Understanding Spirituality in Community Programming: Final Report

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EXECUTIVE SUMMARY

Though faith- and community-based organizations are an integral part of this nation's social service delivery network - particularly to some of the most disenfranchised members of society - there is a paucity of rigorous empirical examinations on program effectiveness and client outcomes. Attention to the ability of these organizations to effectively provide services to clients is certainly needed. Specifically, how well do these organizations address the needs facing many of their clients, and how do the services affect improved outcomes? In addition, what is the value of providing these professional services in a manner that not only addresses the social and physical needs of clients, but also nurtures and seeks to strengthen their spiritual side as well? These are the critical questions that we address in this research.

Employing a multi-method quasi-experimental design, this study seeks to assess the impact of participating in faith-based treatment on client outcomes, namely, recidivism, substance abuse, and social support ties. By partnering with five faith-based treatment programs located in the Baltimore area, client behaviors were measured at a baseline (pre-intervention) stage and at a follow-up (post-intervention) stage, and were compared against outcomes reported by clients in a matched comparison sample who did not receive faith-based treatment services. In addition to interviewing program participants and reviewing their program files, treatment counselors and neighborhood business owners were interviewed. This allows for a more robust picture of the faith-based treatment experience to be drawn. In particular, how counselors view substance abuse addiction (its causes and treatments) and how they view the role of faith in delivering treatment is important in understanding behavior change in clients. In addition, how the community perceives the treatment program is important in evaluating how the organization fits into the fabric of the community, the local social support network, and hence, the larger network of providers in the state and nation.

To begin to address the gap in the research concerning the effectiveness of faith-based organizations in providing care to substance abusers, and other disenfranchised members of the community (i.e., the homeless, criminal offenders), the results of this research project is presented in three sections, each addressing a different aspect of the interplay between faith-based organizations, their clients, and the communities they serve.

Part I, *Faith-Based Organizations and the Clients they serve: Literature Review and Current Study Findings*, presents an overview of the literature and the state of the research field to date. Baseline and follow-up findings from personal interviews conducted with 74 clients in faith-based programs are presented, and findings are examined across sites to assess differences in target populations, treatment services, and treatment outcomes. In addition, results from interviews with 19 treatment counselors, particularly with respect to their treatment philosophies, are presented. At the conclusion of this section, best-practices are outlined – practices which were identified by the research team as most influential on impacting client outcomes and which can be disseminated to other programs seeking to model those participating in this project.

Part II, *The Impact of Faith-Based Organizations on Client Outcomes: A Quasi-experimental Design Comparison*, presents the findings from a quasi-experiment designed to empirically test the impact of faith-based treatment participation on client outcomes. With this design, an individual matched comparison group was created from a sample of clients who did not participate in faith-based treatment programming (a sample recruited from the local probation and parole office). The results from descriptive and inferential analysis suggest strong treatment impacts of faith-based participation on reducing recidivism and substance use during the follow-up period, though results were much more modest with respect to reforming social support relationships.

Finally, Part III, *What can Faith-Based Organizations Offer? : A Review of Study Findings*, presents the findings from interviews with a small sample of community business owners located around the various faith-based treatment sites participating in this study. Though it was hypothesized that area businesses would not repond favorably toward having a substance abuse treatment facility in their community, faith-based or not (the 'not in my backyard' response), of the resident respondents, there was a unanimous feeling that, in fact, the organization was a good neighbor and a beneficial part of the community. In all, no feelings of opposition to the organizations continued operation were expressed.

In sum, with the passage of Executive Orders 13198 and 13199, and the opening up of opportunities for faith-based programs to receive funding from governmental sources through various charitable choice legislations, it is important to rigorously examine the effectiveness of these organizations. Particularly, since these organizations are being relied on more and more as a way to elevate the strain placed on formal social support systems. While the findings presented

in this report suggest benefits associated with providing substance abuse treatment (and other needed services) within a faith-based environment, future research including larger samples of participants across many different modalities of treatment (both faith-based and secular) is duly warranted.

PART I.
FAITH-BASED ORGANIZATIONS AND THE CLIENTS THEY SERVE: LITERATURE REVIEW AND CURRENT STUDY FINDINGS

Introduction

The majority of Americans profess some belief in the existence of a higher power (Applegate, Cullen, Fisher, & Vander Ven, 2000; Miller & Thoresen 2003) and that they turn toward this higher power for strength and guidance during times of hardship (Ferraro & Koch 1994; Pargament, Smith, Koenig & Perez, 1998). It is, therefore, reasonable that individuals experiencing particularly hard times, namely criminal offenders and substance abusers, would benefit from a treatment program with a spiritual focus. This supposition, however, has not been fully examined with these populations in a community setting. In light of this insufficience, this paper seeks to explore the relationship between spiritually guided community treatment and client outcomes, specifically, recidivism, drug use, and social support systems.

With more than 600,000 offenders being released this year back into their host communities, and with nearly 4 million adults currently serving a community supervision sentence, many suffering from substance addiction, the need for treatment in the community is vast (Taxman, Young & Byrne 2002; Hughes and Wilson 2003; Nolan 2004). While some released offenders will be required to attend treatment as part of the condition of their release on to community supervision, the criminal justice system and other social service agencies are unable to adequately support the provision of treatment to all of those in need. In addition to struggling with substance abuse addiction, offenders face a multitude of barriers to successful reintegration including locating adequate and affordable housing, finding and maintaining legitimate employment, and reestablishing relationships with friends and family members. And, most importantly, offenders - particularly drug offenders - face continuous opportunities in the community to reoffend. Without treatment and assistance, it is inevitable that many offenders will return to their previous criminal and substance abusing lifestyles.

Whereas the criminal justice and institutional systems attempt to provide reintegrative services, the sheer number of returning offenders to communities, and the failure of formal institutions to provide effective services obliges the need to look elsewhere - toward community

organizations that can provide more individual and holistic services, and services that rely upon informal social controls; organizations which often work in support of the goals of overburdened formal institutions and with financial support from them. Thus, the ever-widening gap between those in need of services, particularly offenders and substance abusers, and the availability of treatment, it is suggested, can begin to be bridged by an increased reliance on faith-based organizations within the community – a realization that many state governments have come to embrace and support, both legislatively and financially [e.g., Texas (Ebaugh 2003); Florida (Crew 2003); Montana (Miller 2003)]. While the church (or other place of worship) may not hold the same central position in individual's lives as it once had, "religious beliefs still contribute meaningfully to American culture" (Applegate et al. 2000:720; Layman 1997). As such, places of worship can serve, if only indirectly, as an important supportive link between individuals in need of help and the communities with which they wish to reintegrate back into. And, through state sponsored legislation such as Charitable Choice Provisions, many faith-based organizations are able to receive financial support from government entities to provide services through their programs at the local level.

This notion was forwarded by the actions of President Bush with the signing of Executive Orders 13198 and 13199, which established the White House Office of Faith-Based and Community Initiatives and thus facilitated the process by which religious charities can receive federal funds. Serving as an example of a "Charitable Choice" statute (that is, a statute enacted, in part, in an effort to encourage state and local governments to contract with faith-based organizations), the passage of the Executive Orders furthers the following assumptions (Kennedy 2003:1):

(1) That religious providers have been discriminated against – that they have encountered barriers not required by the First Amendment to their full participation in the contracting process;

(2) That the faith community contains significant untapped resources that might, with encouragement, be marshaled to help the poor; and

(3) That FBOs are more effective than their secular counterparts – that they do a better job at a lower cost.

In conjunction with these Executive Orders, several evaluation studies were funded to examine the effectiveness of faith-based treatment programs in providing needed services and to identify best practices, which could serve as models for new programs. The current study was funded by the Initiative and in this paper findings are presented from a field study involving clients participating in community faith-based organizations compared to a matched comparison sample of non-participants. Interviews were also conducted with treatment providers and area community business owners as a way to broaden an understanding of the spiritual and philosophical approach of faith-based counselors toward clients, and an understanding of the role of and response toward faith-based treatment organizations within their communities.

Despite the fact that the provision of substance abuse treatment as well as other social services is critical to the successful reintegration of offenders (physically and mentally), the availability of these services are limited through formal institutional channels. The overall effectiveness of the services provided through faith- and community-based organizations, however, is not known (Monsma & Mounts 2002; Vidal 2001). In addition, research on the effect of "intentional religion," that is, gaining "exposure to religion…at a particular time in life for a particular purpose" (Johnson, 2003:2) is rare. As noted by Johnson (2003), this overlooked dimension to the study of the impact of religion on client lives is unfortunate given the recognized influence of religion and religious practices on a wide array of health and social outcomes. Thus, research is warranted to examine the role of these organizations in the lives of their clients and the community social service provider network more generally and to identify 'best practices,' particularly in the areas of transitional housing, substance abuse, and offender reintegration. While researchers affirm the value of spirituality as a variable in recovery (Ferraro & Koch 1994; Pargament et al. 1998), little is known about how faith and spirituality are intertwined with the delivery of clinical services. We seek to answer these questions.

Literature Review

The Drug-Crime-Employment Nexus

Participation in integrated treatment services that adequately address the needs of drug offenders can contribute to moderating the relationship between drug use and criminal activity

which has been well established in the literature (Anglin, Longshore & Turner 1999; Reuter 1997; Inciardi 1992; Fagan 1992; Taxman 1998). In addition, research suggests the importance of 'natural systems' – namely the family and religious and social organizations – as playing a critical role in reducing individual criminal activity (Sampson & Laub 1993; Taxman, Young & Byrne 2002). This drug-crime relationship, however, has been strengthened through the introduction of drug markets into urban low-wage sector areas, which provides many unemployed individuals and even people working within the legal sector with viable economic options above and beyond those available through legitimate employment. Additionally, many younger individuals are lured away from seeking legitimate, low paying, low status employment into the fast paced, seemingly high paying world of drugs (Harrell & Peterson 1992; Reuter 1997). Consequently, increased participation in the drug market culture has led to increases in drug related criminal activity and subsequent drug related arrests (Reuter 1997). For example, it has been found that offenders commit crimes four to six times more often when using drugs than when not (DeLaRosa, Lambert, and Gropper 1990). Studies consistently indicate that chronic users of heroin, cocaine, and crack commit a vast amount of crime, most often during periods of addiction, thus illustrating a clear correlation between the amount of drugs used and the amount of crime committed (Hanlon, Nurco, and Bateman 1998; Inciardi 1992; Inciardi & Pottieger 1991). Consequently, from 1986 to 1995, arrests for drug abuse violations increased by 59.2 percent[1] (Federal Bureau of Investigation 1995), and by the end of 2000, almost half (41%) of all probationers under supervision for a drug law violation were required to participate in a substance abuse treatment program as part of a sentence condition (Office of National Drug Control Policy (ONDCP) 2001).

The relationship between the employment of offenders and recidivism reduction has also been well established in the literature (Taxman, Byrne & Moline 2000; Byrne & Kelly 1989; Finn 1997, 1998, 1999; Bouffard, MacKenzie & Hickman 1999; Needles 1996). However, "many offenders have difficulty finding permanent, unsubsidized, well-paid employment after release because they lack job-seeking experience, a work history, and occupational skills; furthermore, many employers refuse to hire individuals with criminal records" (Finn 1998: 2). Employment opportunities for offenders are limited by both individual and macro level

[1] This figure includes only drug abuse violations, specific arrests and non-arrests for other drug-related crimes (i.e., murder, aggravated assault, burglary, prostitution).

characteristics. For instance, in addition to lower literacy and education levels and a lack of employable skills, offender employment opportunities have been impacted by the concentration of jobs in the low-wage labor market (Bernstein & Houston 2000; Piehl 1998; Rubin 1994), the introduction of drug markets into urban centers (Fagan 1992; Shannon 1986; Sullivan 1989; Wilson 1987), and the rise in drug use and addiction (Anglin & Hser 1991; Prendergast, Anglin, & Wellisch 1995). Despite these overwhelming obstacles, particularly for offenders under criminal justice supervision, working legitimately is a widely held value, even by those who face limited employment options (Harrell & Peterson 1992). In 1999, the majority of male respondents in the ADAM survey reported being employed either full or part-time at the time of arrest. Across 34 sites nationwide, it was reported that the employment rate of drug arrestees had a range of 53 to 81 percent (National Institute of Justice 2000). However, offenders are often faced with low-paying employment prospects. According to the Bureau of Justice Statistics' (2001) survey of jail and prison inmates (in 1996), these individuals report very low pre-arrest incomes. Almost half of all offenders earned less than $600 in the month prior to their arrest – at most $7,200 a year – and 22% reported receiving some form of financial support from the government (welfare, AFDC, food stamps, Social Security). Offenders not only earn less than non-offenders prior to their current conviction, but this income gap grows with each subsequent conviction (Waldfogel 1994).

