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The Faith Community, Substance Abuse, and Readiness for Change: A National Study

Dnika J. Travis^a, Joy A. Learman^a, Drew Brooks^b, Trish Merrill^b & Richard T. Spence^c

^a The University of Texas at Austin, School of Social Work, Austin, TX

^b Faith Partners Inc., Austin, TX

^c The University of Texas, School of Social Work, Austin, TX

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The Faith Community, Substance Abuse, and Readiness for Change: A National Study

Dnika J. Travis
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ABSTRACT. There are many paths to recovery from substance use disorders, and recognition is growing for the vital role that faith communities play. This study examines a theory-driven model of congregational readiness (defined as a faith community's intention and preparedness to address and support recovery from substance use disorders) using a national cross-sectional study of 45 faith communities (composed of 3,649 members). Findings revealed that addiction and recovery attitudes and perceptions of self-efficacy (rather than one's experiences) were determinants. Directions for future research focus on developing culturally relevant means of working with faith communities and congregational leadership to bolster readiness over time.

KEYWORDS. Congregational readiness, faith communities, substance abuse, organizational and community readiness, substance use disorders, addiction and recovery attitudes and perceptions

For many individuals, spirituality and religion are important components of treatment for and successful recovery from substance abuse (Fallot, 2007; Heinz, Epstein, & Preston, 2007; The National Center on Addiction and Substance Abuse at Columbia University [CASA], 2001). Previous research has focused on the impact of religiosity on prevention (Substance Abuse and Mental Health Services Administration [SAMHSA], 2007) and the im-

pact of spirituality on substance abuse recovery (Fallot; Heinz et al.). Yet, scholars have asserted that there remains a shortage of research on the effect spirituality has in helping individuals address substance use disorders (Heinz et al.; Miller & Bogenschutz, 2007; Pardini, Plante, Sherman, & Stump, 2000).

Spirituality-based research has focused on treatment programs, particularly 12-step programs, such as Alcoholics Anonymous (see

Dnika J. Travis, MSW, PhD, is an Assistant Professor at The University of Texas at Austin, School of Social Work, Austin, TX.

Joy A. Learman, MSSW, is a doctoral student at The University of Texas at Austin, School of Social Work, Austin, TX.

Drew Brooks is Executive Director of Faith Partners Inc., Austin, TX.

Trish Merrill is a co-founder and former Executive Director of Faith Partners Inc., Austin, TX.

Richard T. Spence, PhD, is Director of the Addiction Research Institute at The University of Texas, School of Social Work, Austin, TX.

Address correspondence to: Dnika J. Travis, MSW, PhD, The University of Texas at Austin, School of Social Work, 1 University Station D3500, Austin, TX 78712-0358 (E-mail: dtravis@mail.utexas.edu).

Carter, 1998; Green, Fullilove, & Fullilove, 1998; Laudet, Morgen, & White, 2006; Zemore & Kaskutas, 2004). Additionally, a number of informative studies linking spirituality to positive recovery outcomes have already taken place. As examples, Pardini et al. (2000) identified a link between spirituality and a number of positive attributes, such as increased social support and resilience and decreased anxiety. Piderman, Schneekloth, Pankratz, Maloney, and Altchuler (2007) found that spirituality was associated with factors, such as belief in one's ability to refrain from drinking, which in turn was associated with positive recovery outcomes. Researchers have also shown that both teenagers and adults who attended weekly religious services or who stated that religion was important to them were less likely to engage in substance abuse (CASA, 2001). In addition, individuals were more likely to reach positive long-term recovery goals if they added participation in a faith-based program to their regular substance abuse treatment program (CASA).

Contrastingly, researchers have also shown that although turning to spirituality and faith communities can lead to many positive outcomes, undesirable outcomes are also possible (Fallot, 2007). For example, Giesbrecht and Sevcik (2000) argued that some faith communities may deny or mask social problems within their congregations. Feelings of guilt, blame, and shame may also ensue (Giesbrecht & Sevcik). Additionally, instead of social support, individuals may experience isolation or feel ostracized for their perceived moral weaknesses (Fallot). Thus, to minimize these possible undesirable outcomes, it is essential that faith communities are ready to provide the support needed to assist individuals in their recovery from substance use disorders.

Accordingly, this study uniquely focuses on understanding congregational readiness, which we define as a faith community's intention and preparedness to address and support recovery from substance use disorders. We specifically focus on substance use disorders, including abuse and dependency within the distinctive context of the faith community. To this end, 45 faith communities were assessed to reveal which factors are important in assessing congregational readi-

ness to support recovery from substance use disorders. A sample of 3,649 members of these faith communities participated in the study. The purpose of this exploratory study was to: 1) assess congregation members' addiction and recovery experiences, attitudes, and perceptions; and 2) gauge how these experiences, attitudes, and perceptions affect congregational readiness to help those with substance use disorders. Accordingly, the central research questions of the study are:

1. To what extent do congregation members have experiences with addictions (in self or others)? What are members' attitudes toward addiction and recovery and perceptions about the level of support one's congregation has in addressing addiction, as well as one's perceived support and self-efficacy to help others in need?
2. How do these experiences, attitudes, and perceptions influence congregational readiness to support recovery from substance use disorders?

LITERATURE REVIEW

Context

The United States of America is considered a religious nation. Results from a 2-year study of the impact of spirituality and religiousness on substance abuse demonstrated that an astounding 95% of Americans believe in God (CASA, 2001). In terms of religiosity, estimates range from 63% of Americans belonging to a church or synagogue (SAMHSA, 2007) to upward of 92% claiming a religious affiliation (CASA). Religiosity has also been shown to affect decision-making and thus impact prevention. In fact, the National Survey on Drug Use and Health (a nationally representative survey of almost 70,000 individuals, which investigated religiousness, among other topics) revealed that 75% of adult research participants stated their decisions were affected by their religious convictions (SAMHSA, 2007).

