in my multivariate analysis. The full NCS sample is made up of 1331 congregations in 2012 and 1262 congregations in 2018–19. Removing non-Christian congregations left a total sample of 1285 Christian congregations in 2012 and 1195 Christian congregations in 2018–19. After using list-wise deletion to remove cases with missing values, I was left with 971 Christian congregations in 2018–19 for the multivariate analysis. No individual variable had more than 9% of values missing.

My outcome measures were created from five questions in the NCS that pertain to the provision of mental health services in the last 12 months: (1) If the congregation

had a group, meeting, class, or event to support people with mental illness; (2) If the congregation had a group, meeting, class, or event to support people struggling with drug or alcohol abuse; (3) If the congregation offered a social service involving substance abuse programs; (4) If the congregation offered a health-focused program addressing mental health conditions; and (5) If the congregation offered a health-focused program addressing issues of substance abuse or addiction.

The methodology for these five measures in the NCS varied. All religious congregations were explicitly asked if they had a group, meeting, class, or event to support people with mental illness or to support people struggling with drug or alcohol abuse. For both the social service and health-focused program questions, the congregations reported these programs in response to an open-ended question.

To gather information on social services, the NCS asked if the congregation participated in or supported social service, community development, or neighborhood organizing projects of any sort within the past 12 months. If they answered affirmatively, they were asked to list the four most important social service activities. These open-ended answers were then coded to reflect the main issue being addressed by the social service.

To gather information on health programs, the NCS asked if the congregation had any organized effort to provide members with health-focused programs such as blood pressure checks, health education classes, or disease prevention information. If the congregation responded affirmatively, they were prompted by a list of possible health programs, as well as offered the opportunity to offer three health-focused programs in an open-ended manner. These were then coded to reflect the main health condition being addressed by the health-focused program.

Because a congregation could potentially answer yes to multiple of these questions with a singular program in mind, I created three composite measures: (1) A binary measure representing whether a congregation reported offering any mental health programming addressing substance use disorder or addiction; (2) A binary measure representing whether a congregation reported offering any mental health programming addressing "mental illness," broadly defined; and (3) A binary measure representing whether a congregation reported offering any of the mental health programming—whether it address substance use disorder or "mental illness," broadly defined.[2]

The first measure, concerning substance use disorder, was constructed using the three questions from the NCS that explicitly related to substance use disorder and addiction: whether the congregation had a group, meeting, class, or event to support people struggling with drug or alcohol abuse; whether the congregation offered a social service involving substance abuse programs; and whether the congregation offered a health-focused program addressing issues of substance abuse or addiction.

The second measure, concerning mental illness services, broadly defined, was constructed using two of the above questions from the NCS: whether the

[2] Including substance use disorder under the umbrella of mental health is in accordance with past research on the congregational provision of mental health programming (Frenk 2014), as well as *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (American Psychiatric Association (2013)).

congregation had a group, meeting, class, or event to support people with mental illness; and whether the congregation offered a health-focused program addressing mental health conditions. The third measure, concerning any mental health services, was constructed using all five of the questions that pertain to the provision of any mental health services.

Additionally, I controlled for measures that past research has demonstrated to predict the congregational provision of mental health services: specifically, congregational resources, congregational mobilization of their resources for service, congregational leader characteristics, congregational location, and congregational religious tradition. I included measures of the number of regularly attending adults (logged), the percentage of congregants under age 60, and whether the congregation was located in a census tract with at least 30% of residents living below the poverty line.

I included measures of whether the congregation had a group to assess community needs, whether the congregation had hosted a social service representative as a visiting speaker, and if any congregational staff member spent at least 25% of their working time on congregationally provided social services. I also included a measure of congregational collaboration, indicating the number of types of collaborations the congregation reported engaging in to provide social service programming.

I included measures of the age of the head clergy person, whether the head clergy person had at least a master's degree, and the nativity of the head clergy person. I included a categorical measure of the four major Christian traditions: Roman Catholic, white conservative or evangelical Protestant, Black Protestant, and white liberal or Mainline Protestant, using Mainline Protestant as the reference category. I also included a measure of whether tongues were spoken during a main worship service in the past twelve months. Table 1 presents the demographics of the analytical sample of congregations.

