OPENING THE BLACK BOX OF FAITH-BASED SERVICES: MEASURING PROGRAM COMPONENTS AND TREATMENT DOSE

Fred J. De Jong
Claudia Horn

What is the significance of faith in substance abuse recovery programs? How is faith used and in what ways does it help a person recover from addiction? Is faith in God, relationships with others, or both the way to a clean, sober, and more responsible lifestyle? These are some of the questions that inspired 17 Gospel Rescue Missions (GRMs)—faith-based providers of substance abuse treatment and recovery support programs that rarely receive state or federal funding—from around the country to participate in a pilot study to help translate *faith* into measurable research indicators. This research involved working with the leadership and staff of these GRMs to engage in a process to help define and measure the faith-motivated help provided to homeless and drug-dependent persons. The aim of this research was to document the nature of the GRMs' work and to lay the foundation for testing program effectiveness.

The role that faith plays in faith-based organizational settings is not well understood (Johnson, 2002). Thus, there is a need to better understand how faith is defined at the organizational level in terms of services and interactions with clients and at the client level in regard to how individual faith is related to behavioral outcomes (Jeavons, 1994). This paper reports on a unique pilot study that examined the faith-based service provision of the GRMs.

To develop measures of the components of faith that permeate the GRMs at the organizational and service levels, work groups were convened composed of various staff members and interviews conducted with key stakeholders about the organizational mission and services. The information derived from these activities resulted in a set of initial measures of organizational faith that were piloted through a Web-based survey with the 17 GRMs. This paper reports on the results of the pilot survey measuring organizational faith, client faith, and the interactions between providers and clients. Follow-on research will focus on examining the effects of the program faith components on client outcomes, such as substance abuse and recovery.

A MIXED PUBLIC-PRIVATE SYSTEM OF CARE

When examining the role of faith in social service programs, it is helpful to review the history of and role that faith has played in the development of social service provision. The founders of our nation discussed the importance of "public religion," as Ben Franklin called it, to promote moral

consensus and improve public life. “The great news about America,” according to Jon Meacham (2006) “is that religion shapes the life of the nation without strangling it.… The balance between the promise of the Declaration of Independence, with its evocation of divine origins and destiny, and the practicalities of the Constitution, with its checks on extremism, remains perhaps the most brilliant American success” (p.5).

Given this context, it is not surprising that religious institutions have long played an important role in social service delivery in the United States. For example, the colonists responded to the needs in their communities in the ways they had been taught and had observed in their homelands, where churches and synagogues took the lead in providing communal support for the poor ever since the breakup of Europe’s feudal estates (Specht & Courtney, 1994). Settlement houses, the message of the social gospel, and a multitude of charity organizations—from the international reach of the Salvation Army to the tiny one-person ministry that serves a neighborhood’s troubled youths—represent the diverse influences that shape the present-day response to those in need (Ellor, Netting, & Thibault, 1999).

The historical result of these efforts is a mixed public-private human services delivery system that depends largely on federal resources, is often administered by states, and sustains many thousands of local voluntary organizations with programs to serve populations in need (Karger & Stoesz, 2005). Most localities offer publicly delivered services, such as child protective services, and contract with private, community-based providers, many of which are faith-based (Ambrosino, Heffernan, Shuttleworth, & Ambrosino, 2001). Local entities providing publicly funded services often represent a variety of religious motivations or may have no religious orientation at all, such as advocacy organizations for the disabled, local urban leagues, associations for the blind, labor unions, and fraternal organizations (Karger & Stoesz, 2005).

A Changing Service Delivery Environment

Recently, there are new opportunities for faith-based organizations, particularly small organizations and congregations, to compete with secular organizations for federal grants and support, while maintaining their religious identity (Cnaan & Boddie, 2002). The Charitable Choice provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and the current Centers for Faith-Based and Community Initiatives in 10 major federal agencies encourage faith-based and community-based initiatives. The Bush administration has recognized the trust much of the public places in the role of faith and faith-related organizations to facilitate individual change in program participants (Boddie and Cnaan, 2006; Smith & Sosin, 2001). Moreover, many people believe that persons with religious commitment “go above and

beyond the call of duty with clients or act in ways that inspire an unusual degree of trust among program beneficiaries" (Dilulio, 2002, p.56).

BUILDING AN EMPIRICAL BASE FOR FAITH-BASED SERVICE DELIVERY

Although public policy and public discourse may support faith-based and community-based initiatives, there is little empirical evidence to support the relative effectiveness of faith-based versus secular service delivery. Johnson (2002) noted that although much has been written about faith-based interventions, very few sources specify the exact elements of the intervention. If faith-related services are to compete for mainstream resources, decision-makers will require evidence of effectiveness. The standards for testing effectiveness are well-known, but they are rarely applied to the majority of human service interventions (Johnson, 2002). Thus, more rigorous evaluation studies are essential to gain transparency in the "appropriate management and design of social service in specific settings for particular groups of clients" (von Furstenberg, 2006, p.58).

The Current Literature

The literature presents an emerging body of empirical findings related to faith-based social service delivery, welfare-to-work programs, youth and parent education models, transitional housing, and substance abuse treatment. However, faith-based service evaluation is in its infancy (Boddie & Cnaan, 2006). Overall, the extant research has found that faith-based services are neither inferior nor superior to services provided by secular organizations.

Boddie and Cnaan (2006) recommended key "next steps" for developing the knowledge base on faith-based services, such as applying social science methods to help open the "black box" of faith-based service delivery to increase understanding of the services that clients actually receive and how these services make a difference in their lives. Specifically, Boddie and Cnaan suggest research to carefully measure the extent of faith-based program elements in a particular service and to track participant exposure to faith components. Outcome measures should be specific enough to link the faith-based aspects of a service to client change over time. Grettenberger, Bartkowski, and Smith (2006) further recommended that future research use secular comparison groups to help determine the differential effect of faith-based services, and warned against selection biases that may funnel only some types of clients, such as the most religious or the most motivated, to faith-based services. An additional key research concern is sample size (Boddie & Cnaan, 2006; Grettenberger et al., 2006). Thus, future research should recruit larger

and more representative samples of clients and take steps to limit the high attrition or loss of study participants during the course of a study.

CONCEPTUAL CLARITY: MEASURING PROGRAMMATIC FAITH

Measurements of faith can benefit from a history of testing as well as several well-established scales, such as the Faith Maturity Scale (Benson, Donahue, & Erickson, 1993). Research is beginning to test ways of measuring faith and its role in individual health outcomes. Koening, McCullough, and Larson (2007) reported that the connection between faith and various health and mental health variables has been widely studied. Fowler's (1981) stages of faith development provide a helpful way to measure the function of faith through the life span. On a clinical level, social work practitioners use spiritual assessment as a way to evaluate their clients (Hodge, 2001).

However, faith in the context of program service delivery requires new ways to measure its effect on social service delivery models. Positive outcomes cannot be replicated if a study does not identify the type of faith components delivered, how much of this component was received (i.e., the dose), and the mode of delivery (e.g., group treatment, counseling, nonstaff lay mentoring). As in other human service interventions, a goal for faith-based program evaluation is to provide clear and systematic measurement of both the helping process and expected individual outcomes. To accomplish this, it is necessary to understand what faith means and how it is applied in social service programs.

A program's faith elements and the manner in which they are communicated are referred to as "programmatic faith." DiIulio (2002) views programmatic faith as the expression of organizational religiosity through a variety of program components. Programmatic faith can be a measurable component of a service, with its own measures of activities and related outcomes. Individual change through a faith-based service program could be seen as the product or result of a program's "value-expressive activity" on behalf of its organization's mission (Jeavons, 1994).