Physical and Mental Health of Offenders

Offenders under criminal justice supervision disproportionately suffer from mental health problems, infectious diseases, substance abuse, and a number of socioeconomic problems (National Alliance for the Mentally Ill (NAMI) 2001; Hammet 1998). For example, an estimated 16% of offenders report staying over night in a mental hospital at some point in their lives (Bureau of Justice Statistics 1999) - a population almost 10 times the number of people in state mental hospitals throughout the country (NAMI 2001). In addition, AIDS is almost six times more prevalent among inmates than in the total U.S. population. Almost 70% of state inmates report using drugs regularly, a figure that is almost twice the estimated national drug use rate of 40% (ONDCP 2001). African Americans comprise a large portion of offenders on supervision. Approximately one-third (34%) of probationers and almost half (44%) of parolees are African

American. In addition, 16% of probationers and one-fifth of parolees (21%) are Hispanic (Bureau of Justice Statistics 2001). These figures are important because socioeconomic status affects the culture of the offender, and these may have influences on the physical and mental health, mental illness, and patterns of health care utilization. For example, social and cultural factors, particularly exposure to poverty and violence, are prominent influences in causation of depression (Department of Health and Human Services (DHHS) 1999). Racial and ethnic minorities in the United States, however, are less likely than whites to seek needed mental health care treatment (DHHS 1999; Sussman, Robins, and Earls 1987; Kessler et al. 1996; Vega et al. 1998; Zhang, Snowden, and Sue 1998), which may be a function of the availability of such services.

African Americans and Hispanics, particularly those living in poverty (e.g., low income, homelessness) have higher rates of physical (somatic) disorders than whites and this has significant implications on their mental health (DHHS 1999; American Psychological Association 1998). Minority individuals who do not have mental disorders are at a higher risk for developing problems such as depression and anxiety because chronic physical illness is a risk factor for certain mental disorders (DHHS 1999). Substance abuse addiction compounds medical conditions already of concern to African American and Hispanic populations, particularly those living in low-income urban communities, which further contributes to widening the gap in health disparities between them and whites. Drug addition is also related to other sub-optimal life style behaviors such as poor diet, little exercise, and cigarette smoking – all risk factors for cardiovascular disease, the leading cause of death for all racial and ethnic groups (Gerber & Stewart 1998; National Institutes of Health (NIH) 1999).

While 14% percent of all whites and 33 % of all poor whites report a lack of health insurance coverage, 21% of all African Americans and 24% of all poor African Americans report a similar lack of health insurance. Hispanics report the greatest numbers without health insurance. Among all Hispanics, 33% have no health insurance, while among poor Hispanics this figure is 41 percent (Leigh & Lindquist 1997). Caring for Medicaid and non-insured patients is often expensive, due to their high incidence of disease, stressful environments, internal and external barriers, unfamiliarity with the importance of prevention and early reporting of symptoms, and compliance with therapy (Gerber & Stewart 1998). Because of the barriers they face (lack of availability, travel time and distance) when they attempt to access care, studies

have shown that the medically indigent are most likely to omit preventive health care (Harwood, Hubbard, Collins & Rachal 1988; Lipkin 1994).

Treatment of Offenders

As part of a sentence condition, nearly half (41%) of probationers are required to participate in a substance abuse treatment program (ONDCP 2001) and many more are in need of substance abuse as well as mental and/or physical health treatment services. Resource constraints, however, often limit drug treatment availability (resulting in inappropriate treatment placements), having an adverse effect on treatment quality. A number of recent reviews of the drug treatment literature (Taxman & Bouffard 2000) have documented such problems as inadequate service levels (Dennis 1990); the use of inappropriate services (Andrews et al. 1990); short duration of treatment programs (Prendergast et al. 1994; Taxman 1998); lack of staff training (Gustafon 1991); and lack of essential program components (Gendreau 1996; Taxman 1998).

Several empirical studies have illustrated the positive impact of drug treatment services on offender criminal behavior and drug use (Anglin et al. 1999; Simpson, Joe & Brown 1997; Lipton 1995; Taxman 1998; Simpson, Wexler & Inciardi 1999). Specifically, these studies demonstrate that offenders participating in drug treatment services are less likely to be rearrested or return to jail or prison than similar offenders who are not participating in drug treatment services. Substance abuse treatment services, however, are not always available to the criminal justice offender (Duffee & Carlson 1996; Drug Policy Strategies 1996) with less than 15% of offenders receiving some type of services. This practice continues although many researchers, policy-makers, and practitioners have recognized the potential effectiveness of drug abuse treatment in reducing recidivism among offenders (National Research Council 2002; National Institutes of Health 1999; Anglin & Hser 1990; Gerstein et al. 1994; Hubbard et al. 1989; Leukefeld & Tims 1988, 1990; Lipton 1995; Petersilia & Turner 1993; Visher 1990). It appears that the current organization and structure of the provision of services hinders the delivery of effective drug treatment (Harrell et al. 2002; Schlesinger & Dorwart 1993; Duffee & Carlson 1996), particularly for the criminal justice offender (Duffee & Carlson 1996; Falkin 1993; Scarpitti, Inciardi, and Martin 1994; Wexler, Lipton, & Johnson 1988).

Religious Faith and Criminal Activity

While testing the effects of providing social services through faith-based programming in the community has not been the focus of much research to date, the impact of religion and religious beliefs on offender behavior has. For example, Clear and colleagues (1992) in their study of prison adjustment for over 700 inmates nationwide found that participation in religious activities helps inmates overcome the depression, guilt, and self-contempt that often accompany the serving of a prison sentence. In addition, they found that inmates oftentimes immersed themselves in the teachings of faith as a way of restoring a sense of self-control. They concluded that "for some, life is improved by finding the emotional supports religion can supply…religion provides an environmental support structure" (p. 7). In a later study, Johnson, Larson, and Pitts (1997) not only examined the impact of participation in religious activities on institutional adjustment, but also tested the impact of such programming on recidivism rates following release. The author's note:

> There are scientific reasons to predict that religion might affect behavioral and social change. Religion targets antisocial values, emphasizes accountability and responsibility, changes cognitive approaches to conflict, and provides social support and social skills through interaction with religious people and communities… Such emphases seem to be consistent with what many rehabilitation workers would call principles of effective treatment (p. 148).

And, indeed, their findings indicate that those inmate's who were most active in one form of religious programming, Bible studies, were significantly less likely to be rearrested within one year. The findings from Johnson et al. are consistent with another important work by Evans et al. (1995), which found that participation in religious activities was a persistent and non-contingent inhibitor of adult crime. These authors conclude that while the social sciences are beginning to understand the processes that link religion and crime, much work remains. Moreover, the needed research must include obtaining more reliable and comprehensive examinations of the interplay between religion and offender's post release success.

As noted by Knepper (2003), the increase in the relationship between religion and criminal offending by criminologists is well documented; though research in the area has been

continuing for more than 30 years. Interest by some has focused on furthering the “faith factor”, or the argument for including faith-based interventions in crime prevention strategies. Specifically the argument suggests: “if faith ‘works,’ then government should not discourage, and even support, faith-based interventions in crime prevention. In making criminal policy based on the social-science evidence concerning faith and crime, government is not advocating religion, but science” (p. 331). This argument is put forth particularly by those social scientists part of the Pennsylvania School, notably Johnson and DiIulio (see Johnson, Spencer, Larson, & McCullough 2000; Johnson, Sung, Larson, & Spencer 2001; DiIulio, 2002), who see faith as an agency of informal social control. Johnson et al. (2001:39) note “the theoretical importance of religion as a social institution of information social control and socialization in understanding delinquency.” As such, the contribution of the federal government in examining, and furthering the understanding of the role of, faith in crime prevention is important social scientifically.

Faith-based Organizations

The U.S. Department of Housing and Urban Development defines faith-based organizations as: (1) congregations; (2) national networks, which include national denominations, their social service arm (for example, Catholic Charities, Lutheran Social Services), and networks of related organizations (such as YMCA and YWCA); and (3) freestanding religious organizations, which are incorporated separately from congregations and national networks. As acknowledged in the literature, however, the knowledge base surrounding the effectiveness of faith-based organizations program delivery is limited (Monsma & Mounts 2002; Vidal 2001). Despite the paucity in scientific research on the roles, activities and impact on client outcomes of faith-based organizations, it is generally accepted that these groups are an integral part of the social service delivery network of this nation. For example, as one study reports:

> These religious organizations represent a major part of the American welfare system…people are being helped by all kinds of programs, from soup kitchens to housing services, from job training to educational enhancement classes. One can only imagine what would happen to the collective quality of life if these religious organizations would cease to exist (Cnann, Wineburg & Boddie 1999:275).

The available literature is largely descriptive and anecdotal, thus lacking the ability to provide empirical and generalizable conclusions (one notable exception is a current study underway by the Center for Urban Policy and the Environment in Indianapolis, designed to empirically test the effectiveness of Charitable Choice legislation in three states). In their recent examination of approximately 500 welfare-to-work programs, including government run, for-profit, secular non-profit, and faith-based, Monsma and Mount (2002) found that while, in general, faith-based organizations have a limited capacity (due to limited funding and staffing resources) to provide various programs, they do demonstrate the interest and desire to meet a much larger proportion of the community's needs than they are currently capable of serving, particularly given the physical and mental health issues faced by target populations. These authors also found that, in contrast to earlier studies (see Chaves 1998), faith-based organizations are able to provide both short-term temporary assistance such as emergency shelter, food, and clothing, and long-term holistic programming in the areas of work preparedness, life skills, and mentoring.

In addition, Monsma and Mount found that while many faith-based organizations do receive government funding (local, state, and federal), these organizations fare much worse in terms of the number and amounts of grants received. For example, while government funding (either directly from federal, state, or local sources, or indirectly through block grant monies) comprises nearly 73% of the budgets of non-profit and secular community organizations, it only accounts for 30-50% of faith-based programs. Moreover, though faith-based organizations do not seek out and apply for government funding in the form of grants at the same rate as non faith-based programs[2], either from federal or state sources, of those that have applied, more than 20% have been turned down. It is statistics such as these that the passage of Executive Orders 13198 and 13199 seeks to improve. Given the limited governmental funding streams, the budgets for community organizations, and in particular, faith-based organizations, are comprised by a mix of public and private monies (this is found too in the current study of faith-based organizations and is presented in a later section of this report).

However, though the federal government touts the need for increased reliance on faith- and community-based organizations for helping to alleviate various social ills at the local level

[2] Reasons cited for not actively seeking government funding include: having to deal with the seemingly endless paperwork required, fear of not being able to pursue certain religious programs, fear of having to compromise current faith-based programming, and the greater ability of faith-based organizations to raise funds through private sources.

(hence the passage of the above noted Executive Orders), and seeks to increase its funding streams to faith-based organizations (either directly or through state block grant funds) in support of this notion, there remains a paucity of empirical research on the effectiveness of these organizations. Though functioning as an arm of the government due to receiving government monies (technically, a mechanism of formal control), these organizations, due to their community level interests and involvement, are seen as informal (or natural system) sources of control. This is an important distinction empirically because formal systems of control are perceived by and reacted to differently than are those seen as less formal - the connotation being that less formal sources of control are more nurturing, responsive, and holistic. This distinction, too, however, has received limited attention by researchers and the differential impacts of formal mechanisms of control and informal ones on client outcomes are worthy of examination. This current study seeks to address these, and other, gaps in the research.

The Current Study

This study seeks to examine the specific roles and activities of area faith-based organizations, the social and demographic characteristics of the clients they serve, and the nature of the treatment counselors charged with their care. In all, this research was conducted in order to identify, describe, and prepare for the dissemination of 'best practices' for the delivery of social services by similar organizations servicing similar populations. Moreover, this research seeks to begin to bridge the gap between service delivery at the community level and awareness by other faith- and other community-based organizations of 'best practices' for doing so. This study draws its samples from the Baltimore City/Baltimore County area. The treatment sample was drawn from five partner faith-based organizations and the matched comparison sample from a Baltimore City probation and parole office.