Statistical Analysis

To assess the prevalence of the congregational provision of mental health and substance use disorder programming, I focus on descriptive results. All means in reported in the results section and Tables 1, 2, and 3 report means weighted by the NCS weight "WT_ALL4_CONG_DUP." To assess the predictors of these congregational programs, I also estimated multiple logistic regression equations. After running diagnostic tests recommended by Winship and Radbill (1994) and DuMouchel and Duncan (1983), the regression results were produced from analyzing unweighted data.

Findings

Table 2 presents the rates of congregational provision of mental health services among all religious congregations in the United States in 2018–2019. Exactly half (50.0 percent) of all religious congregations offered some kind of mental health service, whether it be a service directed at mental illness, broadly defined,

Table 1 Demographics of U.S. Religious Congregations, 2018–19. Source: National Congregations Study, 2018–19

	% congregations, mean, or median value
Religious tradition	
Catholic	6.1%
White evangelical protestant	42.7%
Black protestant	21.3%
White mainline protestant	20.9%
Non-Christian	9.0%
Worship practices	
Speaks in tongues (only asked of Christian congregations)	29.4%
Congregational resources	
% attendees < 60 y/o	57.5%
% attendees > $140 k/yr	10.2%
# reg attending adults (median)	50.0
Mobilization for service	
Staff member > 25% work on soc serv	14.7%
Assesses community needs	54.0%
Speaker from soc serv	28.4%
Collaboration for service	
Number of partnerships in providing social services	2.2
Clergy characteristics	
Master's degree	57.55%
Age (median)	57.0
Born in U.S	85.1%
Geographic location	
Census tract > 80% Black	3.9%

All percentages are weighted using the WT_ALL4_CONG_DUP weights in the NCS cumulative dataset

Table 2 U.S. Congregational Provision of Mental Health Services, 2018–19. Source: National Congregations Study, 2018–19

Mental health service	% Congregations
Any mental health service	50.00
Service targeted at mental illness	26.58
Group to support people with mental illness	*26.24*
Health-focused program addressing mental illness	*0.47*
Service Targeted at Substance Use Disorder	43.60
Group to support people struggling with substance use disorder	*42.81*
Social service for people struggling with substance use disorder	*2.93*
Health-focused program addressing substance use disorder	*1.21*

All percentages are weighted using the WT_ALL4_CONG_DUP weights in the NCS cumulative dataset

Table 3 Change in Provision of Mental Health Services among Christian Congregations, 2012 to 2018–19. Source: National Congregations Study, 2012 and 2018–19, limited to Christian congregations

Mental health service	% Congregations	
	2012	2018–19
Any mental health service	39.91	51.53
Service Targeted at Mental Illness	21.60	27.10
Group to support people with mental illness	*21.60*	*26.71***
Health-focused program addressing mental illness	–	*0.52*
Service Targeted at Substance Use Disorder	37.56	45.73
Group to support people struggling with substance use disorder	*36.99*	*44.85**
Social service for people struggling with substance use disorder	*3.41*	*3.21*
Health-focused program addressing substance use disorder	–	*1.33*

All percentages are weighted using the WT_ALL4_CONG_DUP weights in the NCS cumulative dataset

*Statistically significant difference between 2012 and 2018–19, $p < 0.05$

*Statistically significant difference between 2012 and 2018–19, $p < 0.01$

or a mental health service targeted specifically at substance use disorder. The most prevalent form of mental health service that religious congregations offer was a group, meeting, class, or event held to support individuals struggling with a substance use disorder, with almost half (43.6 percent) of congregations offering such a program. Congregations also offered a group, meeting, class, or event to serve individuals with mental illness at high rates, with over a quarter (26.2 percent) of congregations offering this resource. Significantly lower rates of congregations offered health-focused programs targeting mental illness, broadly defined (0.5 percent), health-focused programs targeting substance use disorders (1.2 percent), or social services targeting substance use disorders (2.9 percent).

As seen in Table 3, Christian congregations increased their provision of mental health services over time in two of the three the measures that were asked in both the 2012 and 2018–19 waves of the NCS. In 2012, 21.6 percent of Christian congregations had a group, class, meeting, or event to support people with mental illness, which increased to 26.7 percent in 2018–19 ($p < 0.01$). Similarly, in 2012, 37.0 percent of Christian congregations had a group, class, meeting, or event to support people struggling with substance use disorder, which increased to 44.9 percent in 2018–19 ($p < 0.05$). The final measure that was asked in both 2012 and 2018–19 regarded the provision of social services for people struggling with substance use disorder. The percentage of Christian congregations who offered this social service did not change between 2012 and 2018–19.