Defining Faith

Researchers have just begun to develop specific measures of programmatic faith; however, it is clear from the literature that there are no "one size fits all" measures of faith. The definition of faith may vary depending on the program and organizational context. One approach developed by Unruh and Sider (2005) delineates nine elements of faith-based programs with which to measure programmatic faith: religious references in program self-descriptions, objects with

religious associations in the program environment, invitations to a religious service or activity, use of prayer in service provision, use of sacred text in service provision, worship, sharing of personal testimonies, religious teachings or discussions, and invitations to a personal commitment to faith or spiritual renewal. Although Unruh and Sider's conception of programmatic faith more closely inspects faith-related program elements, it mixes program descriptions, service environment measures, curricular content, modes of worship, and personal activities particular to only some faith traditions.

Hugen, De Jong, and Venema (2005) added clarity to Unruh and Sider's approach by developing a distinct set of countable measures of organized, faith-related program services. They developed three distinct measures of programmatic faith: the centrality of spirituality within a program, the manner in which a program communicates its faith content to those it serves, and the type and frequency of faith-related program elements matched to a particular faith tradition. These three elements guide the development of measures capturing the faith framework of organizations. The next step in the measurement process is to make these measures specific to the organization's service components and religious elements.

IDENTIFYING A PROGRAM'S FAITH FRAMEWORK

Selecting ways to measure a program's faith-related components requires an intimate knowledge of the program's faith framework. Valid measures will reflect the meaning and intended effect of each of the program's components, which originate in the organization's system of beliefs and resulting program choices.

In human services organizations in particular, organizations use implicit moral theory about human needs to select the appropriate problems their organization seeks to address. Hazenfeld (1983) noted that an organization's set of beliefs present "desired moral values to be upheld and achieved when responding to these needs and problems, and the acceptable modes of response…. Patterns of service delivery will conform to these ideologies" (p. 100).

Consequently, one could expect organizational belief systems to be especially strong in faith-saturated service environments, such as the GRMs, where the organization's faith content is believed to be relevant to the whole range of organizational characteristics. The GRMs' beliefs will shape their mission, goals, structure, decision-making process, staff selection criteria, "change technology" or choice of intervention for participant change, manner of service delivery, and desired client outcomes (Jeavons, 1994). These authors suggest that the sum of these beliefs, value choices, and faith-shaped preferences constitute a faith framework for a program of

service. The impact of different religious traditions on such faith frameworks in organizations remains an undeveloped aspect of the literature, as one can expect that Buddhist, Muslim, or Jewish conceptions, for example, will differ dramatically in aspects of their faith-shaped program components, perceived essential services, the value placed on individual spiritual commitment and beliefs, and conceptualizations of how individuals change.

TESTING PROGRAMMATIC FAITH IN SUBSTANCE ABUSE TREATMENT

Substance abuse treatment provision has several qualities that make it a good modality of service in which to test faith-based services. First, substance abuse treatment programs are common in nearly every urban area in the United States, which would facilitate research access to large and varied samples in all regions. Second, most substance abuse treatment providers target similar high-risk, low-income populations as public treatment programs, making the recruitment of conventional treatment groups easier and offering broader applicability to findings. Third, these programs often entail a strong spiritual element, offering in most samples the complete range of faith-related measures and useful comparisons of extreme scores between faith- and nonfaith-related tests. Overall, rigorous research of faith-based substance abuse rehabilitation efforts affords the potential to "provide appropriate information to further practice and policy development... [because] successful recovery, one that lasts for a significant period of time, includes some form of personal transformation and change in lifestyle" (Zannis & Cnaan, 2006, p. 90).

The development of defensible measures of faith-based program components and outcomes would lay the foundation for comparative effectiveness studies with secular substance abuse treatment providers. The results could guide public policy by identifying which elements of faith-based treatment programs show the greatest effect for positive outcomes and which treatment populations show the greatest benefit.

The literature documents the widespread use of spiritual and religious support groups as a means for treating addictive diseases (Chen, 2006; Ellis & Schoenfeld, 1990; Koenig, 1998; Warfield & Goldstein, 1996). Since the founding of Alcoholics Anonymous (AA) in 1935, over a million members have sought recovery from substance abuse through its emphasis on spirituality, peer support, and accountability (Pardini Plante, Sherman, & Stump, 2000). In addition, "a vast majority of [substance abuse] treatment programs are based on the spiritual program of AA" (Pardini et al., 2000, p. 348).

Although success rates are low in substance abuse treatment in general, the chances of successful recovery may be enhanced by conscious and deliberate use of programmatic faith components (Miller, 1997). Some individuals may find sufficient strength in religion and spirituality to abstain or to reduce their substance use and improve their quality of life (Gorsuch, 1995). Other research sees positive effects for substance abuse treatment participants if they focus on developing a spiritual understanding as well as participating in a religion (Koenig et al., 2001). Although many authors theorize about how spirituality could be effective in substance abuse treatment, little empirical research analyzes how these spiritually driven programs assist individual transformation or how to measure programmatic impact on individual outcomes (Pardini et al., 2000).

To study the effect of programmatic faith in substance abuse treatment programs, the GRMs were selected because they make up an affiliation of organizations whose faith framework for service is well developed and permeates nearly all aspects of GRM substance abuse recovery programs. A review of GRM mission statements, goal areas and choice of service objectives, decision-making processes, staff selection, the type and manner of mission services (their change technology), and the range of desired participant outcomes demonstrates the strong influence of organizational beliefs and value preferences.

METHODS

Sample Description

Across the United States, 20 substance abuse treatment programs within 17 GRMs participated in the National Recovery Initiative (NRI) Pilot Study (see Appendix A). NRI included participating GRMs in 12 states—Northeast (ME, NY, PA), South (GA, NC, SC), Southwest (AZ, CA), Northwest (ID), and Midwest (IN, OH, TN)—and the District of Columbia.

GRM Background

Although "the primary purpose of GRMs is to save lost souls" (Hertel, 1999), the GRMs are major providers of faith-based substance abuse treatment and recovery support programs. Refusing state or federal funding for most of their programmatic work, the GRMs' approach to solving substance abuse problems hinges on the application of strong Christian values placed on personal, faith-driven transformation (i.e., being "born-again"). Their faith framework drives a commitment to improving the lives of the urban poor, the homeless, and the chemically addicted through providing food, shelter, clothing, safety, health care, and family aid. The Association for Gospel Rescue Missions (AGRM) now represents over 300 missions around the world. Almost

100 years since its inception, the AGRM, of which the NRI pilot GRMs are members, is one of the 10 largest nonprofit human service systems in the country.

Data Collection Experience

AGRM members often have little experience in data collection. For example, many AGRM members use voluntary self-report surveys and questionnaires, as opposed to regularly scheduled service and results-based reports. Further, they often rely on data collected by other professional vendors and governmental programs. For instance, a study called the "Snapshot Survey of the Homeless" is compiled annually, wherein current data are compared with data collected in the previous year. Data are collected on about 20,000 participants representing 150 missions. These data share some similarities with the pilot evaluation in that they represent data collection in an environment usually not experienced in data collection for tracking service delivery and client outcomes.