Overview of the Study Area

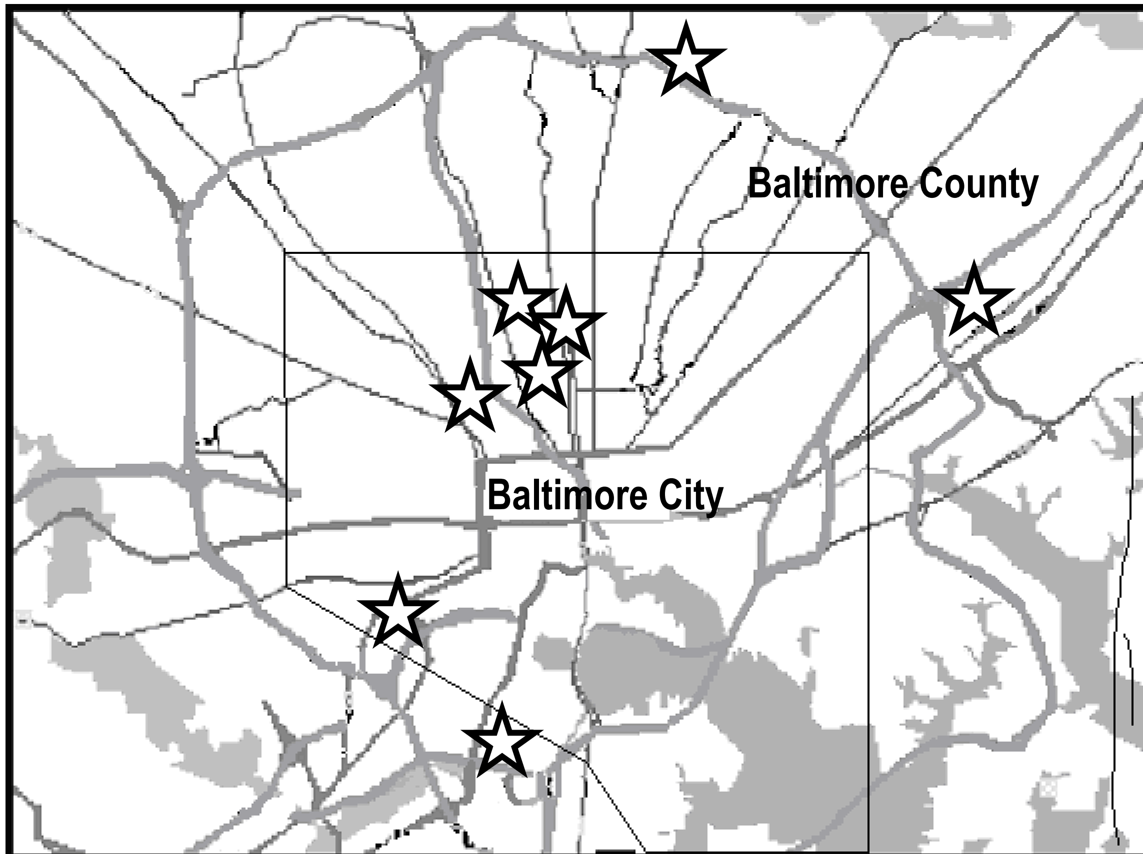
The study area for this project, Baltimore City and parts of Baltimore County, is well suited for the examination of the impacts on clients in need by faith-based organizations. Specifically, the organizations included in this study service communities with high-needs populations; particularly, communities comprised of high-minority populations, with low educational and income levels. Populations, too, which suffer from reduced access to medical treatment, both physical and mental health services (as described in the preceding section). Following is a general description of the larger Baltimore City/Baltimore County areas.

Baltimore City and Baltimore County are located in the central part of the state of Maryland and together comprise approximately 25% of the state's population (U.S. Census, 2003). Baltimore City is two-thirds (65.6%) African American compared to Baltimore County, which is only about one-fifth or 21.1% African American. Both areas have substantially higher proportions of African American residents than the national average (12.3%of the population). Both the city and the county mirror the state and national populations regarding the male to female ratio, with females comprising more than half of the population. Individuals from Baltimore City have a much lower educational attainment level than Baltimore County. In the city, only 16.6% of the population has attained at least a bachelor's degree compared to roughly one-third of the population in the county and the rest of the nation. Relatedly, residents of Baltimore City are much more likely to be unemployed and to earn a lower income than those in neighboring Baltimore County, and than the rest of the nation more generally. For example, residents of Baltimore City earn, on average, $32,337 per year as compared to the average income earned of $53,282 in Baltimore County. The state earned income average is slightly higher than Baltimore County at $55,650, while the national average is lower at $43,057. Additionally, the unemployment rate in the city is 8.1% compared to 5.3% in the county, 6.3% in the state, and 7.4% in the nation as of 2002.

The following figure (Figure 1.1) presents a map of the Baltimore City/Baltimore County area, highlighting the locations of our partner faith-based organizations (across 7 locations, see following description) including the location of the probation and parole office from which our comparison sample was drawn. For purposes of maintaining confidentiality of the sites, the site

locations are not identified as to which partner organization (including the probation and parole office) they represent.

Figure 1.1 Map of Study Area and Partner Organization Site Locations



Treatment Sites and their Clients

Overview of Partner Faith-Based Treatment Organizations

We partnered with five faith-based organizations for this study, which are identified simply by number (FBO1 through FBO5) to protect their identity. Following is a descriptive overview of each organization based in part on their organizational literature and our research observations. These differences also presented more succinctly in Table 1.1.

Faith-based Organization One (FBO1) is a large organization serving up to 62 clients with 19 staff dispersed across two locations, one in Baltimore City and the other in Baltimore County. The mission of the organization is to assist homeless persons in the Baltimore Metropolitan Area. At the Baltimore City location, FBO1 targets homeless men over the age of 18, with an emphasis on those with chronic substance abuse issues. Six staff members serve in a supportive service capacity with the clients in this residential program that lasts up to two years. Services include, but are not limited to: substance abuse education and prevention, individual counseling, group counseling, referrals for outpatient substance abuse treatment, skills development training, life skills classes, transportation services, follow-up services, and Narcotics Anonymous (NA) meetings held onsite.

At FBO1's Baltimore County location, the organization offers housing for women over the age of 18 and, if applicable, up to three of their children. There are two staff members who provide direct service to these homeless women and children in this residential program lasting up to two years. The staff also provides individual counseling and recreational activities for the clients. The primary focus in servicing the client at this location is to provide referrals for a range of medical, vocational, educational, psychological, childcare, and housing needs.

Faith-based Organization Two (FBO2) also operates at two locations, both in Baltimore County. The larger site is a residential facility, providing housing for 49 homeless males over the age of 18, with up to 12 of them in an intensive, faith-centered Protective Care program. Seven full-time staff members operate the facility and perform a number of functions; in addition to direct support to the clients, staff members are also tasked with administrative and custodial duties. The goal of this program is to empower the men with the tools needed to permanently end their cycle of homelessness. Services provided to the men include: group counseling, individual counseling, religious fellowship, prayer meetings, marital counseling, transportation, and referrals for particular housing needs, job readiness, and substance abuse counseling. Based on the different individual needs and motivation levels of the clients, residents can stay in the program up to one year.

The second location for FBO2 has a different mission than the first; its goal is to provide a healthy Christian family environment for women in crisis (typically in the form of counseling for pregnancy, homelessness, and/or substance abuse problems). Women from age 12 to 50 have entered this intimate residential program. The program allows up to 7 women and their children

to reside in this facility, which mimics a residential home. In addition to the counselor who, along with his/her family, resides with the females, there are 11 other staff onsite, with 5 providing direct support services to the clients. Each female is also assigned a mentor from the church parish. Additional services include: domestic skills training, recreational activities, individual counseling, and referrals for a range of needed services. The residents are not assigned an affixed term of stay, but the average length is approximately 9 months.

According to its promotional literature, Faith-based Organization Three (FBO3) is a tough love, spiritually based, residential program with the goal to help drug addicts become physically and spiritually healthy individuals. The program, lasting from 6 months to 3 years, is open to 8 substance-abusing males over the age of 18 who have completed an intensive drug detoxification program at an area facility. There are 5 staff members who provide direct client services including: individual and group counseling, regular urinalysis, transportation, referrals for various individual needs, and monitoring of client adherence to parole/probation protocol, if applicable.

The fourth Faith-based Organization (FBO4) is a large, residential facility in Baltimore City, providing services for 109 homeless, adult men between the ages of 21-60. FBO4's mission is to assist these men with recovery from substance abuse, reconciliation with family, and skill development. There are 25-35 staff that support the program in some capacity, with 8 of them providing direct client support. Services available to clients include: bible study, substance abuse relapse prevention, Alcoholics Anonymous (AA), group counseling, individual counseling, recreational activities, Narcotics Anonymous (NA), referrals for individual needs, and life skills training.

The fifth Faith-based Organization (FBO5) is located in Baltimore City and provides a residential environment for 72 homeless women over the age of 18 and, if applicable, their children. The facility provides a safe haven for individuals interested in rebuilding their lives. Of the 72 clients, up to 19 are part of the transitional housing program, which seeks to improve clients' life skills, job skills, education, money management, and emotional health. The remaining space in the facility is reserved for those staying on an emergency basis, and these clients are provided food, housing, and appropriate referrals. There are 13 staff members at the facility, all of who provide some direct client support. Only 2 of the staff, however, engage in

case management. Services provided include individual counseling, life skills training, and referrals for other needs.

Table 1.1. Programmatic Differences between Study Sites

Program Descriptive	FBO1	FBO2	FBO3	FBO4	FBO5
Number of clients	75	50	8	109	72
Gender of clients served	Both	Both	Men	Men	Women
Modality of treatment	Residential	Residential	Residential	Residential	Residential
Number of treatment staff	21	12	5	30	2

Funding Sources

The budgets of these organizations are comprised of a combination of monies from public and private arenas, with most of their funding (45%) coming from federal, state, and/or local government grants. Corporate and individual donations make up about 36% of their budgets with private foundation and other source monies comprising a very small proportion (See Table 1.2). It is interesting to note that these programs do currently receive a substantial proportion of their funding from government sources and it is worth examining over time how the passage of Executive Orders 13198 and 13199 impacts their ability to apply for and receive funding and thus their overall budgets (either with the increased availability of funds directly from federal or state sources or via block grants).

Table 1.2. Funding Sources for Partner FBOs

Funding Source	%
Percent of budget funded by Government grants (federal, state, local)	45
Percent of budget funded by private (corporate, individual) donations	36
Percent of budget funded by private foundations	5
Percent of budget funded by from another source	7

Client Characteristics by Site

Clients in the treatment group were recruited from the five partner faith-based organizations and were accepted into the study as long as they had not been in the treatment program longer than 30 days (pre-intervention status) – thus decreasing any possible treatment effects that might be more prevalent among longer-term clients. Once deemed eligible for the study, clients signed informed consent forms indicating their awareness of the confidential nature of the information collected, of their ability to withdraw from the study at any time without fear of reprisal, and the granting of their permission to allow us to review their treatment case files and official arrest records. At the baseline interview clients also voluntarily provided a urine sample, which was tested in their presence and then discarded. At the conclusion of the baseline interview clients provided locating information (e.g., including addresses and telephone numbers for relatives and friends who might know their whereabouts) so that we could contact them for a follow-up interview. Clients were paid $25 in food vouchers as compensation for their time.

In total, 126 individuals were recruited, deemed eligible to participate in the study, and completed a baseline interview. Of these, 74 were located and interviewed at the follow-up time period, a follow-up rate of 59%, with follow-up interviews occurring on average 188 days (or 6 months) post baseline. At both interview times, clients were asked questions regarding their family situation, employment experiences, drug use, criminal activities, mental/physical health status, psychological functioning and religiosity. At the follow-up period, clients were also asked about their treatment experience with the partner faith-based organization. In addition to interviewing these clients face-to-face, information regarding their treatment experience was also gathered by reviewing and coding their treatment files maintained by the faith-based organization. Information collected included the types of services participated in, the number of hours of treatment, and the completion status of treatment.

The following tables present client characteristics by organization to provide a sense of the different types of clientele each organization accommodates. These characteristics are based on information provided in the course of face-to-face, self-report baseline interviews with our treatment sample of 74 clients. Table 1.3 presents demographic descriptions of the clients interviewed at each partner FBO site.