Table 4 contains the odds ratios and 95% confidence intervals for the three logistic regression models which constitute the multivariate analysis. The outcomes of the three models were whether the congregation offered any mental health service of any kind, whether the congregation offered a mental health service which was broadly defined as targeting mental illness, or whether the congregation offered a mental health service which was specifically defined as targeting

substance use disorders. Each of these models accounted for the predictors that past research has found to be significant indicators of the congregational provision of mental health services: religious tradition, worship practices, congregational resources, congregational efforts to mobilize resources, and clergy characteristics, as well as a measure of congregational collaboration in service efforts.

White Mainline Protestant congregations were significantly more likely than white evangelical Protestant and Black Protestant congregations to offer the composite measure of the provision of any mental health service ($p < 0.05$ for both), as well as more likely to offer services targeted at substance use disorder specifically than white evangelical Protestant congregations ($p < 0.05$), and more likely than Black Protestant congregations to offer services regarding substance use disorders ($p < 0.01$). Whether or not someone in the congregation had spoken in tongues at their most recent worship service was a significant and positive predictor in of providing services targeting substance use disorder specifically ($p < 0.05$), but not of the congregation's provision of mental health services broadly defined or of the composite measure of any mental health service.

Among congregational resources, the number of regularly attending adults positively predicted the composite measure of any mental health service, the provision of services for mental illness, as well as the provision of services targeted at substance use disorders ($p < 0.001$ for all three). Congregations with a higher percentage of younger parishioners were more likely to offer the composite measure of any mental health service, as well as more likely to offer services targeted at mental illness, broadly defined ($p < 0.05$ for the composite measure; $p < 0.01$ for mental illness services). Congregations that were located in a census tract with over 30% of the population living below the poverty line were more likely to offer any mental health services and to specifically offer a service targeting substance use disorders ($p < 0.01$, $p < 0.05$; respectively).

Congregations that had specific efforts to assess the needs of their surrounding geographical community were significantly more likely to offer mental health services in all three of the models ($p < 0.001$ for all three models), as were congregations which hosted a speaker from a social service organization ($p < 0.001$ for all three models). Additionally, congregations who employed a staff member to spend more than 25% of his or her work time on the congregation's social service efforts were more likely to offer services targeted as mental illness, broadly defined, as well as to predict the composite measure of any mental health service ($p < 0.05$ for the model predicting the composite measure; $p < 0.01$ for the model predicting services targeting mental illness, broadly defined).

Finally, congregations that collaborated with a greater number of organizations outside of their congregation in providing social services were more likely to offer all three of the services related to mental health ($p < 0.05$ for the composite measure, $p < 0.01$ for mental illness generally and substance use disorder specifically). Clergy characteristics did not have an impact on the provision of mental health services when accounting for all other predictors.

Table 4 Predictors of Mental Health Service Provision Among Christian Congregations, 2018–19. Source: National Congregations Study 2018–19, limited to Christian congregations