Faith Framework

The GRM faith framework—the faith principles and philosophy that guide the GRMs' work and service delivery choices—could be characterized as a fundamentalist, Protestant Christian framework. Similar to other faith-based organizations, the GRMs view substance abuse as a "life-controlling" circumstance that requires a holistic recovery approach (Ebaugh, Chafetz, & Pipes, 2006; Neff & McMaster, 2005; Sider & Unruh, 2004). Faith-based programs, such as the GRMs, seek to change the views and beliefs of participants in order to form "religious coping strategies" (Neff & MacMaster, 2005).

Developing Measures of Programmatic Faith in the GRM Context

The NRI procured financial support from two foundations to develop a pilot study for measurement development for substance abuse treatment programs in a GRM setting. During two week-long meetings, GRM leadership and management staff convened four work groups to articulate their faith framework into valid measures. The outcome of the first work group was a services received checklist for use by GRM participants in a substance abuse recovery program and as a GRM service taxonomy, including definitions and units of measurement. These were developed for two areas: measures of program service activities that are not heavily faith-based, such as substance abuse education classes, recreation, and skill development; and program service activities and participant outcomes that are heavily faith-based, such as one-on-one counseling, group therapy, spiritual instruction, and communal worship. The Service Activity Checklist form is completed daily by program participants to measure the program dose of faith-based and secular services.

The second GRM work group chose measures for non-faith-related outcomes of substance abuse residential treatment, indicators of recovery, and the data collection method. The third work group developed measures of participation in mission-sanctioned, therapeutic relationships with staff and mentors while in a recovery program.

The fourth GRM work group identified a set of faith indicators with multiple applications. In contrast to an organizational faith framework, which focuses on faith-driven choices around organizational variables, these measures of faith targeted the faith status of program participants and were intended to operationalize a personal faith framework as viewed by the GRMs. The indicators include self-identification by "being born-again" and several measures of faith status (faith maturity, spiritual growth measures, faith practices, and personal qualities affected by faith). These measures are an important part of the GRM pretest at intake and posttest at discharge, constituting an important personal faith change outcome for the GRM recovery programs.

By the conclusion of this work, four sets of reliable measures for a GRM faith framework had been generated. An extensive substance abuse residential treatment literature review contributed standardized forms of many of the non-faith-based service activities and treatment outcomes.

Draft hard-copy data collection instruments were then developed and circulated for comment, first to the NRI Steering Committee and then to all NRI member missions. After revisions, the draft hard-copy forms were reviewed by expert key informants drawn from GRM staff. On-site pretests at three GRMs (in Indiana, Ohio, and Tennessee) led to further refinements in the measurements and data collection protocol.

The final hard-copy data collection instruments were translated to Web-page presentation for centralized data collection and database management based on data input from Internet-connected work stations at each mission. Training on data input and Web page utilization was conducted via conference call, with extensive phone-based technical assistance throughout the implementation phase. The pilot survey covered the period from September 2007 to February 2008. When administered one-to-one by staff, the interview requires approximately 30 to 40 minutes.

NRI Pilot Study Measures

The complete set of NRI Pilot measures includes intake variables, such as client demographic information, baseline substance use and recovery indicators, a service activities checklist, measures of relationships between clients and staff, and faith status indicators. The service

activities checklist (see Appendix B) creates a cumulative record of service type and units of service received measured in hours. This measure is considered the program dose of services. The checklist is updated daily by clients.

A second set of indicators (see Appendix D), measures clients' individual faith. These include four scales measuring (1) faith maturity, (2) spiritual growth, (3) faith-related activities, and (4) personal qualities. Another important faith measure includes one question about whether clients are "born-again."

Details of the last set of measures regarding the relationships between clients and staff and clients' ratings of their individual skills and self-esteem are also provided in Appendix D. The two measures of relationships include (1) the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989) and (2) Trust Staff Scale developed and tested with this project's data. The two measures of an individual's psychological adjustment include (1) Lovejoy's Life Skills Scale (1995), and (2) Rosenberg's Self-Esteem Scale (1965). The individual faith, relationships, and client's psychological adjustment scales are administered at intake and then every 30 days after intake for a maximum of four repeated measures of each scale.

FINDINGS

Intake data were collected from 597 participants between the ages of 18 and 65, with a mean age of 40. About half of the participants provided demographic information at intake. Among those, the largest racial groups are White (53%) and African-American (42%). The GRM population is largely male (90%) and single (51%). About one in three has less than a high-school education (36%), and another one in three concluded their education with high-school graduation (37%). At intake, only one in four was employed full time. The participants' principal drugs of choice are alcohol (36%), cocaine (27%), and marijuana (16%).

Type and Amount of Faith-Based Services Received

A Services Received Checklist serves as a measure of each participant's experience with the GRMs' faith-based program components. This is a daily record of services received, as recorded by participants. Service utilization data were submitted by only a portion of the GRMs participating in the NRI Pilot, which explains the variable sample size per measure. Another complicating factor is that program participants' service participation data were counted during the study period, although the clients had different enrollment dates throughout the study. Therefore, exposure to program services varies by client.

Despite these limitations, there was notable variation in participant receipt of the faith-based program components and the program dose (see Table C-1 in Appendix C). Mission-related supervised work is by far the most common faith-based program component received, followed by chapel/worship and then resident-initiated spiritual activity, although there is large variation in the number of service units reported per participant for the same time period. Clients had low participation in individualized services, such as counseling or pastoral counseling. Figure C-1 (see Appendix C) shows that the majority of clients participated in five or more of the nine services that comprise the faith-related program elements. Only 12% of clients received one to four components, whereas 35% received five to six services, 29% received seven services, and 24% received eight to nine service components. Figure C-2 shows wider variation in the amount of faith-based services received in hours. Because it is unclear if the variation in program dose is due to participants' enrollment date, this will be an important control variable in future analysis.

Individual Faith Indicators

Examining whether individual faith and spiritual growth indicators increased throughout the study are important outcome measures for the GRM participants. One of the goals of the GRMs is to contribute to the spiritual growth of the clients they serve. Five measures of faith status track the individual's process of change from intake to discharge or follow-up: the Faith Maturity Scale, "born- again" self-report, a spiritual growth scale score, the faith activities scale, and the faith-related personal qualities scale.

Another faith measure marks spiritual growth by agreement with seven principal GRM beliefs. Table C-2 (see Appendix C) reports the mean responses to each of the seven questions included on the scale for approximately 350 clients. Clients were asked these questions at intake and every month during the pilot period. Because the responses included in this table represent clients' last response to the scale, these results are not considered as pretest or posttest measures of individualized faith. Data for this measure indicate that clients have strong agreement in belief and intention. While it is evident from Table C-2 that clients participating in the pilot study experience, on average, strong spiritual growth, they rate their ability to apply the biblical principles in their lives much lower.

Another faith status measure uses self-report to ask, "Do you have a personal relationship with Christ (e.g., are you born-again)?" In results not shown in the tables, nearly half (48%) of participants responded yes (n=285). Because almost half of participants considered themselves born-again at intake, this finding may indicate a significant selection or social desirability bias in

which half of the clientele coming into the GRMs already identify with the mission faith framework

Measures of faith-related activities presented in Table C-3 (see Appendix C) vary significantly. While solitary prayer is the most frequently practiced activity, the range of responses varies. Attending worship services and personal devotions are the next most frequently cited activities. The GRM clients found it difficult to demonstrate biblical stewardship of money/income. This is not surprising given the low incomes of the clients served by GRMs.