Although the United States may be considered a highly religious nation, its population struggles with a number of social issues, with

addiction to alcohol and drugs being a key issue affecting many individuals. In fact, in the United States, more than 28% of the adult population (those aged older than 18 years) drink at at-risk levels (National Institute on Alcohol Abuse and Alcoholism, n.d.). According to the representative National Epidemiology Survey on Alcohol and Related Conditions ($n = 43,093$ individuals) administered during 2001 and 2002, a total of more than 9% of Americans suffer from an actual addiction to alcohol or drugs; that is more than 19 million people (Join Together, 2004b). Furthermore, according to the findings of the National Survey of Substance Abuse Treatment ($n = 13,428$ treatment facilities), an estimated 1 million people a day receive substance abuse treatment (Join Together, 2002). Given this background, it is essential to recognize that the faith community is in a unique position to assist with the national crisis Americans are facing in terms of addiction (Hester, 2002).

For added perspective, organizations and communities in the United States have had a long history of using spiritual means to help individuals recover from addictions. This history started during the revivalist period of the late 1800s and was strengthened in the 1930s with the development of Alcoholics Anonymous (White & Whitters, 2005). Within the last decade, the importance the faith community plays in the recovery process has gained substantial attention through programs such as the Access to Recovery Program and the Center for Substance Abuse Treatment's Recovery Community Support Program, which assist in the creation and growth of faith-based organizations' involvement in substance abuse treatment services (White & Whitters). In addition, legislation referred to as "Charitable Choice" has provided faith-based organizations with greater access to federal funds in order to provide social services, including recovery services (Hester, 2002).

The White House Faith-Based and Community Initiative (WHFBCI, n.d.) has also advanced America's understanding of the role that faith-based organizations and communities play in the United States. Addressing alcohol and drug addictions was highlighted in this initiative as one of the key priorities for partnership between the federal government and faith-based

organizations (WHFBCI). This initiative's belief in the power of faith communities to address addictions is echoed by Kaplan (2008), who stated:

Faith-based organizations may serve a vital function in recovery-oriented systems of care, particularly in underserved areas and those areas with a large number of ethnic and racial minorities. Trusted by their members, they are often the center of community life, and most have a strong commitment to serving their faith community. Engaging faith-based organizations in a recovery-oriented system of care can help expand the types of recovery services offered to people and families seeking such support. (p. 10)

Readiness for Change

With a history of faith communities serving as a pathway to recovery as well as their future potential to do so, understanding readiness to develop mechanisms to support recovery from substance use disorders is paramount. This is because principles of readiness are essential to ensuring that programs are designed to fit the norms and attitudes of those most affected by the potential change (Oetting et al., 1995). For example, Beebe, Harrison, Sharma, and Hedger (2001) determined that there are five areas that affect teen substance use: perception of alcohol, tobacco, or other drug problem; support for prevention; permissive attitudes toward substance use; perception of access; and perception of community commitment. Hence, we see that readiness is linked to perceptions and support. This knowledge can shed light on the processes involved in setting the stage to address substance use disorders programmatically.

What is readiness for change? In this study, the literature on community and organizational readiness offers perspective for conceptualizing readiness in the faith community. Community readiness has been defined as "the relative level of acceptance of a program, action or other form of decision-making activity that is locality-based" (Donnermeyer, Plested, Edwards, Oetting, & Littlethunder, 1997, p. 68). Community

readiness focuses on how to mobilize communities by creating programs that match the community's level of readiness, while also being responsive to the local dynamics of the community, including its cultural heritage (Thurman, Plested, Edwards, Foley, & Burnside, 2003). Similarly, Weiner, Amick, and Lee (2008) characterized organizational readiness as "the extent to which organizational members are psychologically and behaviorally prepared to implement organizational change" (p. 3). Based on these definitions, for this study, congregational readiness is defined as faith communities' intention and preparedness to address and support recovery from substance use disorders.

Readiness can be a critical component to spark any type of change (Weiner et al., 2008) in organizations and communities. However, gearing up individuals in communities and organizations to engage in change tends to be quite involved due to the need of articulating shared values and building consensus among members (Donnermeyer et al., 1997). Nonetheless, one of the benefits of involving multiple individuals in this process is that it recognizes the capacity of community and organizational members, creates buy in, and facilitates member investment, thus ensuring that programming is culturally relevant (Thurman et al., 2003).

Research has also shown that it is essential to involve key informants to determine readiness levels (Beebe et al., 2001; Oetting, Thurman, Plested, & Edwards, 2001). Once readiness levels have been assessed, then specific individuals can be trained to foster their own capacity to effectively bring about change. Thus, these individuals are often referred to as change agents (Prochaska, Prochaska, & Levesque, 2001) and can build skills and knowledge (through training and development) to work toward creating community readiness teams (Oetting et al., 2001). Training ensures that teams can tailor programs to the community's level of readiness and to the unique attributes of the community, such as culture, community resources, and barriers (Oetting et al., 2001).