Table 1.3. Demographic Descriptions of Clients by FBO Site - Baseline

	Faith-Based Organizations				
	FBO1 (N = 19)	FBO2 (N = 7)	FBO3 (N = 5)	FBO4 (N = 33)	FBO5 (N = 10)
Demographics					
Male, % ***	95	86	100	100	0
Black, %	84	57	100	64	70
Age, years (sd) **	44 (9)	37 (9)	37 (2)	40 (7)	33 (7)
Single/ never married, % *	63	57	80	67	20
Education, years (sd)	11.1 (2.4)	11.4 (1.8)	11.8 (1.1)	11.1 (1.9)	11.8 (1.6)
Unemployed past year, %	42	14	40	39	50

*** p < .01 ** p < .05 * p < .10 Numbers in parentheses are standard deviations

In general, the faith-based organizations in our study provide services to a mostly male, African-American population, with the exception of FBO5, which is a female only treatment site. The average age of clients at these sites ranges from 33 to 44, which is significantly different across sites. With respect to marital status, the predominantly male sites have residents who, on average, are single and never married, while at the all female site, the majority of clients are currently, or have been, married. The educational level of clients at each site is fairly consistent with an average number of years of education at or below a high-school graduation level. And, the average unemployment rate of clients varies across sites from a low of 14% to a high of 50%, though this range is not significant.

Table 1.4. Offending and Drug Use History Characteristics of Clients by FBO Site - Baseline

	FBO1	FBO2	FBO3	FBO4	FBO5
Offending/ Drug Use History					
Ever arrested, % ***	100	86	80	97	20
Number of prior arrests (sd)	7.5 (8.3)	11.7 (9.4)	6.8 (6.3)	12.3 (10.7)	5.0 (4.2)
Used drugs/alcohol past year, % ***	84	86	100	97	40
Positive urine sample, %	5	0	20	9	0

*** p < .01 ** p < .05 * p < .10 Numbers in parentheses are standard deviations

Across most sites, again with the exception of the female-only site, clients of these faith-based organizations have extensive offending and drug use histories, with the majority (if not all) of the clients at each site, having had at least one arrest in their lifetime and with the majority of clients having had used drugs and/or alcohol in the past year (a finding not unexpected with this type of sample) (see Table 1.4). Furthermore, these offending histories include numerous arrests, even for the female-only site, with the number of prior arrests ranging from an average of 5 to a high of 12.

Table 1.5. Family/Social Relations of Clients by FBO Site - Baseline

	FBO1	FBO2	FBO3	FBO4	FBO5
Family/Social Relations					
Had significant problems with family members in the past year, % *	53	71	80	76	40
Lived in an unstable residence past 30 days, % *	21	14	60	24	60

*** p < .01 ** p < .05 * p < .10 Numbers in parentheses are standard deviations

As shown in Table 1.5, across sites, the majority (or near majority) of clients have experienced significant problems with family members in the past year (40% to a high of 80%), which could account in part for the fact that many clients have also had unstable living arrangements in the past month (from a low of 14% to a high of 60%); both of these variables are significant across sites.

Table 1.6. Physical Health Status of Clients by FBO Site - Baseline

	FBO1	FBO2	FBO3	FBO4	FBO5
Physical Health Status					
Ever tested for HIV, %	95	100	100	88	80
HIV Positive, %	11	0	0	0	0
Uninsured, %***	63	71	80	85	0
Number of Medical Office visits past year, mean (sd)	6.3 (8.4)	5.7 (5.7)	4.6 (5.9)	3.6 (3.1)	6.4 (7.9)
Number of ER visits past year, mean (sd)	2.6 (2.9)	3.5 (2.1)	3.3 (2.5)	2.9 (2.7)	2.0 (.8)
Any tobacco use, %**	84	29	60	79	60

*** p < .01 ** p < .05 * p < .10 Numbers in parentheses are standard deviations

As presented in Table 1.6, the majority of clients have been tested for HIV, however, only one site in this study has clients who are currently HIV positive (FBO1) with 11% of the sample; given the low sample sizes in this study, this difference is not significant statistically, though is significant from a public health standpoint. This finding is significant too in light of the extremely high numbers of uninsured clients at these facilities. With the exception of FBO5 (who rely mostly on Medicare/Medicaid for health coverage), the majority of clients (ranging from 63% to 85%) at each of the other sites do not have any type of health insurance (private or public aid). Despite the low level of insurance coverage, clients in this sample have visited a doctor, medical clinic, or the emergency room on average once every six to eight weeks, or about 8 times per year; a rate almost triple the number of doctor visits per year by the average

American (Woodwell 1997). Potentially contributing to this high reliance on medical resources is the fact that the majority of clients (about 63% across all sites) also use tobacco products on a regular basis; again, a prevalence rate about two and half times the rate for American adults (World Health Organization 2002).

Table 1.7. Mental Health Status of Clients by Site - Baseline

	FBO1	FBO2	FBO3	FBO4	FBO5
Mental Health Status					
Depression past year, % **	47	71	100	82	40
Anxiety or tension past year, % ***	37	100	40	73	30
Beck Depression Index (BDI) Score, range 0 – 63, mean (sd)	13.6 (9.9)	12.3 (8.1)	20.6 (6.0)	13.6 (8.3)	8.6 (13.9)
DASES, range 16-112, mean (sd)***	83.6 (22.4)	86.5 (19.3)	63.0 (16.5)	72.3 (15.6)	104.4 (6.1)

*** p < .01 ** p < .05 * p < .10 Numbers in parentheses are standard deviations

A review of client's mental health status across sites, as shown in Table 1.7, reveals significant differences with respect to treating clients who have suffered from depression (with a range from 40% to 100% of the clientele) and anxiety/tension (range of 30% to 100%) over the past year. In addition, results from the Beck Depression Index (BDI) scores reveal low overall levels of depressive feelings and behaviors, but varying levels consistent with self-report experiences. The BDI measures the severity of depressive symptoms corresponding to the psychological, nonsomatic criteria for diagnosing major depressive disorders in the DSM-IV. The higher the score indicates a higher level of depression. While depression levels vary, they are still significantly higher than average rates reported by American adults of only 9.5% (with men reporting rates of only 7% and women reporting rates of 12%) (Regier 1993). Reported prevalence rates among clients, across sites, for feelings of anxiety are also significantly higher than the national average of only 13% (NIMH 2001).

Additionally, drug avoidance self-efficacy, or one's belief in their ability to avoid using drugs, was measured using the Drug Avoidance Self-Efficacy Scale (DASES) (see too Martin, Wilkinson, & Poulos 1995) with a higher score indicating a higher level of drug avoidance self-efficacy. Results indicate significant differences across sites regarding client's perceived levels of drug avoidance self-efficacy with scores ranging from a low of 63 to a high of 104. A measure such as this is important since self-efficacy beliefs provide the motivation for undertaking tasks; the first step in achieving desired goals, for example, abstaining from drug

use. As presented by Bandura, his key contention about the role of self-efficacy beliefs is that "people's level of motivation, affective states, and actions are based more on what they believe than on what is objectively true" (1997:2). For this reason, how people behave can often be better predicted by the beliefs they hold about their capabilities than by what they are actually capable of accomplishing.

Table 1.8. Religiosity Experience of Clients by FBO Site - Baseline

	FBO1	FBO2	FBO3	FBO4	FBO5
Religiosity Experience					
Considers self to be religious, %	90	100	100	94	90
Religiosity Score, range 1-6, mean (sd)	4.6 (.99)	5.3 (.41)	5.2 (1.0)	4.6 (.77)	4.5 (1.1)
Attended religious service within past two months, %	68	100	100	88	60
Attended bible studies in past year, %*	26	71	80	64	40
Attended religious education in past year, % *	16	71	40	55	40
Attended prayer meetings in past year, %	26	43	40	33	30

*** p < .01 ** p < .05 * p < .10 Numbers in parentheses are standard deviations

As expected, clients of these organizations are highly religious and consider themselves to be a religious person (range from 90% to 100% of clients interviewed) (see Table 1.8). Additionally, their level of religiosity was examined by asking questions borrowed from religiosity scales presented in Evans et al. (1995); combined into a new scale, the reliability coefficient (alpha) was .74 (see Appendix A for Religiosity Scale Questions). The scale ranged from 1 (strongly disagree) to 6 (strongly agree); thus a higher score represents a higher level of religiosity. The sites show consistency with respect to the level of religiosity held by their clients with a range in scores from 4.5 to 5.3 (a non significant difference). Across sites, most clients (57%) have attended bible studies and/or some form of religious education (46%) in the past year, with an average of 35% attending prayer meetings. With respect to bible studies, participation ranges significantly across sites, with clients at sites 2, 3, and 4 attending at much higher rates (64 to 80%) than clients at sites 1 and 4 (only 26% to 40%). Sites 2 and 4 also have clients with the highest rates of attending religious education (55 to 71%), with rates ranging significantly different across sites (with a low of 16% in Site 1). Attendance rates across sites for prayer meetings are more consistent and are not significantly different.

Client Treatment Outcomes

As shown in Table 1.9, significant differences were found across sites with respect to the average length of time clients remained in treatment and whether or not clients successfully completed treatment (or were still in treatment at the time of the interview). Clients participating in treatment at FBOs 1 and 2 remained in treatment the longest, on average almost 6 months), while clients at FBO3 had the shortest treatment stays of less than 3 months. FBO3 also has the lowest successful completion rate of only 20%, while FBOs 4, 1, and 2 range in successful completion rates between 53% to 71%. FBO5, with an average length of stay of about 4 months, also boasts a 100% successful completion (or current treatment) rate.

Table 1.9. Treatment Outcomes for Clients by FBO Site – Follow-up

	Faith-Based Organizations				
	FBO1 (N = 19)	FBO2 (N = 7)	FBO3 (N = 5)	FBO4 (N = 33)	FBO5 (N = 10)
Treatment Outcomes					
Length of time in treatment, days (sd)***	182 (74)	167 (59)	83 (55)	133 (50)	115 (80)
Completed treatment successfully/ Still in treatment at time of interview, %**	65	71	20	53	100
Participated in drug/alcohol treatment, %***	95	100	100	100	30
Participated in life skills treatment[1], %*	62	57	40	30	70
Participated in bible studies/prayer meetings, %*	79	100	80	100	80

*** p < .01 ** p < .05 * p < .10 Numbers in parentheses are standard deviations

[1]Life skills treatment encompasses anger management; family counseling; employment, educational, and housing assistance; and life/parenting classes

Clients at each of these sites participated in a wide range of treatment services ranging from various life skills programming to intensive drug/alcohol treatment, to specific religious classes such as bible studies and prayer meetings. While not unexpected, the majority, if not all, of the clients at each site (with the exception of FBO5) participated in drug related treatment. Only 30% of clients at FBO5 did so, however, which might be a function of the fact that services were most often referred out, and as reported above, only 40% of clients reported having a drug/alcohol problem, and none tested positive for any drug at the time of the baseline interview. Compared to clients at the other sites, it therefore seems that this particular all-female group has less severe drug and alcohol related problems. This group of women, did, however, participate

in life skills treatment at a higher rate, which is not surprising given the stronger relationship between women and their social support networks (including other family members and children), and the greater dependence placed on them to support other family members (thus accounting for their high rates of participation in educational and employment services). Participation in specific religiously focused programming, such as bible studies and prayer meetings was also high across sites with a range of 79 to 100% of clients participating.

Treatment Counselors

For this study, 19 counselors from participating faith-based treatment sites were interviewed. Though this number may seem small, this actually reflects a high rate of involvement with 90 percent of those eligible for the study consenting to be interviewed. The process of gaining consent began by compiling a list of all staff that had contact with clients. The senior member of the staff who served as our liaison for the project generated this list. Interviewers then contacted the individual staff members to solicit their consent. Many of the staff members were aware of the project, but to ensure full disclosure, we provided each staff member with a brief introduction to the project before asking for their participation. After establishing an appropriate time for conducting an interview, interviewers visited the staff to administer the 1-2 hour survey in a private location at the treatment site. Informed consent was obtained from each counselor and they were compensated with a $25 money order for their time.