The 15-item short version of the Faith Maturity Scale (Benson et al., 1993) provides a standardized measure of faith status at intake as well as change over time. The scale conceptualizes faith as a combination of vertical (the relationship between self and transcendent reality) and horizontal (the relationship of faith to serving humanity, mercy, and justice) dimensions of faith. In the GRM faith framework, consistent demonstration of certain attitudes and behaviors shows the opposite of characteristic addictive attitudes and behavior, indicating the progress of an internal change process. The understanding of spirituality in 12-step programs shows a similar conception; that is, spiritual change equals being honest, open-minded, and willing to change. Table C-4 (see Appendix C) indicates that, overall, the clients served by the GRMs have high ratings of faith maturity; however, there is some variation, with higher scores in helpfulness, gratitude and respect for others, and lower scores for the use of offensive language.

Relationship Building as a Faith-Based Services Mediating Variable

GRM residential substance abuse programs provide longer-term treatment than in most publicly supported settings. Among the GRM substance abuse treatment programs participating in the NRI Pilot, between 6 and 13 months is devoted to treatment, whereas many publicly supported residential substance abuse treatment programs provide 28 days or fewer of treatment (Neff, Shorkey, & Windsor, 2006). The GRM staff report frequent, therapeutically beneficial relationships developing between staff and participants or between program-sanctioned mentors and participants.

Several relationship measures track participant exposure to relationship components of GRM substance abuse treatment programs. Four composite measures gauge the strength of variables that impact relationships, three of which are commonly used, published scales: the quality and strength of a participant's relationship with the staff person most influential in their recovery, as measured by the Working Alliance Inventory (Horvath & Greenberg, 1989); the self-rating Lovejoy Scale of Relationship Skills (Lovejoy, 1995); and Rosenberg's Self-esteem Scale

(Rosenberg, 1965). Notably, the GRM clients rate their life skills and self-esteem as quite low on average. The fourth measure is the Trusting Staff Scale (see Appendix D), which measures the degree of trust placed in treatment staff. Analysis repeatedly shows statistically significant correlations between relationships while in treatment and the several measures of faith status. Table C-5 (see Appendix C) indicates that clients developed high levels of trust with GRM staff. Examining the correlations between worker trust and indicators of individual faith reveals that clients' faith is positively associated with the development of relationships with the staff.

DISCUSSION

The NRI Pilot Study lays a preliminary foundation for more rigorous evaluation research by highlighting the need for greater conceptual clarity, specificity, and operationalization of key measures of programmatic faith. The answer to how faith program components actually contribute to individual outcomes begins to be found in greater specification of the faith-conditioned service or treatment. Inside the black box of faith-based service delivery, not all faith-based services are the same. In fact, faith-based service interventions and treatments vary considerably depending on the choices inherent in their faith frameworks as well as the specific treatment modality used by a program.

Moving forward, greater attention should be focused on understanding how the ideologies, beliefs, and inherent value preferences of a faith framework, both as applied to the client as well as the organization, can influence the kinds of services offered, the target population served, service delivery choices, and the types of participant outcomes valued by the faith-based providers. Organizational theory literature may help explain more specifically how a GRM faith framework permeates its service setting and the participant treatment experience. A systematic analysis of faith framework dimensions and their measures could potentially buttress the validity of faith-based service measures. Alternate faith frameworks, particularly non-Christian and those of the major world religions, deserve equivalent explication.

Effectiveness studies will depend on very careful examination of the aspects of a faith framework influencing a program's service-related preferences. In fact, the kind of care taken in cross-cultural research, with its repeated checks on validity and partnering with indigenous experts, should be applied as well to the faith frameworks that shape faith-based service delivery.

The great variation in participant exposure to services in a faith-based environment should not be surprising. Similarly, variation in participant experience could be found in many non-faith-based, nonprofit service organizations. The range of service types received and the extent of their

receipt constitute the participant's dose of faith-based treatment. How much intervention, for how long, delivered in what manner, and to whom are legitimate questions asked in human services effectiveness research. Faith-based service provision requires the same level of scrutiny.

The NRI Pilot Study puts flesh on the bones of programmatic faith and depicts a way to operationalize the faith content present in program components. While the precise substantive content of faith-based program components may vary by faith framework, programmatic faith is a useful concept that can connect the sphere of belief and values with the realm of implementation. It is here where the provider's beliefs, values, and preferences translate into program components intended to shape an individual's change process. Jeavons (1998) was correct when he conceived of faith-based service as the "value expression" of organizational mission.

The description of the GRM sample had an unexpected quality: about half of the participants—often residents of the most beleaguered parts of central cities and beset with addiction—share the mission faith framework. If the mission of the GRMs is to reach "the lost," then about half of those they serve are not part of this target population. The GRM goal of individual faith transformation appears to have already been achieved prior to intake for this proportion of participants. Serious effort should be directed at measuring the degree of social desirability response in participant self-report; that is, respondents may provide information they think their interviewer wants to hear. However, self-selection into treatment settings is a common phenomenon. Service participants, when given the choice, will gravitate to the service setting that appeals to their backgrounds, or perhaps represents a familiar set of beliefs or shared values. The threat to an effectiveness study arises when such consonance of faith and value disproportionately sorts into faith-based programs those participants better equipped with coping skills or those with a higher level of motivation or greater access to social support and other recovery resources. Randomized assignment to treatment and comparison groups would help to mitigate such bias, and quasi-experimental matched comparison group designs can help fill the gap when randomization cannot be applied.

Programmatic faith may not drive all of the participant change process. The consistently significant and positive correlations between relationship aspects of treatment and the several measures of participant faith status suggest an interaction of relationship factors and faith status indicators. Longitudinal testing could remove the ambiguity of causal direction between relationship assets and faith status.

The greater duration of GRM substance abuse residential treatment programs provides the opportunity for therapeutic and mentoring relationships to develop and perhaps to mediate the participant service experience. Multivariate testing could shed light on the proportionate influence of relationships versus faith, when controlling for known factors that impact substance abuse treatment outcomes. Further testing could indicate which types of relationships and which kinds of relationship transactions (e.g., accountability, emotional support, spiritual mentoring) exert the greatest positive effect on outcomes. Secular substance abuse treatment programs of equivalent duration to GRMs should be included in effectiveness studies to assess the independent effect of relationships or other factors inherent in a longer treatment period when compared with faith-based treatment settings.

Limitations

The challenges of introducing a measurement and tracking system in a faith-saturated environment should not be underestimated. A planned national demonstration by NRI to test the effectiveness of faith-based substance abuse residential treatment will depend on consistent, thorough, and accurate data input by GRM staff. Improved protocols for data entry will decrease the attrition rate among the pilot's sample, experienced as great as 50% or more on many pilot items. While the missing data speak almost entirely to provider variables rather than to participant characteristics that would bias findings, a great degree of statistical power is lost and the ability to analyze subgroups degraded by such sample loss.

While the NRI Pilot Study achieved its goals for measurement development and feasible data collection protocols, data quality suffered from understaffing and the tendency among many GRMs to employ their treatment programs graduates before persons with better qualifications. The provision of greater Web-based programming controls on data entry and error checking, and providing greater staff accountability and regular technical assistance via communication technology could improve sample retention throughout data collection.

Implications

Effectiveness findings in rigorously controlled trials of faith-based services may help clarify current public policy related to Charitable Choice, faith-based service delivery, or community-governed provision for need. Over time, with improved methods and more rigorous research, it is not unreasonable to expect a refinement of claims. As the knowledge base advances, faith-based service effectiveness within select populations, for some kinds of need, under particular service conditions, may be better understood.