	Any mental health service	Service targeted at mental illness	Service targeted at substance use disorder
	Odds Ratio [95% conf int]	*Odds Ratio [95% conf int]*	*Odds Ratio [95% conf int]*
Intercept	0.037*** [0.010, 0.126]	0.009*** [0.002, 0.032]	0.049 [0.015, 0.154]
Religious tradition, ref white mainline protestant			
Catholic	0.680 [0.396, 1.670]	0.713 [0.425, 1.194]	0.667 [0.407, 1.091]
White evangelical protestant	0.605* [0.388, 0.940]	0.625* [0.395, 0.985]	0.736 [0.486, 1.111]
Black protestant	0.505* [0.285, 0.892]	1.225 [0.699, 2.150]	0.494** [0.290, 0.839]
Worship practices			
Tongues spoken during service	1.241 [0.823, 1.884]	0.962 [0.639, 1.443]	1.614* [1.096, 2.395]
Congregational resources			
% attendees < 60 y/o	1.009* [1.001, 1.016]	1.011** [1.003, 1.019]	1.006 [0.999, 1.013]
#reg attending adults	1.466*** [1.276, 1.690]	1.341*** [1.175, 1.535]	1.393*** [1.227, 1.587]
Census tract > 30% below pov level	1.961** [1.261, 3.100]	1.450 [0.955, 2.198]	1.604* [1.074, 2.418]
Mobilization for Service			
Staff member > 25% work on soc serv	1.553* [1.020, 2.401]	1.795** [1.231, 2.620]	1.097 [0.754, 1.604]
Assesses community needs	2.697*** [1.976, 3.693]	4.084*** [2.870, 5.888]	2.092*** [1.556, 2.817]
Speaker from soc serv	2.146*** [1.536, 3.013]	2.046*** [1.477, 2.837]	1.812*** [1.332, 2.472]
Collaboration for Service			
Number of types of collaborations	1.116* [1.025, 1.216]	1.129** [1.037, 1.230]	1.114** [1.030, 1.207]
Clergy characteristics			
Master's degree	0.827 [0.564, 1.210]	1.041 [0.696, 1.561]	0.848 [0.590, 1.216]
Age	1.004 [0.990, 1.018]	1.009 [0.995, 1.024]	1.003 [0.990, 1.016]
Born in U.S	1.353 [0.828, 2.198]	0.651 [0.401, 1.058]	1.334 [0.847, 2.099]
R squared	0.176	0.201	0.124

*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$

Discussion and Conclusion

Half (50.0 percent) of all religious congregations in the United States reported offering at least one mental health service in 2018–19, with 44 percent of congregations offering a program targeting substance use disorder and 27 percent of congregations offering a program targeting mental illness, broadly defined. This is a higher rate than was previously reported, both because of increasing numbers of Christian congregations offering these services, as well as methodological updates that allow researchers to better document the diverse types of mental health services that congregations offer. Because of these added measures, researchers can now gain a greater understanding of the prevalence, predictors, and types of mental health assistance offered by congregations than has been possible in the past.

Despite recent findings that religious beliefs continue to perpetuate and reinforce mental health stigma (Adams et al., 2018; Peteet, 2019), the increased rates of mental health service provision among Christian congregations between 2012 and 2018–19 may reflect that mental health stigma has decreased among these congregations. Alternatively, it may be that the pattern of religious reinforcement of mental health stigma that has been found at an individual level is not upheld at a congregational level. Further, recent research from a nationally representative sample of congregational leaders found that clergy overwhelming embrace a view of the causes and treatments of mental health in line with modern medicine, rather than blaming mental illness on religious and spiritual struggle or shortcomings (Holleman & Chaves, 2023). The fact that more Christian congregations are offering mental health services than in the past potentially points to a trend toward fewer barriers to seeking assistance from religious institutions for struggles related to mental illness and substance use disorder.

However, based on these results, it appears that religious congregations that offer mental health services are significantly more likely to offer services that provide social support to these individuals, rather than explicitly medicalized support. Though social support is a valuable and needed resource for individuals with mental health conditions (Seeman, 1996; Cohen et al., 2000; Moak & Agrawal, 2010), it is a different type of resource than a more targeted health-focused program. The fact that 26% of congregations reported that they offered a group to support people with mental illness, but only 0.5% of congregations reported offering a health-focused program addressing mental illness, for example, illustrates that congregations may not have an explicitly medicalized understanding of the services they are offering to individuals in need of mental health services.

From the multivariate analysis, a few findings stand out that are especially worthy of note. First, Mainline Protestant congregations are more likely than any other Christian religious tradition to offer a service targeting substance use disorder and to offer at least one of any of the mental health services measured in the NCS. This is in line with the findings of Frenk (2014), who also found that mainline Protestant congregations were the mostly likely to offer mental health services (combining services targeting substance use disorder and mental illness). However, this contradicts the pattern found by Torres et al. (2022), who found that conservative Protestant

congregations were the most likely to provide services targeting substance use disorders, and it also contradicts the pattern found by Tsitsos (2003), who found that Black Protestant congregations were the most likely to provide services targeting substance use disorders.

Further, the present analysis mirrored past work in finding that congregations that have a practice of speaking in tongues in religious services are more likely to offer mental health services when accounting for religious tradition. Though the present analysis overall mirrors past work in the predictors identified—namely, that congregational resources, the mobilization of resources, and religious tradition and practices matter for predicting which congregations offer mental health services—the fact that a lack of clarity exists on the precise way in which religious tradition matters is a matter for continued research going forward.