Among the staff members interviewed, 74 % were male, 58% African American, with an average age of 47.5. The average number of years of education was 15.8, or high-school plus some college experience. The average number of years experience with their current employer is 4.5 years. However, in general, the staff had a high cumulative number of years of counseling experience with the average counselor having 12.8 years experience in the field. Many of the counselors have struggled with their own substance abuse problems with 42% admitting to a prior alcohol or drug addiction, though most stated that while their addiction posed a significant problem in the past, it currently was not a real problem.

While religious affiliations of the staff varied in terms of denominations, based on the answers to a number of questions regarding religious beliefs and activities (borrowed from Evans et al. 1995) it was clear that the staff were committed to their religious beliefs and participated in

religiously focused programming at a high rate (see Table 1.10). And, all of the staff agreed that faith is an important part of the counseling process. Various explanations included: religion inspires counselors to be more empathetic, belief in a higher power helps a person change, and faith is commensurate to hope, which is a necessary component to recovery.

Table 1.10. Religiosity Experiences of Treatment Staff

Treatment Staff Religiosity Characteristics	
Considers self to be a religious person, %	100
Attends religious services at least weekly, %	79
Reads religious material at least weekly, %	84
Participates in AA/NA, %	11

To get a sense of the workload of these counselors and the types of treatment services offered at these faith-based sites, questions were asked about each counselor's caseload and the number of hours they spent performing certain treatment related tasks (see Table 1.11).

Table 1.11. Treatment Staff Duties and Hours by Task

Treatment Staff Duties	
Average case load, number of clients (sd)	23.8 (21.2)
Average hours spent per week on intake (sd)	3.7 (4.7)
Average hours spent per week on case management (sd)	9.9 (10.3)
Average hours spent per week on group counseling (sd)	8.4 (9.9)
Average hours spent per week on individual counseling (sd)	8.9 (10)
Average hours spent per week on AA/NA (sd)	6.0 (7.1)
Average hours spent per week on bible studies (sd)	5.9 (9.4)
Average hours spent per week on religious education (sd)	2.8 (3.2)
Average hours spent per week on job readiness (sd)	3.0 (1.5)
Average hours spent per week on employment placement (sd)	3.5 (2.1)
Average hours spent per week on life skills classes (sd)	2.1 (1.2)

Numbers in parentheses are standard deviations

As shown in Table 1.11, on average, treatment counselors at the faith-based sites had a caseload of about 24 clients, a caseload about 10 clients higher than counselors stated would be more manageable. Counselor hours are spread out throughout the week conducting various treatment sessions from group and individual drug treatment, to specific religious programming, to life skills and employment placement.

Counselors were also asked about their perceptions of the causes of and ability to recover from substance abuse addition and the appropriateness of various types of treatment (see Table 1.12). Results from an administered Treatment Philosophy Survey comprised of nine different scales (see below) suggests that counselors of these sites saw items measuring labeling, social control, social learning, antisocial values, cognitive-behavioral, and psychopathic as likely to be causes of substance abuse (see Appendix B for survey); with responses ranging from 1 "strongly disagree" to 5 "strongly agree", a higher score therefore indicating a greater support for that set of items (see Taxman, Simpson, and Piquero 2002).

Table 1.12. Treatment Staff Treatment Philosophy Measures

Treatment Philosophy Scale	Mean scale score
Conflict Scale[3]	2.6 (1.0)
Labeling Scale	3.8 (.65)
Social Control Scale	3.9 (.62)
Social Disorganization Scale	2.8 (.77)
Social Learning Scale	3.8 (1.0)
Strain Scale	3.1 (.94)
Antisocial Values Scale	4.0 (.76)
Cognitive-Behavioral Scale	3.9 (.64)
Psychopathic Scale	3.8 (.79)

Numbers in parentheses are standard deviations

Treatment counselor philosophy is an important concept to measure since it allows for insights to be gained into how treatment is delivered and how this delivery can impact client response to treatment. Furthermore, client response to treatment is related to the continuation or abstention from particular behaviors, which treatment counselors seek to curb, such as continued criminal offending and substance use. In examining the results in Table 1.12, while it is important to note those things that counselors do feel are contributors to substance abuse, it is also important to note those things that counselors do not feel are so. This particular information gives a sense of how the counselor (and by extension, the larger organization) views substance abuse addiction and how best to treat it. In the case of the five faith-based organizations in this study, the three areas most felt to contribute to the causes of substance abuse were anti-social

[3] The Cronbach alpha reliability scores for each of the scales with this sample are as follows: conflict (.84); labeling (.56); social control (.70); social disorganization (.86); social learning (.98); strain (.90); antisocial (.75); cognitive-behavioral (.87); and psychopathic (.77).

values, social control, and cognitive-behavioral issues. The two least influencing factors were conflict (e.g., differences based on social classification such as gender or race) and social disorganization. This last finding is somewhat surprising given the identified relationship in the literature between different types of neighborhood instability, for example, high levels of unemployment is linked to high crime rates and to high substance abuse rates (Anglin et al. 1999; Reuter 1997; Fagan 1992). Perhaps, however, given that these organizations are located in, and service, communities that by some accounts could be considered unstable, and that counselors themselves are often from these, or similar, communities – have also suffered from substance addiction and have overcome their addiction – substance addiction is seen in more personal terms and as overcome only by personal triumph. Future research would be served well by examining this finding more closely, particularly the link between treatment counselor philosophies and treatment delivery styles.

Discussion

The purpose of this study was to examine the types of services provided by faith-based organizations and to gain an understanding of how faith is incorporated into the delivery of social services. In addition, this study sought to identify the social and demographic characteristics of the clients served by these types of organizations as well as the characteristics and nature of the treatment counselors who served them.

One important finding from this study is that while all of the faith-based organizations included in this study integrate a spiritual component into their treatment regimen, this component varies widely among the organizations. Spirituality has multiple meanings, especially according to the different treatment philosophies of the organizations. For example, at one of the facilities, clients are encouraged to overcome substance abuse through a strengthening of their faith. They are provided one-on-one intensive counseling regarding their spiritual connection to God. After gaining internal strength from their religious convictions, the clients are then encouraged to overcome their substance addiction.

Other facilities do not share this specific approach to substance abuse recovery. In particular, another of the facilities interprets substance abuse as a symptom of a wide range of social, psychological, and spiritual issues. While religious education is offered, the one-on-one

sessions with treatment staff are not specifically spiritual in nature. A key difference between the two programs mentioned above is a function of the fact that the providers in the first program are primarily ordained religious counselors, while in the second organization the counselors are primarily trained as social workers.

The other three organizations, by observation and a review of their organizational literature, fall some where in between the two described with respect to overt displays and the inclusion of spiritual beliefs into the recovery process. The importance of presenting these distinctions is to recognize that the concept of faith-based varies considerably in terms of how the programs perceive the role of faith in substance abuse recovery. While there are many faith-based organizations, there is not a clear definition of what it means to be faith-based, and more importantly, what the role of faith is, and how it is (or should be) included in, providing substance abuse treatment.

In addition, an interesting finding emerged in a review of the budgets of each of these organizations. Particularly, at present, the majority of these organizations funding is provided by government entities; thus, these organizations are part of the few that currently do apply for and receive governmental support (beyond that of direct aid from state and local governments). It is anticipated, however, that this proportion will increase, for these and other like organizations, with the institution of easier funding mechanisms and application processes for these types of community organizations - as proposed by the Federal Faith Based Initiative (per Executive Orders 13198 and 13199). Moreover, it is anticipated that with streamlined application processes, more community programs will apply for available funds directly from the federal government or for funds available through state and federal programs (either supported by state funds or through federal block grant monies awarded to the states).

Based on observations of data collected directly from clients and treatment providers, and from numerous site visits to each of the partner faith-based organizations, it is clear that certain treatment components prove more beneficial with respect to improving client outcomes (see Part II of this report). To achieve these outcomes, a number of practices were observed in the delivery of faith-based treatment services, practices which could possibly serve as “best practice” models for other faith-based programs seeking to replicate the work of the organizations highlighted in this study. Components of service delivery by faith-based programs in this study

identified as either directly and empirically tied to reducing recidivism, or indirectly so through observation, include:

- The employ of counselors who self-identify as "religious" or "spiritual" and who feel that faith (regardless of religious denomination) is an important component of the treatment process;
- The employ of counselors who view substance addiction as a personal and societal problem, similar across all clients, and not stemming from particular social group failings or inadequacies;
- The delivery of services in a holistic manner that treats more than just the substance abuse problem, but also other systemic problems of low education and employment training, physical and mental health issues, and weak family/social relationships;
- The inclusion of different types of specific faith-based programs and activities beyond AA/NA, such as bible studies, prayer meetings, religious education, and opportunities to attend religious services off-site;
- The availability of treatment services for a sustained length of time up to several years;
- The inclusion of family members into the treatment process either by allowing them to also stay in the treatment facility (e.g., the children of female clients), or to attend specifically designed family counseling sessions.

PART II.

THE IMPACT OF FAITH-BASED ORGANIZATIONS ON CLIENT OUTCOMES: A QUASI-EXPERIMENTAL DESIGN COMPARISON

Introduction

As outlined in Part I of this report, there is paucity in understanding of the effectiveness of faith-based organizations to positively impact the lives of those they serve. Specifically, given the populations they serve (namely, the homeless, criminal offenders, and substance abusers) it is important to examine the influence of faith-based participation on client outcomes such as recidivism and abstinence; outcomes which are important to curb in light of their extreme tolls on society. This study, therefore, seeks to examine the specific roles and activities of area faith-based organizations with respect how a religious foundation impacts client outcomes and how effective these organizations are in the reintegration process of criminal offenders back into the community. Outcomes of client participants of the study faith-based organizations are compared with outcomes of clients participating in another form of social control (though arguably, a more formal type of control), community supervision. It is important to examine client behavior in comparison to that of clients receiving other types of intervention services. Future research would be well served to examine these differences in comparison to other community treatment programs, especially those without a faith-based component. The positive impact of treatment participation on client outcomes is well documented (Anglin et al. 1999; Simpson, Joe & Brown 1997; Lipton 1995; Taxman 1998; Simpson, Wexler & Inciardi 1999). However, the added benefit of providing treatment with a spiritual component is not known. It is therefore important to compare client outcome findings across varying treatment modalities – particularly, given the current support (financially and otherwise) by the federal government for faith-based programming.

In this study, a quasi-experimental pre-post intervention design was employed (see Campbell and Stanley 1966) using an individual matched sample of clients from the treatment and comparison groups (see Figure 2.1). This design was implemented and successfully executed and thus, for this matched group analysis, will allow for inferences to be made regarding the impact of the treatment intervention on client outcomes.

Figure 2.1. Matched Group Sampling and Research Design

	Client Baseline Interview	Participation with Services	Client Follow-Up Interview
Treatment Group (N=30)	0_1	X	0_2
Comparison Group (N=30)	0_1		0_2

The Matched Sample

The matched group was drawn via a one-to-one matching process of clients from whom we had follow-up interviews from our partner FBOs and clients from the probation and parole office. Using the matched group design, one of the most prevalent in the field, increases statistical power of the study, thus allowing the design to be structured like a pretest-posttest experiment where similar information is collected at baseline and then at follow-up. Johnson and colleagues (1997) successfully used this method in their study examining the impact of religious programs on institutional adjustment and recidivism rates. The key to employing this type of comparison successfully is to assign each faith-based client with an equivalent match who is not participating in this type of programming using a multivariate matched sampling method. Thus, clients in the comparison sample were recruited from the Probation and Parole Office located in the same jurisdiction as the partner faith-based organizations. In this way, we were able to meet a primary 'match' criterion – the possession of a criminal offending history.

From the total follow-up sample of 110 (74 from FBO clients and 36 from probation and parole clients, as discussed above), a matched group of 60 was drawn (30 FBO clients and 30 probation and parole clients). On the basis of a multivariate individual-to-individual matched sampling method, 30 clients from the treatment group were matched to 30 clients in the comparison group based on client characteristics of gender, race, and age (see Table 2.1).

Table 2.1. Descriptive Data for the Treatment and Comparison Matched Groups

	Treatment Group (N = 30)	Comparison Group (N = 30)
Descriptive		
Male, %	70	70
Black, %	97	97
Age, years (sd)	40 (9.1)	40 (9.8)

Numbers in parentheses are standard deviations

While a propensity score matching method is often used (based on the predicted probability of participation given observed characteristics), the manual one-to-one method used in this study (appropriate given the small sample sizes) ensured that the matched control for each treatment participant has exactly the same value of the selected control variables: gender, race, age (see too Baker 2000). As shown in Table 1, the matched study groups have equal numbers of males (70%), African Americans (97 %), and clients of the same mean age (40 years).