ACKNOWLEDGMENTS

The National Recovery Initiative Pilot Project, an initiative of Atlanta Union Mission, Inc., is funded by two foundations: the National Christian Foundation with the recommendation of the Maclellan Foundation, and by a second corporate foundation that wishes their support to remain anonymous.

APPENDIX A:
NATIONAL RECOVERY INITIATIVE PARTICIPANTS

Mission / Ministry	Location
1. Fort Wayne Rescue Ministries	Fort Wayne, IN
2. Trinity Mission	Lafayette, IN
3. Phoenix Rescue Mission	Phoenix, AZ
4. Water Street Rescue Mission	Lancaster, PA
5. Wheeler Mission Ministries	Indianapolis, IN
6. Miracle Hill Ministries	Greenville, SC
7. Rescue Mission of Utica	Utica, NY
8. Union Gospel Mission Twin Cities	Minneapolis-St. Paul, MN
9. Memphis Union Mission	Memphis, TN
10. Manna Inc.	Bangor, ME
11. Light of Life Mission	Pittsburgh, PA
12. Gospel Rescue Ministries	Washington, DC
13. Charlotte Rescue Mission	Charlotte, NC
14. Haven of Rest	Akron, OH
15. Rescue Mission Alliance	Ventura County, CA
16. Atlanta Union Mission	Atlanta, GA
17. Wheeler Mission Ministries	Indianapolis, IN

APPENDIX B:

NATIONAL RECOVERY INITIATIVE (NRI) PILOT STUDY

SERVICES RECEIVED CHECKLIST ADDENDUM ©

Protocol: Below are definitions and examples of services to help you when filling out your checklist. Administration: This can be used with EITHER the Daily Services Received Checklist OR the Weekly Services Received Checklist. Missions may use either format based on what works best for them in order to ensure that participants fill out this information each day.

PERSON DISTRIBUTING FORM: It is EXTREMELY IMPORTANT that you read the following introduction word-for-word when you give the Services Received Checklist to a resident:

This checklist is to help us know what services you receive as part of your recovery and how often you receive each service. It is extremely important that you complete a Services Received Checklist EVERY DAY that you participate in the recovery program. If you have any questions about any items on the Checklist, there is a Services Received Checklist ADDENDUM that explains and gives and example of everything on the Checklist.

1. Academic Services

   Definition: A*cademic programs which may include but are not limited to reading, comprehension, vocabulary, spelling, memory, mathematics, writing, computer literacy and GED preparation that occur either in the agency or off-site*

2. Life Skills Education

   Definition: *Various small groups or classes on life skills issues to help build and maintain appropriate relationships with self and others.*

   Examples:

   - *Personal Presentation*
   - *Personal Financial accountability*
   - *Nutrition*
   - *Family Relationships*
   - *Sexual Integrity Classes*
   - *Family Dynamics*
   - *Inter-personal relationship skills*
   - *Anger Management*
   - *HIV/AIDS education*

3. Individual Counseling (by Mission staff)

   Definition: *One-on-one (minimum of 30 minutes including counseling participant documentation) between a participant and a program counselor regarding a significant recovery or life issue.*

4. Mission-Related Supervised Work

   Definition: *Paid work role done by participant while residing at the Mission*

5. Mission-Related Supervised Education/Training

   Definition: *classes towards an educational goal or for job skills done while residing at the Mission.*

6. Relapse Prevention Education

   Definition: *Educational Classes or Groups led by qualified staff for Relapse Prevention*

   Examples:

   F.A.S.T.E.R. Scale Worksheet

   - Forgetting Priorities
   - Anxiety
   - Speeding up
   - Ticked off
   - Exhausted
   - Relapse (total)

   P.A.W.S. Education Class

   - Post
   - Acute
   - Withdrawal
   - Syndrome

7. Faith-Based or Conventional 12 Step Recovery Group

   Definition: A *twelve- step or comparable type of recovery group (internal or external to the agency)*

   Examples:

   - Alcoholics Victorious
   - Celebrate Recovery
   - Overcomers in Christ
   - Alcoholics Anonymous
   - Narcotics Anonymous
   - Sexual Addiction

8. Mentor Interaction

   Definition: *Telephone or face-to-face contact with a non-paid, not mission-staff confidant or helper who meets with a resident for any purpose on a regular basis*

9. Resident Initiated Spiritual Activity

   Definition: *Any spiritual activity, broadly defined (e.g., prayer, Bible study, special topic study fostering spiritual growth and maturity) that occurs on a formal or informal basis as a result of resident(s) efforts. It may or may not include mission staff or volunteers as participants.*

10. Mission-Organized/Supervised Recreation

    Definition: *Individual or group recreation to promote positive and enjoyable social interactions or physical recreation without substance abuse.*

11. Mission-Organized/Supervised Physical Exercise

    Definition: *Physical Activity that works up a sweat.*

12. Resident-Initiated Recreation

    Definition: *Individual or group recreation that is initiated by the resident to promote positive and enjoyable social interactions or physical recreation without substance abuse.*

13. Resident-Initiated Physical Exercise

    Definition: *Physical Activity initiated by the individual resident that works up a sweat.*

14. Individual Pastoral Counseling

    Definition: *Individual counseling with the mission chaplain or pastor in order for the client to develop a closer relationship with God.*

15. Group Bible Study

    Definition: *Group of less than 15 that focuses on understanding, utilizing, and growing in the Word.*

16. Chapel/Worship

    Definition: *Attendance at a chapel service or communal worship time at the mission.*

17. Group Counseling (by Mission staff)

    Definition: *Group of less than 15 participating in interactive discussion lead by a qualified program counselor (excluding relapse prevention).*

    Examples of Group Counseling Topics:

    - Sexual Issues
    - Anger Issues
    - Chemical Dependency Treatment
    - Relationships/Community Living
    - Educational Progress
    - Discipleship Progress
    - Behavioral Issues

18. Employment Service

    A. Pre-Employment Services

       Definition: *Services provided to clients prior to employment, which can include background checks, drug tests and assessments. These services allow employers to "check out" prospective employees before hiring them.*

    B. Employment Coaching

       Definition: *Provides tools and strategies to participants to assist in gaining or retaining employment. These strategies include implementing new skills, changes and actions to ensure participants achieve their targeted results.*

       Examples:

       - Resume writing

- Interview Skills
- Career Choices
- Job Search Skills

19. Transportation

    Definition: *Providing a means of transport for clients to travel from one location to another*

20. Drug Testing

    Definition: *A test to screen for drug and alcohol use performed randomly*

21. Total Referrals and follow-through

    Definition: *Process outside of the Gospel Rescue Mission by which program counselor recommends services to the client to meet appropriate recovery needs AND the client follows through on the referral. Only count those referrals in which you know that the client responded and met with the referral source.*

    Examples:

    - Legal Services
    - Medical Services
    - Mental Health Services
    - Substance Abuse Services
    - After Care Services
    - Education Services
    - Peer-to-peer Recovery Support Services
    - Other _____

APPENDIX C

Table C-1. Exposure to Faith-Related Program Elements, September 2007–February 2008

How many hours were each of the following services provided?