Although we know about the components that are important in moving communities and organizations toward change, the same degree of knowledge about what works for faith com-

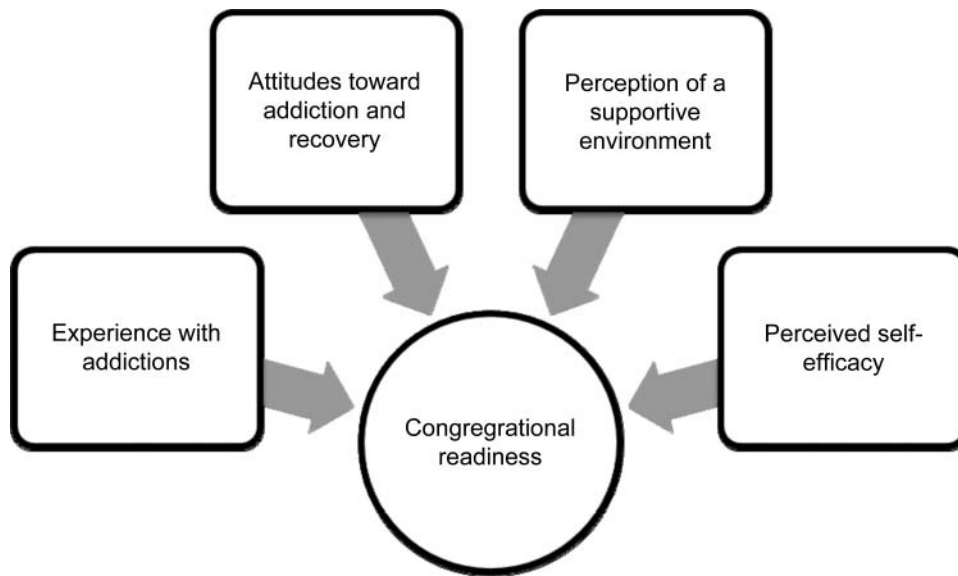
munities is relatively nonexistent. For example, we have discussed the importance of cultural relevancy while addressing readiness and we know that sensitivity to diverse faith traditions and religious views is an important component of culturally competent practice (Yarhouse & VanOrman, 1999). Yet this term takes on new meaning in the context of faith communities, in which issues of cultural relevance may center on the doctrine, theological teachings, practices, and social principles unique to each faith tradition. Hence, this study seeks to fill a gap in the literature by exploring readiness to support recovery from substance use disorders in the context of the faith community.

CONCEPTUAL FRAMEWORK

Figure 1 depicts this study's conceptual model, which features four domains of congregational readiness: experience with addictions, attitudes toward addiction and recovery, perception of supportive environment, and perceived self-efficacy. The theory of planned behavior (TPB; Ajzen, 1991) and the transtheoretical model (Prochaska et al., 2001) help guide this study's conceptual model based on the theories' emphasis on readiness and other critical change processes. These theories also have previously been used to guide change efforts at a macro level. As examples, the TPB has been used in contexts as complex as the provision of national health care (Abraham, Kelly, West, & Michie, 2009) and improvement in access to antiretroviral medication on a national level (Steyn et al., 2009). Further, the transtheoretical model has been used to help organizations create a culture for change by helping to overcome resistance and garner buy-in from organizational members (Prochaska et al.).

Additionally, the model accounts for potential differences based on one's prior experience with addictions, which is an essential component to understanding congregational readiness and is a critical domain within the model. Indeed, one's experiences with addiction and recovery may provide a glimpse into one's familiarity with or perspective on helping those in need based on a shared experience (Dunkel-Schetter & Skokan,

FIGURE 1. Congregational Readiness Model



1990). Specifically, this study takes into consideration whether a congregation member is in recovery, has a family member in recovery, or has a family member with an alcohol or drug problem. Based on early research, it would appear that having the same personal experience as another individual leads to increased empathy (Barnett, Tetreault, Esper, & Bristow, 1986) and that increased empathy can lead to efforts to help the other (Batson, Chang, Orr, & Rowland, 2002). Additionally, research on social support has shown that individuals who have experienced significant stressful events in the past may be more likely to help others undergoing similar circumstances, although this appeared to be true for drug addiction support but not alcohol addiction support (Dunkel-Schetter & Skokan).

The Theory of Planned Behavior

The TPB was developed by Icek Ajzen (1985, 1987) as an extension of the theory of reasoned action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) to account for nonvolitional factors as determinants of a behavior. To this end, the TPB was developed to accommodate the internal (i.e., individual differences, information, skills and abilities, power of will, emotions, and compulsions) and external factors (i.e., time and

opportunity and dependence on other people) that are beyond an individual's control and can impact whether or not a behavior successfully occurs (Ajzen, 1991). According to the theory, intention (understood as readiness to engage in a behavior) is determined by three related components: attitudes about a behavior including one's beliefs that the advantages of success will outweigh the disadvantages of failure; subjective norms that involve an individual's beliefs about whether others think they should comply to perform the behavior; and perceived control, which is composed of beliefs that an individual has sufficient control over internal and external factors that influence their behavior (Ajzen, 1991).

Thus, by extension, the TPB undergirds this study's conceptual model. That is, the four domains included in the model (experiences with addictions, attitudes toward addiction and recovery, perception of a supportive environment, and perceived self-efficacy in helping others) regarding factors that influence congregational readiness are informed by this theory. As a key model domain and consistent with the TPB, attitudes help provide insight into member beliefs about a specific behavior (Ajzen, 1991). In this domain of congregational readiness, attitudes involve the extent to which congregation members think it is important for the faith community—and their

congregation in particular—to help those who have alcohol- and drug-related issues. Attitudes also include whether or not individuals are interested in learning about addictions and/or recovery. This study pays special attention to assessing the attitudes of congregation members because attitudes have been linked to helping behaviors (Batson et al., 2002) and thus, for the purpose of our study, readiness to support recovery.

Just as subjective norms are shaped by one's social environment (Coleman, 1988), one's perception of one's environment can also influence an individual. Moreover, this perception provides clues into contextual and situational considerations that can impact one's familiarity with alcohol and drug issues. Specifically, we consider one's perception of the supportive resources offered by a congregation. This perception of supportiveness can influence whether an individual considers the congregation as a safe place to turn to when impacted by addiction-related issues. Ultimately, this perception may affect an individual's ability to assist another, as well as to engage in help-seeking behaviors themselves.