Table 2.2. Demographic Descriptions of Clients by Study Group - Baseline

	Treatment Group (N = 30)	Comparison Group (N = 30)
Demographics		
Single/ never married, %	57	70
Education, years (sd)	11.7 (1.3)	11.6 (1.9)
Unemployed past year, % *	43	70

*** p < .01 ** p < .05 * p < .10 Numbers in parentheses are standard deviations

As shown in Table 2.2, these groups are also similar, that is, non-significantly different, with respect to being single (57% v. 70%) and years of education (11.7 v. 11.6). These groups do however differ significantly on unemployment status (43% v. 70%), with the comparison group being unemployed at a rate almost twice as high as the treatment group.

Table 2.3. Offending History Characteristics of Clients by Study Group - Baseline

	Treatment Group	Comparison Group
Offending History		
Ever arrested, % **	80	100
Number of prior arrests (sd)	6.4 (5.1)	5.3 (4.9)
Committed any crime past year, %	70	63
Committed drug related offense (sale, possession), %	60	47
Committed non-drug related offense	37	27
Arrested past year, %***	40	80
Incarcerated past year, %	40	43
Length of time incarcerated past year, days (sd)	45 (111)	70 (133)

*** p < .01 ** p < .05 * p < .10 Numbers in parentheses are standard deviations

While the two groups report being criminally active at similar rates over the past year, with respect to overall offending rates and the commission of drug and non-drug related offenses, they do differ significantly in lifetime and past year arrest rates (see Table 2.3). For example, the comparison group has a lifetime arrest rate of 100% (compared to the treatment group which has an 80% rate), and a past year rate of 80% (compared to only 40% in the treatment group). Interestingly, while they differ on arrest rates, the groups have comparable rates of incarceration in the past year (40% to 43%) and length of incarceration days in the past year (45 days to 70 days). In addition, they have comparable prior offending histories, with the treatment group reporting one additional prior arrest (6.4 to 5.3), and a slightly higher (though not significant) crime commission rate in the past year (70% to 63%).

Table 2.4. Drug Use History of Clients by Study Group - Baseline

	Treatment Group	Comparison Group
Drug Use History		
Used drugs/alcohol past year, %	85	68
Positive urine sample, % ***	3	40
Ever participated in substance abuse treatment, % ***	100	40

*** p < .01 ** p < .05 * p < .10

As shown in Table 2.4, while the two study groups do not differ significantly on drug/alcohol prevalence rates over the past year (85% to 68), the comparison group tested positive for at least one drug (either cocaine, opiates, marijuana, PCP, or amphetamines) at the

time of the baseline interview at a significantly higher rate (3% v. 40%). Additionally, and not unexpectedly, 100% of the treatment group has participated in prior substance abuse treatment, while only 40% of the comparison group has had similar involvement.

Table 2.5. Change Readiness/Treatment Eagerness of Clients by Study Group – Baseline

Change Readiness/Treatment Eagerness	Treatment Group	Comparison Group
Score, mean (sd)	75.7 (18.5)	68.3 (24.0)

Range (19 – 95) Numbers in parentheses are standard deviations

The two study groups do not differ significantly in their level of change readiness/treatment eagerness at baseline (see Table 2.5) as determined by use of a 19-point scale (with questions ranging from 1 "strongly disagree" to 5 "strongly agree"). The higher the score, the more a client is seen (or perhaps, see themselves) as ready for change of their drug/alcohol habits and as ready to enter into treatment. The non-significant difference between the two groups again indicates the similarity between them with respect to offending and drug use histories. Moreover, it indicates that those in the treatment group are not ready for change or treatment more than those in the comparison group. Thus, with comparable levels of motivation for change at baseline, this is less likely to be a contributing factor if outcomes differences are found between the two groups during the follow-up period.

Table 2.6. Family/Social Relations of Clients by Study Group - Baseline

	Treatment Group	Comparison Group
Family/Social Relations		
Had significant problems with family members in the past year, % ***	60	20
Lived in an unstable residence past 30 days, % ***	43	3

*** $p < .01$ ** $p < .05$ * $p < .10$

As presented in Table 2.6, in contrast to the comparison group, the treatment group reports having had significantly more problems with family members over the past year (60% v. 20%) and having lived in an unstable residence over the past month (43% v. 3%).

Table 2.7. Physical Health Status of Clients by Study Group - Baseline

	Treatment Group	Comparison Group
Physical Health Status		
Ever tested for HIV, %	93	93
HIV Positive, %	4	7
Uninsured, %	53	47
Number of Medical Office visits past year, mean (sd)	4.5 (5.6)	5.2 (5.0)
Number of ER visits past year, mean (sd)	2.9 (2.5)	1.7 (1.9)
Any tobacco use, %	67	73

*** p < .01 ** p < .05 * p < .10 Numbers in parentheses are standard deviations

The treatment and comparison groups do not differ on any physical health status characteristic (see Table 2.7). For example, the groups contain similar numbers of individuals who are currently HIV positive, are uninsured, have visited a doctor/medical clinic or the emergency room in the past year, and who currently use tobacco products. Overall, these figures indicate that both groups suffer from significantly higher medical and health problems than the average American.

Table 2.8. Mental Health Status of Clients by Study Group - Baseline

	Treatment Group	Comparison Group
Mental Health Status		
Depression past year, % **	60	30
Anxiety or tension past year, % ***	50	17
Beck Depression Index (BDI) Score, range 0 – 63, mean (sd)	14.5 (10.8)	8.7 (9.8)
DASES, range 16-112, mean (sd)	89.7 (20.8)	84.8 (20.6)

*** p < .01 ** p < .05 * p < .10 Numbers in parentheses are standard deviations

As presented in Table 2.8, in contrast to the comparison group, the treatment group reports suffering from depression and anxiety at rates double and triple those of the comparison group (60% to 30%; 50% to 17%); rates which are significantly higher. Rates, too, for both groups, which are significantly higher than the national averages reported for depression (9%) and anxiety (13%) (See previous discussion). Interestingly, though, these self-report rates do not manifest necessarily into higher reported rates of depression related behaviors, as BDI scores are not significantly different between the two groups (14.5 to 8.7). Finally, levels of drug avoidance self-efficacy, or one's belief in their capability to avoid using drugs if they so chose,

are similar between the two groups with scores of 89.7 and 84.8 respectively between the treatment and comparison groups.

Table 2.9. Religiosity Experience of Clients by Study Group – Baseline

	Treatment Group	Comparison Group
Religiosity Experience		
Considers self to be religious, %	93	83
Religiosity Score, mean (1-6)	4.8 (.89)	4.9 (1.1)
Attended religious service within past two months, %	83	77
Attended bible studies in past year, %	43	33
Attended religious education in past year, % ***	43	10
Attended prayer meetings in past year, %	32	23

*** p < .01 ** p < .05 * p < .10 Numbers in parentheses are standard deviations

Finally, as shown in Table 2.9, there is not a significant difference with respect to client's views of themselves as religious persons (93% v. 83%), or their scores on the religiosity scale (4.8 v. 4.9). Additionally, there are no significant differences found regarding attendance at religious services, bible studies, or prayer meetings over the past year between the two groups. There is a significant difference with respect to attending some form of religious education, with the treatment group attending at a significantly higher rate than the comparison group (43% to 10%).

Findings

Treatment Participation

Treatment outcomes for the treatment group are reported in Table 2.10. Treatment clients on average remained in treatment for more than four months (126 days) – an important finding given the empirical link between treatment duration and improved client outcomes (Hser et al. 1997; De Leon 1991). In addition, more than half of clients (57%) either completed treatment successfully or were still in treatment at the time of the follow-up interview. The majority of clients (80%) participated in drug/alcohol treatment, life skills programming (57%), and bible studies/prayer meetings (93%).

Table 2.10. Treatment Group Treatment Outcomes – Follow-up

Treatment Outcomes (N = 30)	
Length of time in treatment, days (sd)	126 (59)
Completed treatment successfully/ Still in treatment at time of interview, %	57
Participated in drug/alcohol treatment, %	80
Participated in life skills treatment, %	57
Participated in bible studies/prayer meetings, %	93

Numbers in parentheses are standard deviations

Recidivism

With respect to having an arrest since baseline (see Table 2.11), there are no significant differences found, which could be a function of both the treatment intervention and the fact that many of the comparison group are still under supervision and are abiding by the conditions of their supervision, which includes not having a subsequent arrest.

Table 2.11. Recidivism Outcomes by Study Group – Follow-up

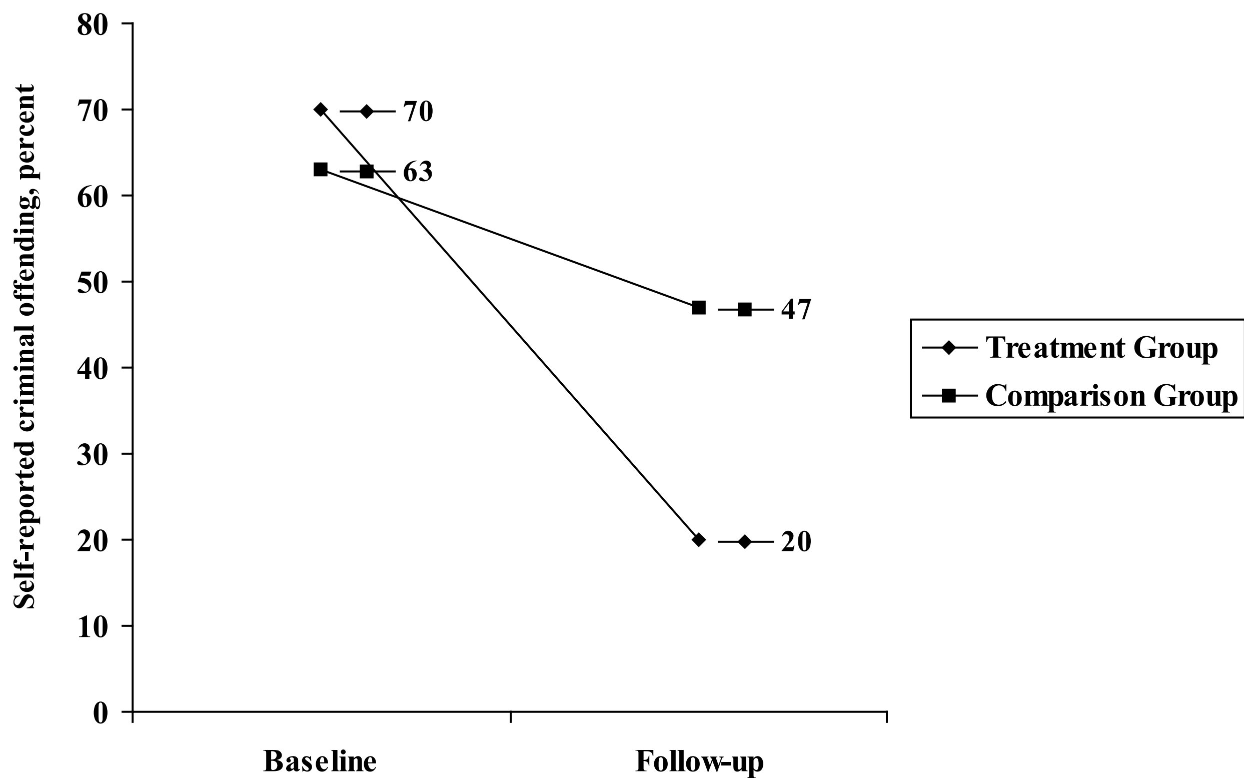
	Treatment	Comparison	Significance	Effect Size
Recidivism Outcomes				
Arrest, %	13.3	6.6	.39	-.23
Committed any crime, %	20.0	46.7	.03	.59

Though not significant, in examining effect size differences, a small negative treatment effect is found (d = -.23). Looking at standardized effect sizes, we gain an overall sense of the magnitude of the effects found in our study (Faul & Erdfelder, 1992). Effect size is used as a simple way of quantifying (standardizing) the outcome differences between two groups, the treatment group and the comparison group for example, and can serve as a measure of observed effectiveness of the intervention. While Cohen (1988) defines a small effect size to be around .20, a moderate effect size around .50, and a strong effect size around .80, it is important to note that in the criminal justice literature, smaller effect size thresholds are commonly observed (see Aos, 1999).