Service	Mean	SD
Individual Counseling (N=227)	7.17	9.20
Mission-Related Supervised Work	125.55	135.51
Faith-Based or Conventional 12-Step Recovery Group (N=269)	16.98	22.02

(continued)

Table C-1. Exposure to Faith-Related Program Elements, September 2007–February 2008 (continued)

How many hours were each of the following services provided?		
Service	**Mean**	**SD**
Mentor Interaction (N=165)	12.47	23.66
Resident-Initiated Spiritual Activity (N=274)	25.23	40.69
Individual Pastoral Counseling (N=150)	4.34	5.77
Group Bible Study (N=322)	16.43	20.25
Chapel/Worship (N=347)	33.15	38.90
Group Counseling (N=235)	17.62	20.66

Figure C-1

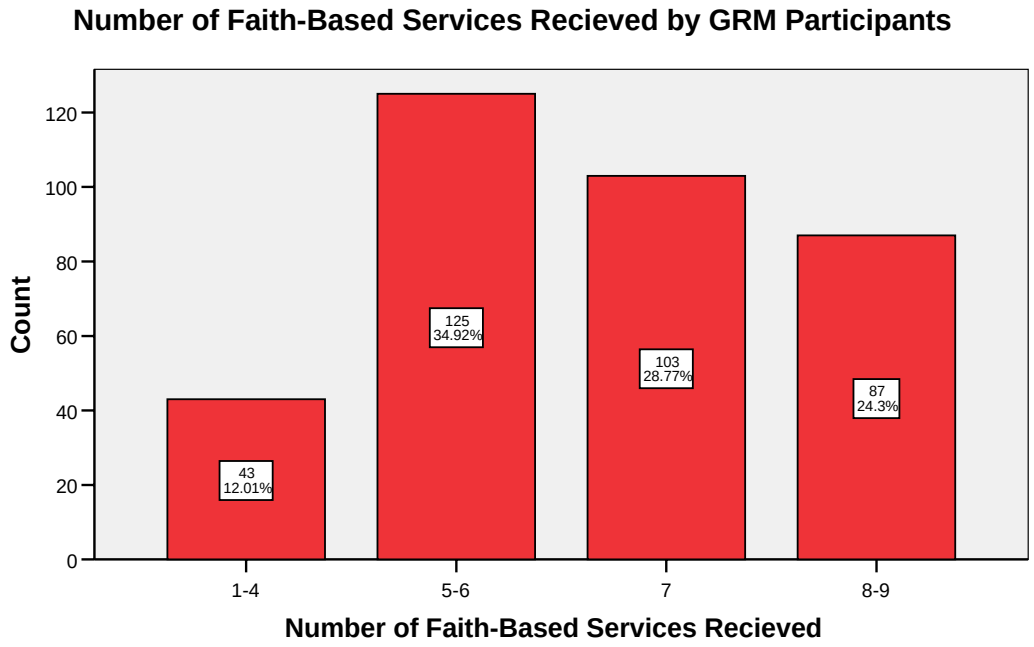

Figure C-2

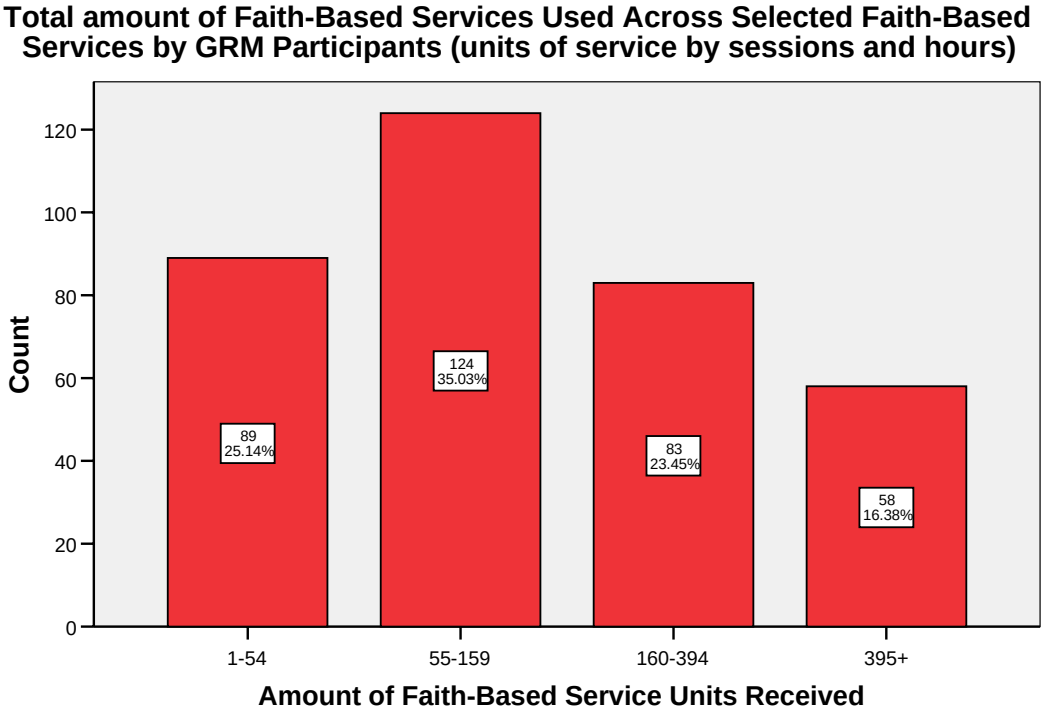

Table C-2. Spiritual Growth Indicators in a GRM Faith Framework

How strongly do you agree or disagree with the following statements? N=348–353 *(1=strongly disagree, 5=strongly agree)*	**Mean**	**SD**
I need a change in my life.	4.81	0.53
I need Jesus to intervene in my life and provide guidance.	4.74	0.63
God is in control.	4.56	0.77
God is the authority.	4.73	0.63
God communicates His authority through Scripture.	4.63	0.69
I am willing to obey biblical principles.	4.32	0.78
I regularly apply biblical principles in my life.	3.59	0.98

Table C-3. Faith-Related Activities in a GRM Faith Framework

Please circle a number for each of the following questions, based on how often you engage in the following faith-related activities on a scale of 1 to 5. (1=never, 5=daily) In the last 30 days…	**Mean**	**SD**
How often did you attend worship services? N=330	2.81	1.31
How often did you participate in Christ-centered community, church, or small group? N=330	2.56	1.46
How often did you demonstrate Biblical stewardship of your money/income? (If currently without money, please circle 8) N=267	1.81	1.13
How often did you serve others on a voluntary basis? N=328	2.44	1.42
How often did you participate in a support group for the purpose of recovery? N=330	2.28	1.51
How often did you engage in group devotional activity or Bible study? N=330	2.45	1.50
How often did you engage in personal devotions or Bible study? N=331	2.83	1.57
How often did you participate in solitary prayer (exclusive of meals)? N=331	3.76	1.53

Table C-4. Personal Faith Qualities in a GRM Faith Framework

How often do you exhibit the following: N=328-332 (1=never, 5=very frequently)	**Mean**	**SD**
Acceptance of God's forgiveness for my past actions	3.92	1.11
Acceptance of forgiveness from others	3.58	1.03
Forgiving others	3.88	0.92
Unselfishness/generosity	3.74	0.94
Helpfulness/servant attitude/kindness – (tenderhearted, sympathetic treatment to others)	4.00	0.86
Gratitude/Spirit of thankfulness	4.03	0.91
Offensive Language (reverse scored)	2.81	1.16
Respect for others/Non-judgmental attitude	4.01	0.87
Submission to authority	3.88	1.04

(continued)

Table C-4. Personal Faith Qualities in a GRM Faith Framework (continued)