Research has also shown that self-efficacy affects which behaviors we engage in and how much effort we put into them (Bandura, 1980). In fact, "perceived efficacy predicts levels of behavior change" (Bandura, Adams, Hardy, & Howells, 1980, p. 40). In fact, research has shown that individuals are more likely to engage in a behavior, such as helping someone else, if they feel competent and knowledgeable (Bandura & Schunk, 1981). Thus, in this study, self-efficacy is related to readiness and is defined as congregation members' reported beliefs that they have the ability to help others with addiction-related issues. Specifically, self-efficacy is viewed as one's comfort and confidence in promoting recovery by helping others.

Transtheoretical Model

Most noted for reflecting individual levels of change, the transtheoretical model is also quite adaptable to organizational settings (Prochaska et al., 2001). The model includes five stages of change (Prochaska et al.); however, alternative stages have been developed to directly as-

sess community readiness (Oetting et al., 2001). The original five stages of change are as follows: precontemplation (one's sense of helplessness to change a situation); contemplation (convinced change is needed, but without a specific commitment to change); preparation (seeking help to find information to support change); action (one's steps toward change); and maintenance (action toward creating stability to sustain change; Prochaska et al.).

Proponents of the transtheoretical model have argued that stage assessment is important because it is essential that a community is sufficiently ready prior to instituting a new program (Prochaska et al., 2001). Further, Oetting et al. (2001) asserted that interventions need to be tailored to match the unique requirements of each stage level. This tactic acknowledges that change is difficult and that action cannot be successful if it is forced on individuals without them being prepared first (Prochaska et al.). This principle has been applied to individuals, community members, and employees, and thus, we argue its use can be extended to congregation members as well. Hence, it offers useful insight on how to move congregation members toward action in supporting those recovering from substance use disorders.

METHODOLOGY

Study Design

This current study involves secondary analysis of cross-sectional data of 45 U.S.-based faith communities' readiness to support recovery from substance use disorders. The institutional review board of record approved all study protocols. The data were collected as part of a larger study evaluating the effectiveness of an 18- to 24-month leadership and congregation team ministry development program. Programs were included in the study based on: 1) a rolling enrollment period that began in June 2007 and ended in July 2008; 2) the establishment of leadership for the program in the participating congregation; and 3) the completion of the 24-item Congregational Readiness Questionnaire upon enrollment into the program.

As context, the congregation team ministry development programs (congregation teams) were created by a nonprofit organization in the Southwestern United States that assists leaders in faith communities (both clergy and laity) in the initiation, development, and sustainment of team ministries to support recovery from substance use disorders and in the engagement of prevention, early intervention, referral assistance, and advocacy. However, this study focuses solely on recovery from substance use disorders. Participating faith communities received training and consultation in five key areas of program development: 1) leadership, 2) team, 3) ministry, 4) programming, and 5) infrastructure. The congregation teams then mobilized their faith community's resources to address addiction issues and work toward building lasting change.

Sampling and Data Collection

A nonrandom national sample of 3,649 members within the 45 participating faith communities completed the Congregational Readiness Questionnaire. The congregation teams received the questionnaires and detailed data collection protocols upon the faith community's participation in the program. Questionnaires were then distributed to congregation members by each faith community's congregation team. The teams chose their method of distribution based on what would be the most effective for their congregation. The most common methods included distribution during weekly worship services and small group activities, as well as inclusion in membership mailings. Once completed, the teams collected and returned the questionnaires to a university-based research center focused on addictions. Following analysis, each faith community received an individualized report outlining descriptive information about their congregation and its responses to the questionnaire. This information was used to inform the work of the team ministries. To protect the anonymity of members, personal identifying information was not collected on any congregation member.

Description of Study Sample

Table 1 provides information on the demographics of the study sample. The majority of

TABLE 1. Description of the Study Sample

Characteristics of the Participating Faith Communities (<i>n</i> = 45 congregations)	Valid Percent
Region	
Southeastern	46.2%
South Central	38.2%
North Central	4.0%
Western	7.7%
Northeastern	3.9%
Faith Tradition	
United Methodist	67.5%
Episcopal	8.3%
Baptist	8.2%
Jewish	7.9%
Nondenominational	2.5%
Presbyterian	2.1%
Assembly of God	1.2%
Mennonite	1.0%
United Church of Christ	0.5%
Methodist Episcopal	0.5%
Church of God in Christ	0.3%
Member Characteristics (<i>n</i> = 3,649 individuals)	
Age	
17 years and younger	9.5%
18–24 years	3.8%
25–34 years	6.2%
35–44 years	14.5%
45–54 years	22.4%
55–64 years	19.5%
65+ years	24.2%
Gender	
Female	62.4%
Male	37.6%

the faith communities included in this study were United Methodists (more than 67%). All regions of the United States were represented, with most of the representation from the Southeastern and South Central states. The ages of the congregation member participants varied, with most being aged 45 years and older. The majority of the respondents were women (62.4%).

Instrumentation

The 24-item Congregational Readiness Questionnaire was developed specifically for this study and the team ministry development program. The questionnaire was developed in consultation with experts from two university-based

addictions research and behavioral health centers.

Demographic Variables

Gender and one's age category (categorized as 17 years and younger; 18 to 24 years; 25 to 34 years; 35 to 44 years; 45 to 54 years; 55 to 64 years; and 65 years and older) were captured to gauge basic demographic information about each faith community's membership. The faith tradition and the geographic region for each participating congregation were also recorded.