Second, the analysis shows that it is not just congregations that have an abundance of resources, but congregations that purposefully seek to mobilize these resources for service, that are most likely to provide mental health services—whether they are targeting mental illness, broadly defined, or substance use disorder specifically. The mobilization of resources was consistently the predictor of largest magnitude across all models, indicating that the congregational provision of mental health services is part of a larger congregational culture concerning service to those in need.

Third, congregational collaborations seem to be especially important for understanding which congregations are the most likely to offer mental health services. Though past research on congregational programming for physical health ailments has found that congregational collaborations are important predictors of service provision, past research on congregational mental health services has overlooked this predictor. Though the current measure of collaboration concerns collaborations generally, and not specifically collaborations in providing mental health services, the present analysis still demonstrates the importance of accounting for these collaborations in understanding which congregations are most likely to offer mental health services.

Fourth, there are slight differences between the predictors of providing a service targeting mental illness, broadly defined, and providing a service targeting substance use disorders. White mainline Protestant are the mostly likely to offer these programs, but the difference is only statistically significant between mainline and conservative Protestant congregations in the model predicting mental illness programming, and the difference is only statistically significant between mainline Protestant and Black Protestant congregations in the model predicting substance use disorders. Further, congregations with younger attendees and with a staff member focusing on social services were more likely to offer mental illness programming, but not more likely to offer substance use disorder programming, and congregations that have a practice of speaking in tongues and congregations that are located in a census tract with a large percentage of residents living under the poverty line were more likely to offer substance use disorder programming, but not more likely to offer mental illness programming. However, both models affirm the same overall theoretical predictors: that congregational resources, the mobilization of resources and collaboration for that mobilization, and religious tradition and practices matter for predicting which congregations offer mental health services.

These results suggest that religious congregations may have responded in tangible ways to the rising need for mental health care between 2012 and 2018. In this period in the United States, deaths due to drug overdose rose (Shiels et al., 2018), deaths due to suicide rose (Garnett et al., 2022), the prevalence of anxiety disorders rose (Goodwin et al., 2020), and the prevalence of major depression rose (Greenberg et al., 2021). Though the NCS data was conducted in 2018–19 on the eve of the COVID-19 pandemic, these findings suggest that congregations were already responding to increasing mental health struggles and prioritizing these services and programs prior to the onset of COVID-19 and its associated social restrictions. As studies have shown that rates of mental illness have further increased in the context of COVID-19 (Bueno-Notivol et al., 2021), more individuals were likely seeking out assistance with their struggles related to mental illness and substance use disorder during this time. These results suggest that religious congregations were potentially well-positioned and ready to help support individuals struggling in this way.

Study Limitations

This research is not without its limitations. Though the data used here is more illuminating than past measures on the nature of the mental health services that are offered by religious congregations, the data still does not contain specifics on the type of mental health conditions being treated. Services pertaining to substance use disorder could range from sponsoring a weekly Alcoholics Anonymous meeting to using the congregation's parsonage for transitional housing for individuals attempting to break an addiction. These two activities clearly demonstrate different levels of investment in this programming.

Additionally, the data used here does not contain specifics on the actual activities and potential treatments being implemented during these groups. These could range from hiring a licensed mental health professional to offer one-on-one psychotherapy, to having a prayer or support group without any trained personnel involved. Again, this data does not allow us to draw these distinctions. Further qualitative work is needed to expand knowledge about the types of services being offered. Finally, data missingness resulted in 18 percent of cases being removed from the regression analysis. Though no individual measure was missing on greater than 9 percent of cases, data missingness remains a limitation of this analysis.

Despite these limitations, the fact that congregations provide mental health services with such prevalence demonstrates the important role that congregations play in the provision of mental healthcare and support. This is also an important finding concerning the ways that religious congregations adapt and change to provide assistance to those in need.

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Data Availability The National Congregations Study is publicly available via the Association of Religion Data Archives (www.thearda.com) and the Inter-university Consortium for Political and Social Research at the University of Michigan (www.icpsr.umich.edu).

Declarations

Conflict of interests The author has no relevant financial or non-financial interests to disclose.

Ethical Approval The protocol of the National Congregations Study was approved by the Duke University Institutional Review Board.

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

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

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