How often do you exhibit the following: N=328-332 (1=never, 5=very frequently)	**Mean**	**SD**
Love – (Unconditional devotion to others)	3.91	0.97
Joy – (Feeling of happiness, delight, and great pleasure)	3.63	1.06
Peace – (Feeling secure, undisturbed, serene, and tranquil)	3.52	1.13
Patience – (Ability to wait or endure without complaint)	3.36	1.07
Faithfulness – (Consistent practice of what you believe and loyalty to people you value)	3.73	.93
Self-Control – (Ability to self-regulate and direct one's actions and thoughts)	3.55	1.06

Table C-5. The Association between Relationship and Faith Measures among GRM Participants in SA Residential Treatment

Relationship Measure	**Minimum Score**	**Maximum Score**	**Mean**	**Statistically Significant Correlations with Faith Measures**
Working Alliance Inventory, N=167 (high=positive)	134	252	226	Faith Maturity Score, r=.342, p=.000 Spiritual Growth Score, r=.193, p=016 Faith Activity Score, r=.417, p=.000 Personal Qualities Score, r=.298, p=000
Trust Staff Score, N=166 (high=positive)	1	20	15.11	Faith Maturity Score, r=.381, p=000 Spiritual Growth Score, r=.217, p=.006 Faith Activity Score, r=.007 Personal Qualities Score, r=.182, =.028
Lovejoy Life Skills Score, N=164 (high=positive)	8	20	14.12	Faith Maturity Score, r=.271, p=.001 Faith Activity Score, r=.266, p=.008 Personal Qualities Score, r=.365, p=.000
Rosenberg Self-Esteem Scale, N=163	11	22	16.09	Faith Maturity Score, r=.191, p=.018 Spiritual Growth Score, r=.018, p=.019 Personal Qualities Score, r=.201, p=.016

These low to moderate strength correlations show a consistently positive association with these measures of faith that is systematic and not due to chance.

APPENDIX D:
TECHNICAL SUPPORTING DATA FOR MEASUREMENT DEVELOPMENT

Faith Measures

Faith Maturity Scale

In the Pilot, 341 participants responded to the 16-item short version of the Faith Maturity Scale. The higher the score, the greater the faith maturity. Respondents show a low score of 20 and a high of 112, a mean of 77, and standard deviation of 21.58. As a published measure of long standing, it has acceptable psychometric properties.

Spiritual Growth Scale

The seven items that constitute the newly developed Spiritual Growth Scale show excellent psychometric properties (Cronbach's alpha=.82). The sum score of these items range from 10 to 35, with a mean score of 31.

Faith-Related Activities Scale

This scale is also new and designed to fit the GRM faith framework for the faith practices aspect of individual change indicators for participants in SA residential treatment. These eight items also show good psychometric properties (Cronbach's alpha=.87). The sum score of these items ranges from 8 to 40, with a mean of 20.

Personal Qualities Scale

The 15 attitude and behavioral measures in Table 5 show high psychometric properties (Cronbach's alpha=.92). The sum score of these items ranges from 15 to 70, with a mean of 53.

Relationship Measures

Trusting Staff Scale

This measure uses five items to reflect the degree of trust placed in treatment staff (alpha=.77). The scores range from 1 to 20, with a mean of 15.11. These items include:

7. In the last 30 days…	**Never**	**Less than 1 time per month**	**1-3 times per month**	**At least weekly**	**Daily**
How often were you able to talk to at least one staff member or volunteer openly and honestly about problems/issues of a personal nature?	1	2	3	4	5
How often did you feel safe (accepted by staff and volunteers) at this Gospel Rescue Mission?	1	2	3	4	5

(continued)

7. In the last 30 days…	Never	Less than 1 time per month	1-3 times per month	At least weekly	Daily
How often did you seek out a staff member or volunteer to discuss a personal matter?	1	2	3	4	5
How often did you voluntarily share personal issues in a private or group meeting?	1	2	3	4	5
How often did you follow advice of a counselor/staff member or volunteer on a matter of personal importance?	1	2	3	4	5

Working Alliance Inventory

The Working Alliance Inventory was completed by 167 respondents. It is a standardized, published scale on the staff relationship to a client most influential in the participant's recovery. The WAI produced scores from 134 to 252 with a mean score of 226. The higher the score the stronger the relationship with this influential staff person. The scale items and format appear on the next page. As a published measure of long standing, it has acceptable psychometric properties.

Working Alliance Inventory (WAI)

***Protocol**: This instrument is to be self-reported by the resident.*

*(The remaining questions are to be answered only at **30 days, monthly thereafter, as well as at discharge, NOT AT INTAKE)***

Below are 36 questions about your relationship with the staff person or Mission-related person that has most helped you to reach your goals. Remember that this information will be kept completely confidential. Your answers will not be connected with your name. The resident should NOT share this information with other staff or residents.

1. Which staff person or Mission-related person has most helped you to reach your goals? _____

2. What is that person's role at the Mission? _____

The following questions all relate to your relationship with _____ (that person)

Using the following scale rate the degree to which you agree with each statement, and record your answer in the space to the left of the item

1 = Not at all true

2 = A little true

3 = Slightly true

4 = Somewhat true

5 = Moderately true

6 = Considerably true

7 = Very true

___ I feel uncomfortable with _____.

___ _____ and I agree about the things I will need to do to help improve my situation.

___ I am worried about the outcome of these sessions.

___ What I am doing in our working relationship gives me new ways of looking at my problem.

___ _____ and I understand each other.

___ _____ perceives accurately what my goals are.

___ I find what I am doing in my work with _____ confusing.

___ I believe _____ likes me.

___ I wish _____ and I could clarify the purpose of our sessions.

___ I disagree with _____ about what I ought to get out of our sessions.

___ I believe the time _____ and I are spending together is not spent efficiently.

___ _____ does not understand what I am trying to accomplish.

___ I am clear on what my responsibilities are in our working relationship.

___ The goals of these sessions are important to me.

___ I find what _____ and I are doing are unrelated to my concerns.

___ I feel that the things I do in our working relationship will help me to accomplish the changes that I want.

___ I believe _____ is genuinely concerned for my welfare.

___ I am clear as to what _____ wants me to do in these sessions.

___ _____ and I respect each other.

___ I feel that _____ is not totally honest about his/her feelings toward me.

___ I am confident in _____'s ability to help me.

___ _____ and I are working towards mutually agreed upon goals.

___ I feel that _____ appreciates me.

___ We agree on what is important for me to work on.

___ As a result of these sessions I am clearer as to how I might be able to change.

___ _____ and I trust one another.

___ _____ and I have different ideas on what my problems are.

___ My relationship with _____ is very important to me.

___ I have the feeling that if I say or do the wrong things, _____ will stop working with me.

___ _____ and I collaborate on setting goals for my recovery.

___ I am frustrated by the things I am doing in our working relationship.

___ We have established a good understanding of the kind of changes that would be good for me.

___ The things that _____ is asking me to do don't make sense.

___ I don't know what to expect as the result of our working relationship.

___ I believe the way we are working with my problem is correct.

___ I feel that _____ cares about me even when I do things that he/she does not approve of.

Lovejoy's Life Skills Scale

How frequently do you do the following things? *(Please circle your answer using the following scale: 0=Never, 1=Almost never, 2=Sometimes, 3=Fairly often, 4=Very often)*

Openly express emotions with others

Have empathy(understanding) for the feelings of others

Reach out and ask for support when upset

Speak honestly

Life Skills Scale scores ranged from 8 to 20 with a mean of 14.11, with a sample size of 166. As a published measure of long standing, it has acceptable psychometric properties.