With respect to self-reports of criminal offending during the follow-up period, however, there is a strong and significant treatment effect found (p = .03, d = .59). Recalling that baseline differences in past criminal offending were not significant between the two groups (see Table

2.3), this finding is particularly noteworthy. Moreover, the treatment group experienced a significant reduction of fifty percentage points (p = .00) in criminal offending rates between baseline and follow-up, from 70% to 20%. Though the comparison group, too, showed a numerical reduction in criminal offending rates, this reduction was not significant. These changes over time by group are presented graphically in Figure 2.1.

Figure 2.2.
Changes in self-reported criminal offending from baseline to follow-up by study group



Drug Use

As shown in Table 2.12, there is a significant difference in drug use rates between the two test groups at follow-up. Though differences were not significant at baseline between the two groups, at follow-up, the treatment group reported lower drug/alcohol use rates since the last interview (38% to 73%) and in the past 30 days (23% to 67%).

Table 2.12. Drug Use Outcomes by Study Group – Follow-up

	Treatment	Comparison	Significance	Effect Size
Drug Use Outcomes				
Any drug/alcohol use, %	38	73	.00	.87
Drug/alcohol use past 30 days, %	23	67	.01	.97
Positive urine sample, %	21	33	.29	.28

Moreover, substance use was reduced from baseline to follow-up by 52 percentage points within the treatment group (a significant at the .00 level). These rates indicate a very strong and significant treatment effect as reflective in the calculated effect sizes of .87 and .97 respectively. And, while the treatment group showed a reduction in drug/alcohol use rates, the comparison group showed an increase in use rates of 5 percentage points from baseline to follow-up. Interestingly, however, a significantly higher number of treatment clients tested positive for a drug at the time of the follow-up interview than at the baseline interview (21% at follow-up compared to only 3% at baseline, a significant increase at the .00 level); rates were still lower (though not significantly) than those of the comparison group (33%).

Figure 2.2 presents changes in drug/alcohol use rates during the follow-up period by study group. In addition, Figure 2.3 graphically illustrates the magnitude of the treatment effect (effect size) on criminal offending and substance abuse outcomes between the baseline and follow-up points.

Figure 2.3.
Changes in self-reported drug/alcohol use from baseline to follow-up by study group

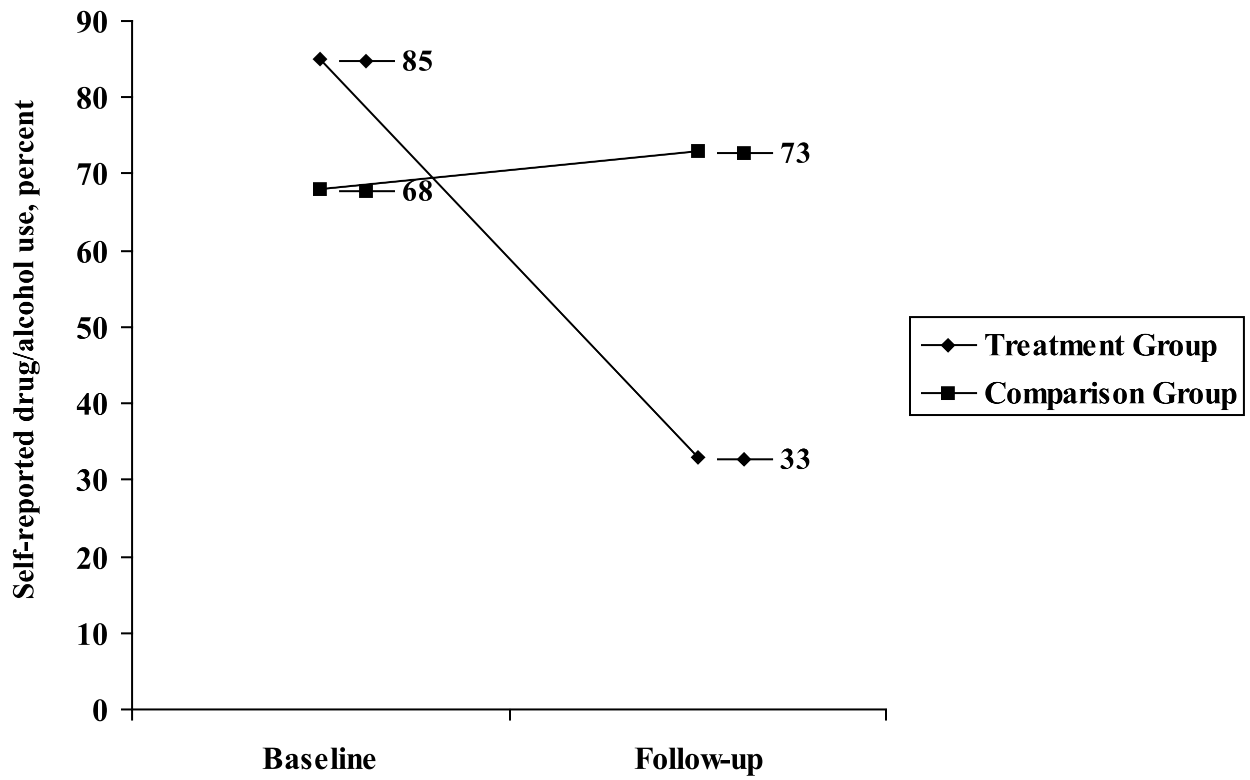
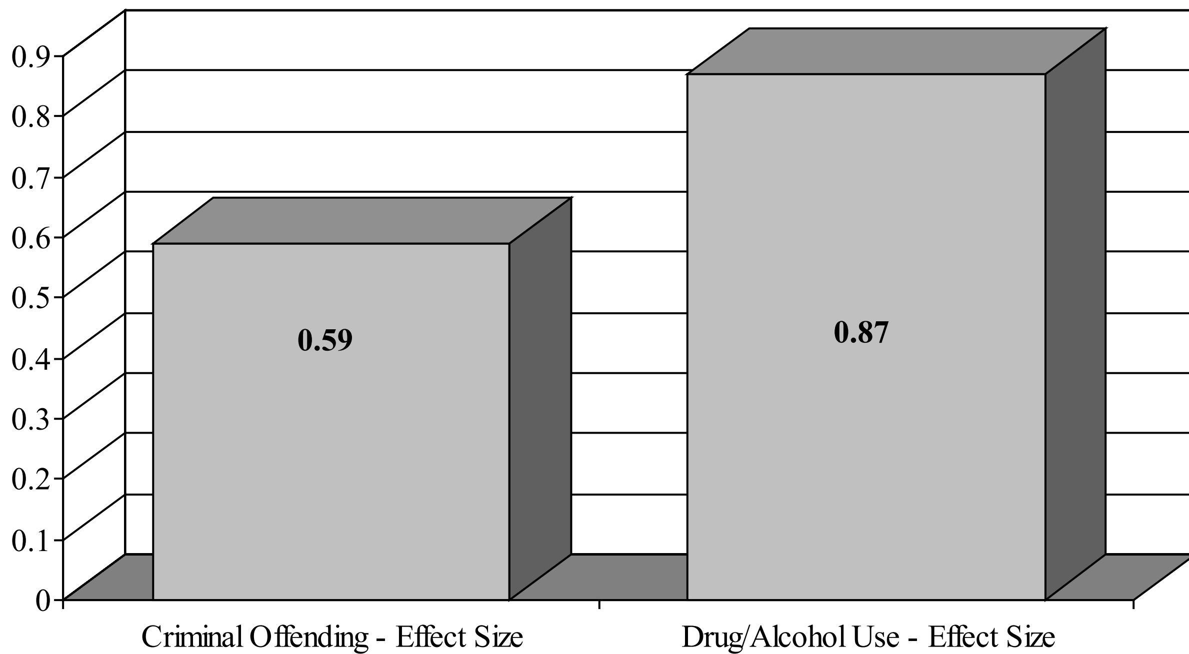


Figure 2.4. Magnitude of Treatment Effect on Recidivism and Substance Abuse



Employment

No treatment effects were found at follow-up with respect to employment (see Table 2.13). The significant difference in employment rates between the two groups at follow-up is comparable to the rates at baseline (with 50% of the treatment group being employed compared to 13% of the comparison group, p = .01). What is most surprising at baseline, and still again at follow-up, is the extremely low employment rates within the comparison group – a group not currently in treatment, which is very time consuming – especially given the fact that a standard condition of supervision is the maintenance of employment.

Table 2.13. Employment Outcomes by Study Group – Follow-up

	Treatment	Comparison	Significance	Effect Size
Employment Outcomes				
Employed at all since baseline, %	47	17	.01	.68
Currently employed, %	40	17	.05	.54

Mental Health

As shown in Table 2.14, self-reported psychological distress (depression and anxiety) rates were high in both study groups at baseline, with the treatment group reporting significantly higher rates than the comparison group. At follow-up, both groups report significantly lower rates of depression (the treatment group down from 60% reporting feelings of depression to 27%, a significant drop at the .09 level; the comparison group down from 30% to 7%); thus, indicating increased levels of well-being. As well-being and psychological distress are opposites poles of singular continuum, more well-being means less distress and more distress means less well-being (Mirowsky and Ross 2003). And, thus, with increased levels of well-being (i.e., a general sense of enjoying life and hopeful about the future), the social costs of distress are reduced. In particular, with lower levels of distress, the number of doctor's visits (including those which are publicly subsidized) is reduced as too are the number of missed days of work; thus alleviating some financial strain put on social services and local employers otherwise (Mirowsky and Ross 2003).

Table 2.14. Mental Health Outcomes by Study Group – Follow-up

	Treatment	Comparison	Significance	Effect Size
Mental Health Outcomes				
Depression since baseline, %	27	7	.04	-.55
Anxiety or tension since baseline, %	17	10	.45	-.20
Follow-up BDI score (sd)	9.1 (10.5)	9.6 (10.0)	.86	-.05
Follow-up DASES score (sd)	85.9 (21.8)	80.4 (21.0)	.35	.26

Numbers in parentheses are standard deviations

These findings are most likely a function of the fact that at the point of recruitment into the study, clients from both groups were either just beginning a new substance abuse treatment program or just beginning a community criminal justice sentence – both, it can be argued, are very stressful psychological life events (thus inducing feelings of depression and anxiety). Six months later, however, at the point of the follow-up, clients may be more settled into their new situations and more at ease with where they are in life. The fact that both groups show such marked differences in depression levels over time does not allow for a statement to be made regarding the impact of treatment. Follow-up BDI and DASES scores remain constant between

both groups from baseline. However, there is a significant correlation found between baseline DASES and drug/alcohol use during the follow-up period for the treatment group, though not for the comparison group. In the treatment group the correlation is -.55 (p = .00), indicating a strong relationship between drug avoidance self-efficacy and drug avoidance; a relationship, it can be argued that is strengthened by participation in treatment more generally, and more specifically, a faith-based treatment program.

Family Relations

While the treatment group continues to report significant problems with family members at a higher rate than the comparison group (a difference which was also significant at baseline), the difference between the two groups has narrowed from a 40 percentage point difference to a 26 point difference) (see Table 2.15). And, while fewer clients in each group report problems with family members, this drop is greater in the treatment group (from 60% at baseline to 33% at follow-up, a significant reduction of at the .02 level).

Table 2.15. Family Relations Outcomes by Study Group – Follow-up

	Treatment	Comparison	Significance	Effect Size
Family Relations				
Had significant problems with family members since last interview, %	33	7	.01	-.71

Multivariate Analysis: The Impact of Faith-Based Treatment on the Likelihood of Recidivism and Drug Use

To determine the likelihood of certain outcomes, namely recidivism (as measured by committing a crime and/or having an arrest during the follow-up period), continued alcohol and drug use, and continued problems with significant family members (seen as the mainstay of one's social support system), binary logistic regression models were formulated. Given that baseline differences were found between the two test groups, certain variables are included in these models as controls. The main independent variables of interest in these models are faith-

based treatment participation and more specifically, bible studies/prayer meeting participation, to test the specific impact of focused religious teaching during the treatment period on outcomes.