Experience With Addiction

Three single-item questions were used to create a composite scale that gauged the extent to which congregation members have personal experiences with different types of addictions. The first part of these questions asked, "Do you have a family member who has a problem with . . .?"; "Do you have a family member who is in recovery from an addiction to . . .?"; and "Are you in recovery from an addiction to . . .?" Respondents then selected the types of addiction-related problems that applied to them. "Alcohol" and "drugs" were listed as two of the response choices for this series of questions. The resultant response choices were dichotomous, with "1" reflecting experience with addictions and "0" indicating no experience.

Attitudes Toward Addiction and Recovery

Three variables were included in this study that assessed member attitudes toward addiction and recovery. Two of the variables were single items: "Are you interested in learning more about addictions?" and "Are you interested in learning more about recovery?" Respondents could select "Yes" or "No." The study assessed members' beliefs on the importance of the faith community to help those with addictions to alcohol and/or drugs. A scale was used to reflect the average of the following two items: "How important is it for the faith community to help those who may have problems with alcohol or drugs?" and "How important is it for our congregation to help those who may have problems with alcohol or drugs?" Response options included: 0, "I don't

know"; 1, "not at all"; 2, "not too important"; 3, "somewhat important"; and 4, "very important." The Cronbach's alpha on this scale was .86.

Perception of Supportive Environment

One's perception of the supportiveness of their congregation's environment with regard to handling addiction-related issues was captured using a seven-item scale created for this project. The responses were based on self-report, as opposed to an actual inventory of activities. These questions measure the respondents' perception of their environment. Each item asked respondents to indicate the extent to which one's congregation engages in several activities geared toward creating a supportive environment for addressing alcohol and drug problems. Example items include: reaches out to people who suffer from addiction, and sponsors programs to help spouses talk to one another about alcohol. Response choices were scored on a 5-point scale. Response options included: 0, "I don't know"; 1, "to no extent"; 2, "to a lesser extent"; 3, "to some extent"; and 4, "to a great extent." The scores for items were averaged to create one measure for knowledge of supportive resources. The Cronbach's alpha on this scale was .919.

Perceived Self-Efficacy

One's perception of their ability to help those who may have a problem with drugs and alcohol was captured with a two-item scale created for the study. The scale score was computed based on an average of the items. The questions were: "How comfortable do you feel talking with someone about their alcohol, drug, or other addiction problems?"; and "How confident are you about helping young people make good decisions about alcohol, tobacco, and other drugs?" Response options included: 0, "I don't know"; 1, "not at all comfortable/confident"; 2, "not too comfortable/confident"; 3, "somewhat comfortable/ confident"; and 4, "very comfortable/confident." The Cronbach's alpha on this scale was .67.

TABLE 2. Bivariate Correlations

	1.1	1.2	1.3	2.1	2.2	2.3	3	4	5
1.1 Self in recovery	1								
1.2 Family member in recovery	.294**	1							
1.3 Family member has problem	.219**	.519**	1						
2.1 Interest in learning about addictions	.108**	.112**	.179**	1					
2.2 Interest in learning about recovery	.095**	.117**	.170**	.715**	1				
2.3 Perception of importance	.050*	.102**	.096**	.213**	.212**	1			
3. Perception of supportive environment	.079**	.081**	.072**	.052**	.027**	.097**	1		
4. Perceived self-efficacy	.172**	.127**	.142**	.223**	.211**	.227**	.161**	1	
5. Congregational readiness	.069**	.090**	.095**	.104**	.105**	.149**	.537**	.164**	1

* $p < .01$. ** $p < .001$.

Congregational Readiness

Congregational readiness was measured by a single question: "Overall, how ready is our congregation to help those who have alcohol or drug problems?" Response options included: 0, "I don't know"; 1, "not at all ready"; 2, "not too ready"; 3, "somewhat ready"; and 4, "very ready." This item was developed specifically for this project to assess organizational readiness for change in a faith community.

Data Analysis

First, descriptive analyses were conducted for all demographics and major study variables. Frequency and percentage statistics were computed for the demographic variables of gender and age, as well as for the three study constructs (experience with addictions, interest in learning about addictions, and interest in learning about recovery). Measures of central tendency and dispersion were also computed for the interval-level variables: attitudes toward addiction and recovery, perception of a supportive environment, and perceived self-efficacy. Bivariate correlations were also examined for multicollinearity for all model variables (see Table 2). Finally, hierarchical multiple regression procedures (Gelman & Hill, 2007; Tabachnick & Fidell, 2001) were used to examine the relative contribution of member's experiences and beliefs regarding congregational readiness (see Table 4). Dummy codes were created for each experience with addiction variables and the two variables regarding interest in learning about addictions

or recovery. Each set of variables comprising the domains of congregational readiness were entered as four blocks into the model (Block 1: experience with addictions; Block 2: attitudes toward addiction and recovery; Block 3: perception of a supportive environment; and Block 4: perceived self-efficacy). This technique allows for determining the relative contribution of each set of predictors (Tabachnick & Fidell).

RESULTS

This study sought to explore predictors of faith communities' readiness to support recovery from substance use disorders. Our first research question centered on gaining a better understanding of members' experiences with addiction, attitudes toward addiction and recovery, perception of a supportive environment, and perceived self-efficacy in supporting others. Next, we sought to answer our second research question to understand how these experiences and beliefs influence congregational readiness to address alcohol and drug problems. We discuss these findings below.

Addiction-Related Experiences, Attitudes, and Perceptions

Congregation members reported having had some experience with addiction, mostly with a family member, rather than themselves. Approximately one third (35.7%) of respondents reported having a family member with an alcohol or drug problem, and more than 22.4%

reported that they also have a family member in recovery. Roughly 5% (4.9%) of members reported they are in recovery from alcohol or drugs themselves.