Rosenberg's Self-Esteem Scale

Please circle your answer using the following scale: 1=Strongly agree, 2=Agree, 3=Disagree, 4=Strongly disagree.

	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel that I am a person of worth, at least on an equal basis with others	1	2	3	4
I feel that I have a number of good qualities	1	2	3	4
All in all, I am inclined to feel that I am a failure	1	2	3	4
I am able to do things as well as most other people.	1	2	3	4
I take a positive attitude toward myself	1	2	3	4
On the whole, I am satisfied with myself	1	2	3	4
I wish I could have more respect for myself	1	2	3	4
I certainly feel useless at times	1	2	3	4
At times I think I am no good at all	1	2	3	4

Self-Esteem Scale scores ranged from 11 to 22 with a mean of 16.09, sample size of 163. As a published measure of long standing, it has acceptable psychometric properties.

NRI Trust Staff Scale Items (developed and tested with NRI Pilot data from GRMs)

	Never	Less than 1 time per month	1-3 times per month	At least weekly	Daily
How often were you able to talk to at least one staff member or volunteer openly and honestly about problems/issues of a personal nature?	1	2	3	4	5
How often did you feel safe(accepted by staff and volunteers) at this Gospel Rescue Mission?	1	2	3	4	5
How often did you seek out a staff member or volunteer to discuss a personal matter?	1	2	3	4	5
How often did you voluntarily share personal issues in a private or group meeting?	1	2	3	4	5
How often did you follow advice of a counselor/staff member or volunteer on a matter of personal importance?	1	2	3	4	5

REFERENCES

Ambrosino, R., Heffernan, J., Shuttlesworth, G., & Ambrosino, R. (Eds.). (2001). *Social work and social welfare: An introduction.* Belmont, CA: Wadsworth/Thompson Learning.

Benson, P. L., Donahue, M. J., & Erickson, J. A. (1993). The Faith Maturity Scale. *Research in the Social Scientific Study of Religion. 5,* 1–23.

Boddie, S.C., & Cnaan, R. A. (Eds.) (2006). *Faith-based social services.* Binghamton, NY: Haworth Press.

Chen, G. (2006). Social support, spiritual program, and addition recovery. *International Journal of Offender Therapy and Comparative Criminology, 50*(3), 306–323.

Cnaan, R. A., & Boddie, S. C. (2002). Charitable Choice and faith-based welfare: A call for social work. *Social Work, 47*(3), 224–235.

Dilulio, J. (2002). The three faith factors. *The Public Interest, 129*(4), 50–64.

Ebaugh, H. R., Chafetz, J. S., & Pipes, P. F. (2006). Where's the faith in faith-based organizations? Measures and correlates of religiosity in faith-based social service coalitions. *Social Forces*, *84*(4), 2259–2272.

Ellis, A., & Schoenfeld, E. (1990). Divine intervention and the treatment of chemical dependency. *Journal of Substance Abuse, 2,* 459-468.

Ellor, J. W., Netting, F. E., & Thibault, J. M. (1999). *Understanding religious and spiritual aspects of human service practice*. Columbia, SC: University of South Carolina Press.

Fowler, J. W. (1981). *Stages of faith: The psychology of human development and the quest for meaning*. New York: Harper & Row.

Gorsuch, R. L. (1995). Religious aspects of substance abuse and recovery. *Journal of Social Issues, 51,* 65–83.

Grettenberger, S. E., Bartkowski, J. P., & Smith, S. R. (2006). Evaluating the effectiveness of faith-based welfare agencies: Methodological challenges and possibilities. In S.C. Boddie & R.A. Cnaan (Eds.), *Faith-based social services* (p. 39–61). Binghamton, NY: Haworth Press.

Hertel, L. (1999) *Man with a mission: Mel Trotter and his legacy for the rescue mission movement.* Grand Rapids, MI: Kregel Publications.

Hodge, D. (2001). Spiritual assessment: A review of major qualitative methods and a new framework for assessing spirituality. *Social Work*, *46*(3), 203–214.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*(2), 223–233.

Hugen, B., DeJong, F., & Venema, R. (2005). Faith makes a difference: A study of faith in human service programs. *Acton Institute: Policy Form, Summer*(6), 1–12.

Jeavons, T. H. (1994). *When the bottom line is faithfulness.* Bloomington, IN: Indiana University Press.

Jeavons, T. H. (1998). Identifying Characteristics of religious organizations: An exploratory proposal. In N.J. Demerath III et al. (Eds.), Sacred *companies: Organizational aspects of religion and religious organizations* (pp. 79–95). New York: Oxford University Press.

Johnson, B. R. (2002). *Objective hope assessing the effectiveness of faith based organizations: A review of the literature*. Philadelphia: University of Pennsylvania, Center for Research on Religion and Urban Civil Society.

Karger, H. J., & D. Stoesz (2005). *American social welfare policy: A pluralist approach.* 4th ed. Boston: Pearson Educational.

Koenig, H. G. (Ed.). (1998). *Handbook of religion and mental health*. San Diego, CA: Academic Press.

Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001). *Handbook of religion and health*. New York: Oxford University Press.

Lovejoy, M. (1995). Patients' perspective on the process of change in substance abuse treatment. *Journal of Substance Abuse Treatment, 12,* 69–82.

Meacham, J. (2006). *American gospel: God, the founding fathers, and the making of a nation*. New York: Random House.

Miller, W. R. (1997). Spiritual aspects of addiction treatment and research. *Mind/Body Medicine*, *2*, 37–43.

Neff, J. A., & MacMaster, S. A. (2005). Spiritual mechanisms underlying substance abuse behavior change in faith-based substance abuse treatment. *Journal of Social Work Practice in Addictions, 5*(3), 33–54.

Neff, J. A., Shorkey, C. T., & Windsor, L. C. (2006). Contrasting faith-based and traditional substance abuse treatment programs. *Journal of Substance Abuse Treatment, 30*(1), 49–60.

Pardini, D. A., Plante, T. G., Sherman, A., & Stump, J. E. (2000). Religious faith and spirituality in substance abuse recovery: Determining the mental health benefits. *Journal of Substance Abuse Treatment 19*, 347–354.

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton; University Press.

Sider, R. J., & Unruh, H. R. (2004). Typology of religious characteristics of social service and educational organizations and programs. *Nonprofit and Voluntary Sector Quarterly*, *33*(1), 109–134.

Smith, S. R., Sosin, M. R. (2001). The varieties of faith-related agencies. *Public Administration Review, 61*(6), 651–670.

Specht, H., & Courtney, M. (1994). *Unfaithful angels: How social work has abandoned its mission*. New York: Free Press.

Unruh, H. R., & Sider, R. (2005). *Saving souls, serving society.* New York: Oxford University Press.

von Furstenberg, G.M. (2006). Detecting and decomposing the faith factor in social-service provision and absorption. In S.C. Boddie & R.A. Cnaan (Eds.), *Faith-based services: Measures, assessments, and effectiveness.* Binghamton, NY: Haworth Press.

Warfield, R. D., & Goldstein, M. B. (1996). Spirituality: The key to recovery from alcoholism. *Counseling and Values, 40,* 196–205.

Zannis, D. A. & Canaan, R. A. (2006). Social service research and religion: Thoughts about how to measure intervention-based impact. In S.C. Boddie & R.A. Cnaan (Eds.), *Faith-based services: Measures, assessments, and effectiveness,* Binghamton, NY: Haworth Press.