Attitudes toward addiction and recovery were reflective of member interest in learning about addiction or recovery and the level of importance that members reported should be given by faith communities to helping others with addictions. Thirty-four percent (34.3%) of respondents indicated an interest in learning more about addictions, and a slightly greater interest was shown in recovery (37.1%). The mean score of 3.69 ($SD = 0.62$) for perception of importance that the faith community address addictions was seemingly high (responses ranged from 0 ["I don't know"] to 4 ["very important"]), suggesting that respondents felt favorably that the faith community and their congregation in particular should address substance abuse issues.

A supportive environment toward helping those with alcohol and drug issues was reflected by members' belief that their congregation reaches out to those in need, sponsors programs, and teaches others about addictions. Respondents' mean level of perception regarding the supportiveness of their environment was 1.60 ($SD = 1.22$). Responses ranged from 0, meaning "I don't know," to 4, meaning "to great extent." This indicated a low-to-moderate level of perceived environmental support in their congregation.

Respondents also showed that they perceived they had a slightly higher than moderate level of comfort and confidence in talking to or providing help to those with addiction problems. The mean score was 2.75 ($SD = 0.84$). Responses ranged from 0, meaning "I don't know," to 4, meaning "very comfortable/confident."

Congregational Readiness to Address Substance Use Disorders

Descriptive statistics provided insight into the reported level of readiness to address recovery from a substance use disorder (see Table 3). As such, a mean readiness score of 1.82 ($SD = 1.46$) indicated that members perceived their communities were moderately ready to address recovery from substance use disorders as an organization.

TABLE 3. Congregational Readiness

Don't know	33.6%
Not at all ready	4.9%
Not too ready	18.5%
Somewhat ready	31.5%
Very ready	11.5%

Range: 0 ("don't know") to 4 ("very ready").

To this end, roughly 30% of the respondents were unsure of whether their congregation was ready, and more than 40% felt that their faith community was somewhat-to-very ready.

Hierarchical multiple regression was used to examine the experiences and beliefs of faith community members on congregational readiness to help those with alcohol and drug problems (see Table 4). In the first step, the three variables on experience with addiction were entered into the model. Although the model was statistically significant ($F = 15.02$, $df = 3$, 3,645, $p < .001$), all three variables accounted for only 1.1% of the variance in congregational readiness. In the second step, three variables reflecting member attitudes toward addiction were added as predictors. The model was statistically significant ($F = 20.76$, $df = 6$, 3,642, $p < .001$) accounting for 3.1% of the variability in congregational readiness. Step 3 included congregation members' perception of the level of support that their congregation provides to foster an environment to address problems with addiction, as well as support recovery. This model was statistically significant ($F = 182$, $df = 8$, 3,640, $p < .001$). The introduction of this variable accounted for 28.3% of the variance in the analysis (F -change = 1,277.39, $df = 1$, 3, $p < .000$). This shift demonstrates that perception of a supportive environment has a significant link to congregational readiness. The final model that included perceived self-efficacy was statistically significant, adding an additional 0.2% variability to the model ($F = 182.09$, $df = 8$, 3,640, $p < .001$).

The final model yielded four statistically significant predictors of congregational readiness. First, member interest in learning about recovery ($b = .153$, $p < .01$) and perception that faith communities should help those with alcohol and

TABLE 4. Hierarchical Multiple Regression

	<i>b</i>	SE <i>b</i>	β	R ²
STEP 1				.011
Self in recovery	.256	.107	.041*	
Family member in recovery	.148	.068	.044*	
Family member has an alcohol or drug problem	.175	.056	.060**	
STEP 2				.031
Self in recovery	.216	.106	.035*	
Family member in recovery	.118	.066	.035	
Family member has an alcohol or drug problem	.125	.056	.043*	
Interest in learning about addictions	.095	.069	.032	
Interest in learning about recovery	.108	.068	.037	
Perceived importance	.264	.038	.118**	
STEP 3				.283
Self in recovery	.043	.091	.007	
Family member in recovery	.049	.056	.015	
Family member has an alcohol or drug problem	.083	.049	.028	
Interest in learning about addictions	.029	.060	.010	
Interest in learning about recovery	.163	.058	.056**	
Perceived importance	.169	.033	.075**	
Perception of supportive environment	.593	.017	.506**	
STEP 4				.284
Self in recovery	.012	.092	.002	
Family member in recovery	.047	.056	.014	
Family member has an alcohol or drug problem	.077	.049	.026	
Interest in learning about addictions	.016	.060	.006	
Interest in learning about recovery	.153	.058	.053**	
Perceived importance	.153	.033	.068**	
Perception of supportive environment	.587	.017	.501**	
Perceived self-efficacy	.072	.025	.043**	

* $p < .01$. ** $p < .001$.

drug problems ($b = .153, p < .001$) demonstrate attitudes that were connected to congregational readiness. Next, members' perception that their congregation had a supportive environment was significantly related to congregational readiness ($b = .501, p < .001$). Finally, the relationship between perceived self-efficacy and congregational readiness was statistically significant ($b = .072, p < .01$).

DISCUSSION

This study makes a significant contribution to the very limited academic literature on substance use disorders and congregational readiness in a number of areas. First, this study provides information on the experience of congregation members in relation to addiction. It also gives insight into congregation members' beliefs about the

role of faith communities in supporting recovery, as well as one's perceived self-efficacy to help others struggling with alcohol or drug problems. Finally, this study provides promising information on the influence of these experiences and beliefs on congregational readiness to support recovery from substance use disorders. Previous to this exploratory study, researchers had little information on which to build a foundation for investigating how to work with faith communities to help individuals in recovery.

Addiction-Related Experiences, Attitudes, and Perceptions

Specifically, this study found that about one third of respondents reported having a family member with an alcohol or drug problem and more than 20% reported also having a family

member in recovery. These numbers are lower than those collected in other research studies in which 63% of respondents reported that an addiction impacted their lives (Join Together, 2004a). For the vast majority of these individuals (72%), the impact was through a family member (Join Together, 2004a). Another nationally representative study conducted by SAMHSA utilizing phone surveys ($n = 1,010$) found that approximately 50% of adult respondents know someone in recovery (SAMHSA, n.d.). The lower reported rate for the congregation members who participated in this study may be due to the lower rates of substance abuse found among those who attend religious services (CASA, 2001). Moreover, research has shown a general trend of underreporting in substance use due to social desirability factors (Johnson & Fendrich, 2005), which may be stronger within the context of a religious setting.

This study also found that respondents had a low-to-moderate perception of the supportiveness of their congregation with regard to promoting recovery from substance use disorders. Nonetheless, members expressed interest in learning more about addiction and recovery. Moreover, respondents felt favorably that the faith community and their congregation should address substance abuse issues. These findings bolster those published by SAMHSA, which stated, "A majority of Americans (80%) have positive feelings about prevention and recovery from substance addictions" (n.d., p. 1). Similarly, approximately the same percentage of Americans believes that spirituality can support addictions recovery (CASA, 2001). Interestingly, this study's respondents also showed they perceived a moderate level of comfort in talking to or providing help to those with addiction problems.

These findings provide valuable knowledge because traditionally this type of information has not been collected from members of congregations. Instead, the focus has generally been on the views of faith leaders (see Hodge & Pittman, 2003). For example, research has shown that addiction-related issues have been deemed critical by more than 90% of faith leaders (CASA, 2001). Furthermore, more than a third of surveyed faith leaders have revealed that

they feel the majority of problems they face in their congregations are due, at least in part, to substance abuse (CASA). The information revealed in this study provides useful insight into the views and knowledge of congregation members—individuals who will be crucial in supporting and participating in faith community efforts to engage in recovery support.

Congregational Readiness

This study revealed that congregation members reported varied levels of perceived readiness regarding their faith community's support of addictions recovery. While more than 40% felt that their faith community was somewhat-to-very ready to help, one third reported not knowing whether their congregation was ready to engage in this type of effort. When considering congregational readiness, the study findings uncovered the importance of a number of factors, such as the congregation members' interest in learning more about recovery; belief that it is important for their congregation to address substance use disorders; perception of a supportive environment to promote recovery; and perceived ability to help others with addiction-related problems.

These results highlighted key perspectives of the faith community regarding substance abuse and readiness for change in three distinct areas. First, one's experience with addictions (for either self or a family member) was not significantly associated with congregational readiness when considered with members' addiction-related beliefs. Based on previous literature, we had assumed that previous experience with a social problem would increase one's desire to help others (Dunkel-Schetter & Skokan, 1990). Our study findings did not support this conclusion. Therefore, additional research is recommended on this topic. Initially in the previous models, however, experiences were significantly related to congregational readiness. This minimization of experiences in the final model underscores the importance of beliefs as a key component of readiness. The focus on beliefs is aligned with the TPB, as it asserts that individual attitudes, subjective norms, and self-control are indicative of one's intention or readiness to support (Ajzen,

1991). Our focus on member attitudes toward alcohol, perception of a supportive environment, and perceived self-efficacy are reflective of these TPB components.

Next, the study findings demonstrated that having a supportive environment is critical to congregational readiness. As such, we specifically homed in on the extent to which members felt that their faith community sponsors programs for addiction-related problems, teaches people about alcohol and drug issues, and reaches out to those in need. Strikingly, when this combined variable was entered into the model (in Step 3), it accounted for 25.2% of the change in the variability of congregational readiness (from 3.1% to 28.3%). This percent contribution to the variance of the analysis remained fairly consistent in Step 4 (from 28.3% to 28.4%), in which perceived self-efficacy was entered into the model. This finding echoes previous research that has demonstrated the importance of a supportive environment, namely social integration, in sustaining recovery and preventing relapse (Havassy, Hall, & Wasserman, 1991).

Finally, taking a step back, this study's findings emphasize the value of the positive aspects of promoting change in faith communities around substance use disorders. To this end, learning about recovery, building a supportive environment, and feeling confident in one's ability to help someone with an addiction were all significant predictors of congregational readiness. Comparatively, one's experience with and interest in learning about addictions were not related to congregational readiness. Simply stated, the more members were drawn to learning about recovery and helping others and the more they perceived their congregation as active in these areas, the greater their sense of readiness. These findings are consistent with current paradigm shifts in the addictions field from focusing on treatment toward creating a movement for long-term recovery (White, 2000). Also, models of positive organizational behavior emphasize building on what is going well with organizations to help sustain change, as opposed to deficit-focused models that aim to repair or limit crises or problems (Luthans, 2002a, 2002b; Spreitzer, Sutcliffe, Dutton, Sonenshein, & Grant, 2005).

Study Limitations

This study utilized a cross-sectional analysis method and a nonrandom sample. Therefore, although it was a national study, it lacks generalizability. It has been documented that difficulties in obtaining a representative sample have been common in research regarding faith communities (Chaves, 1999). This study experienced the same challenge because the sample was mostly from the United Methodist Church and only included Christian and Jewish congregations. The study sample included a high percentage of United Methodist congregations because the study was conducted in the middle of a project the nonprofit organization was conducting with the Special Project on Substance Abuse and Related Violence of the United Methodist Church following its endorsement of the program's congregational team leadership model. All congregations that participated in the study had a previous relationship with the nonprofit organization prior to the beginning of the study.

In addition, the majority of questionnaires were distributed during weekly worship services; therefore, individuals associated with the congregations who may not attend weekly services or who missed the service during which questionnaires were distributed were unintentionally excluded from the study. Furthermore, this distribution strategy did not provide us with information regarding which responses were from faith leaders versus regular members. This information could have provided useful insight; however, individuals were not designated in this manner in an effort to maintain the anonymity of research participants. Finally, the study focused only on recovery. Beneficial and useful information could have been gained by investigating prevention as well. We recommend that future research investigate the prevention of substance use disorders, as well as the recovery from them.

CONCLUSION AND FUTURE DIRECTIONS

There are many different paths to recovery from substance use disorders, and recognition is continuing to grow for the key role that

faith-based organizations play in the recovery process (SAMHSA, 2010; White & Whitters, 2005). The importance of addressing substance use disorders within the context of faith communities is best expressed in the following quote by Joseph Califano Jr., chairman and president of CASA and a prominent leader in the field. He states: "If ever the sum were greater than the parts, it is in combining the power of God, religion and spirituality with the power of science and professional medicine to prevent and treat substance abuse and addiction" (CASA, 2001, p. i). Therefore, it is essential to continue to find ways of translating what the literature teaches us about community and organizational readiness and applying it to the unique context of faith communities.

As such, this study offers several directions for practice and future research through a rare insight into congregational members' attitudes and experiences about addiction and recovery as key factors for congregational readiness. This is essential as individual members may play an instrumental role in participating in and sustaining the efforts of the faith community to engage in recovery support.

First, this study speaks to the importance of assessing faith communities' readiness and preparation to support recovery from substance use disorders. The utilization of readiness assessments may help faith communities move toward action and lay the groundwork for facilitating the transitions necessary to provide the longer-term, more in-depth services needed by their members as well as the broader community. In so doing, positive, long-term recovery outcomes may be supported by creating safe and supportive environments in which addiction-related issues can be addressed early on in an affirming manner. This is essential because when compared to research linking spirituality and recovery, limited research exists on the role of faith-based providers in terms of supporting addiction recovery programs (Cnaan & Boddie, 2001; Hester, 2002; Hodge & Pittman, 2003; Neff, Shorkey, & Windsor, 2006).

Further, although previous research has shown that between approximately 60% and 90% of congregations provide at least one social service program, congregations may be less

likely to address long-term social issues (Chaves & Tsitsos, 2001). Thus, it is estimated that less than 10% of congregations offer programs addressing health and education issues, including substance abuse programs (Chaves & Tsitsos). As such, it can be assumed that an unmet need exists in the faith community. On one hand, individuals struggling with substance use disorders may be willing to seek assistance from their faith community. Yet, on the other hand, faith communities may not have the programmatic structures in place to provide coordinated services to address this need. This has implications for practice and research in terms of developing the readiness and capacity of congregational leadership and members to support individuals struggling with substance use disorders.

Next, the study findings offer insight into which factors are germane to addressing a faith community's readiness to tackle addictions and support recovery. Chaves and Tsitsos (2001) showed that size and financial strength of the congregations, location, and religious tradition impact how much faith communities engaged in the provision of social services. However, based on the TPB as well as the community and organizational readiness literature, the current study found that other attitudinal factors were associated with congregational readiness. These include members' interest in learning about recovery and perception of a supportive environment, as well as their confidence in their ability to help others. This has practice implications in terms of working with members to raise awareness of substance use disorders and increases members' efficacy in supporting others in the recovery process. This is a budding area for further research to better understand how enhancing congregational readiness among members and leaders impacts the effectiveness of recovery-oriented programs in faith communities.

In addition, study findings may also assist in the development of culturally relevant means of working with faith communities by showing how to integrate their services with knowledge in the field while recognizing their unique and important contributions toward healing and recovery. Previous research has shown that treatment is most effective when it complements an individual's beliefs and culture (White &

Whiters, 2005). For faith communities, cultural issues may center on their diverse and unique doctrines, traditions, teachings, and practices regarding the use of substances. Therefore, to be culturally relevant, programs may benefit from being designed in a way that fits, honors, and upholds these social and theological beliefs and practices. Ultimately, the lesson learned from research and assessment about congregational readiness to support recovery from substance use disorders may also be applied to a range of other social issues experienced by congregation members, such as domestic violence, mental health issues, and suicide prevention.

Finally, this study points to the need for further research on the long-term effectiveness of readiness and capacity-building initiatives that help faith communities meet the recovery needs of their members (CASA, 2001; Hodge & Pittman, 2003). As efforts to support recovery from substance use disorders require a multidisciplinary approach (White & Whiters, 2005), we hope this study demonstrates how to increase collaboration between the faith community and academic institutions to conduct research that reveals useful information for assisting those dealing with an addiction. This improved partnership will assist faith leaders, only 12.5% of whom have received any academic preparation on the topic during their seminary training (CASA), as well as social service and medical providers who may not always give sufficient recognition to the important role of spirituality in recovery from addictions (CASA).

In summary, this study's findings fill a gap in the academic literature regarding how to assess readiness to support recovery from substance use disorders at the congregational level. This study offers direction for research on this topic and brings to light the role of the congregation members who will be the mainstay when it comes to changing the attitudes, norms, activities, and environment of their faith communities. It is our hope that this study launches further research that focuses on developing culturally relevant means of working with faith communities and on identifying additional factors associated with congregational readiness. In this way, lessons will be learned so that more individuals struggling with substance use disorders will find the

available support they need when they turn to their faith community.

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