When the models were run, faith-based treatment participation, in general, or participation in bible studies/prayer meetings specifically did not have a significant impact on reducing the likelihood of rearrest during the follow-up period. However, while it did not impact the likelihood of this discreet event (rates of which were very low in both groups during the follow-up period), faith-based treatment participation and attending bible studies/prayer meetings, for this sample, did significantly reduce the likelihood of offending behavior over the follow-up period (see Table 2.16). Specifically, participation in treatment reduced the likelihood of reoffending by 76% controlling for a number of background variables, while participation in bible studies/prayer meetings similarly reduced the odds by 71%. Moreover, these results are similar with respect to impacting continued drug and alcohol use over the follow-up period (see Table 2.17). Participation in faith-based programming and bible studies reduced the likelihood of continuing to use drugs and alcohol over the six-month period by 86 and 87% respectively. There was, however, no significant impact on family/social relations (table not shown).

Table 2.16. Impact of Participating in Faith-based Treatment (Model 1) and Bible Studies/Prayer Meetings (Model 2) on the likelihood of Criminal Offending during the Follow-up Period

	Model 1 Offending		Model 2 Offending	
	B	Exp (B)	B	Exp (B)
FBO Treatment Participation	-1.4**	.24	---	
Bible Studies/ Prayer Meetings	---		-1.3*	.29
Prior criminal offending	-.03		.10	
Readiness to Change	.01		.01	
Gender (male)	-1.8**	.17	-1.8**	.17
Race (African American)	-8.2		-8.2	
Age	-.07		-.07	
Constant	2.7		2.5	
Model x^2	13.5**		12.1*	

*** p < .01 ** p < .05 * p < .10

Table 2.17. Impact of Participating in Faith-based Treatment (Model 3) and Bible Studies/Prayer Meetings (Model 4) on the likelihood of Drug/Alcohol use during the Follow-up Period

	Model 3 Drug/Alcohol Use		Model 4 Drug/Alcohol Use	
	B	Exp (B)	B	Exp (B)
FBO Treatment Participation	-1.9***	.14	---	
Bible Studies/ Prayer Meetings	---		-2.1***	.13
Prior criminal offending	.48		.81	
Readiness to Change	.00		-.00	
Gender (male)	-.36		-.42	
Race (African American)	-9.7		-9.8	
Age	-.08*	.92	-.08*	.93
Constant	4.2		4.1	
Model x^2	18.4***		18.6***	

*** $p < .01$ ** $p < .05$ * $p < .10$

Discussion

Findings from this small, quasi-experimental research study suggest strong and significant treatment effects with respect to reduced recidivism and substance use for clients who participate in faith-based treatment as compared to clients who did not participate in such services. Moreover, findings support the benefits derived from one form of social control, faith-based treatment programs, over another, criminal justice supervision - though, of course, faith-based treatment programs are seen more as an informal form of social control as compared to the more formal type of control exerted by supervision systems. Faith-based programs do receive public funding (and often from similar sources as do supervision agencies), but their programs rely on voluntary participation by clients and are provided in more humanistic and holistic terms – they can be seen, therefore, as quasi-natural treatment settings with informal social control mechanisms in place.

That is, participation in a faith-based treatment program is more often on a voluntary basis and retention in treatment is often a function of the positive relationships that clients form with counselors and other residents; failure to comply with program requirements usually results in program dismissal. Failure to comply with supervision requirements, however, often leads to a much harsher, and formally recorded consequences, such as a violation sanction, warrant, or even incarceration. Given this difference in consequences of failure – failure due to continued

criminal offending and drug use – it is even more noteworthy that clients within the less formal milieu of the faith-based treatment program succeeded so much more than their counterparts within the formal criminal justice system. Thus, the impact of forming informal relationship ties, coupled with treatment delivered within a faith-based setting, on client outcomes is all the more stronger.

Given this, however, it is surprising that while ties to the treatment program were strong for clients, and it was often the relationships they formed with counselors and other clients that kept them in treatment, these same effects were not seen with respect to strengthening family relations during the time of treatment. This could be due to the short duration of treatment examined in this study, and that the mending of wounded family ties takes longer than the stay in treatment. Additionally, many of the clients in this study were struggling with very personal problems, such as drug addiction, and it is possible that more time is needed to deal with this problem before attention can be turned to addressing and healing problems with family members. This particular issue would be worthy of study over a longer period in future research – it seems plausible that treatment effects with respect to strengthening family and other social ties would emerge following a longer stay in treatment and participation in other forms of more socially constructed types of treatment such as anger management, family counseling, and parenting classes.

Findings were null with respect to employment outcomes, which is most likely a function of (1) the low employment rates of both groups overall, including scant lifetime employment histories, and (2) the time demands placed on both groups (as a result of treatment and probation requirements), thus limiting the amount of time available to seek and maintain viable employment. Impacts on mental health outcomes though, particularly experiences of depression, are also worthy of note.

Given the limited number of empirical examinations of the direct relationship between participation in faith-based treatment and client outcomes, despite an increased reliance on these types of organizations by both local and state government social service agencies, findings from this study are particularly important. Especially considering the found treatment effects on reducing recidivism and drug/alcohol use among faith-based treatment participants – participants who, like their comparison group counterparts, have extensive criminal and drug use histories and at present suffer from substance abuse addiction at significantly high rates.

Though this study was able to observe first hand the delivery of treatment services in different faith-based settings, and to identify those practices which produced positive effects for their particular clients, it is important to emphasize that, while findings are very notable, this study does suffer from a number of limitations. While a matched-sample quasi-experimental design was employed and successfully executed with respect to creating comparable samples, the two study groups had relatively small sample sizes. Even still, significant treatment effects were found. Future studies in this vein, however, should include larger samples, from a larger number of faith-based treatment sites, thus strengthening both the power of their results and the generalizability of their findings.

In addition, this study, due to a number of factors, was not able to include a second treatment group for comparison, as had been anticipated. While the study had proposed the inclusion of clients from non-faith based community treatment programs, clients from these organizations were either fewer in number than initially expected, were less likely to be located during the follow-up period, or received treatment services that often mirrored those received in the faith-based setting. That is, some "secular" community treatment programs, in fact, were staffed by counselors who saw themselves as religious and incorporated views of their faith into their programs; moreover, some treatment settings had religious undertones, ranging from spiritual sayings on the walls to the offering of participation in religious education on the side. Future research undertakings need to be cognizant of this finding. And, while it is important to include secular community treatment programs into research designs studying the impact of faith-based organizations, it is also important to identify those "secular" programs that in fact have a faith-based feel from those that truly offer services without the overture of religion.

Finally, this study was only able to follow clients for an approximate six-month period, from the beginning of their treatment stay to just following their completion of treatment (or for some, their continued stay in treatment). Thus, while treatment effects were found, and were strong, it is unrealistic to expect that they will not erode over time, without continued treatment exposure in some form, either through direct counseling, or through indirect maintenance ties with the facility. The length of time until treatment effects begin to wane is important to study and to compare these effects to those of other types of treatment and control mechanisms, such as, secular community treatment programs and community criminal justice supervision. Following clients over the course of several follow-up periods, and through several different

types of treatment (and/or supervision experiences) can greatly add to an understanding of the findings presented in this report, as well as to the larger and more sustained effects of participation in faith-based treatment programs.

PART III.
WHAT CAN FAITH-BASED ORGANIZATIONS OFFER? : A REVIEW OF STUDY FINDINGS

Introduction

While examining direct impacts of faith-based treatment participation on client outcomes is important, as positive findings help to support the claimed benefits of these organizations to their local communities and society at large, it is also important to examine the benefit of these organizations from the perspective of the local community and its residents. In essence, in assessing the effectiveness of faith-based organizations, it is important to consider how the organization fits not only into the larger social service support network, but also within the more local community network.

To assess how the local community perceived the area faith-based organization, positively or negatively, business owners in the area were interviewed as part of the research study. Information gleaned from these face-to-face interviews contribute to the 'not in my backyard' debate. 'Not in my backyard' or NIMBY, has become the symbol for those neighborhoods wishing to exclude certain people because of various social, demographic, or racial characteristics (i.e., the homeless, drug addicts, the poor, the disabled, racial and ethnic minorities) (National Low Income Housing Coalition 2004). Specifically, we sought to assess the level of neighborhood support and/or opposition to these organizations in their communities, as it has been argued, for example, that group homes may lower property values, increase traffic, and change the character of neighborhoods. Moreover, critics of various treatment organizations and homes charge that residents of such facilities can be a nuisance, or worse, a danger to the neighborhood (Andre & Velasquez 1989).

The Current Study and Findings

In this study 13 owners/managers of businesses surrounding the treatment facilities were interviewed. Potential participants were selected by canvassing a five-block radius surrounding each of the facilities. Some of the treatment facilities, however, were located in areas remote enough that no suitable businesses were in close proximity. Around the remaining facilities, 54 suitable businesses were identified. A suitable business was defined as an establishment that

involved retail and depended on customers coming to their location for services. The goal was to determine if the treatment facility had an effect, positive or negative, on nearby businesses.

After identifying appropriate near-by businesses, a letter of introduction was sent to each establishment informing them of the study and asking for their participation in an approximate 10-minute survey. Following the mailing of the letter, an interviewer visited each business to solicit the participation of the owner/manager. Of the 54 business owners/managers approached, 27 were eliminated from the study due to an unawareness of the presence of the neighboring treatment facility. Nine owners/managers refused to participate and three were not able to participate because they did not speak English.

Of the 15 owners/managers who were aware of the presence of the treatment site in the community and agreed to be interviewed, 61.5 % were male. The group was diverse racially with 23.1% identifying as white, 46.2% as African American, and 30.8% as Asian. Of this group, about 23% of the owners/managers had at least a bachelor's degree. Nearly 80% percent of respondents had been working at their establishment for 3 years or more, and because of the length of time that they had worked there, many of the owners/managers had witnessed the inception of the neighboring treatment facility.

Most notable is the finding that the business owners/managers were unanimous in agreeing that the treatment site had been a good neighbor to them; thus countering previous research findings suggesting that community residents often harbor negative feelings toward such organizations (Andre & Velasquez 1989). They also all confirmed that the faith-based treatment site in their community has not had a negative impact on their business and that customers have never complained. Three of the business owners (20%), however, did suggest that occasionally, clients of the treatment site did cause problems in terms of hanging around the neighborhood or loitering in near-by stores, alone or with others, and creating noise. However, even in these cases, the business owners did not contend that these complaints had a negative impact on their business. When asked if the fact that the treatment facility was faith-based influenced their opinion of the facility, only one respondent indicated that this was a positive influence on the community as it indicated to them a moral structure to the program; the remaining respondents did not feel that a faith component to treatment made a difference one way or the other on their opinion of the site in their community.

Discussion

It was a rather surprising finding, and an important one to note, that 50% of the businesses surrounding the treatment facilities were not even aware of their presence in the neighborhood. This finding counters the contentions by some that treatment facilities are community nuisances or worse contributors to criminal activity; if their presence is not even known, then their profile in the community is relatively low and thus not identified as a source of community disruption. Overall, then, the sites included in this study are perceived of as good community neighbors, and neighbors that did not initially, and do not currently, face opposition by the local business community. However, it is also important to note that the perceptions of area residents, if applicable, were not taken into account during this phase of the study. It is very possible that residents may see the location of a treatment facility in their neighborhood in a much different way than do business owners. Moreover, given that these facilities are located in poorer, less educated, minority communities (reflective of the populations they serve), this particular study may not be a true example of the NIMBY syndrome; it is not unexpected that resistance faced by some treatment organizations choosing to locate to more affluent, suburban areas would be significantly greater. Even so, whether it is because of the particular areas the organizations in this study are located or that these particular organizations are exceptions to the rule with respect to how these types of organizations normally interact with their local communities, the faith-based organizations in this study were graciously received and positively perceived by other community members.

In light of these somewhat surprising, but very encouraging findings, it is important to broaden the discussion with respect to what faith-based organizations can offer. While, we have demonstrated the positive benefits of these organizations on improving client outcomes, namely reduced recidivism and substance use, and thus serving to alleviate some of the financial and staff strain placed on public social support systems, these organizations also serve as a benefit to their communities by being good community neighbors. By creating and sustaining a non-disruptive and orderly facility, these organizations provide a good example to others in the neighborhood, while at the same time occupying a building or space which might otherwise remain vacant – these facilities, therefore, provide a beneficial service to society, but do so in a manner that benefits their local communities as well.

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APPENDIX A – Religiosity Scale

On a scale of 1 (Disagree) to 6 (Agree), how would you respond to the following questions?

	Disagree					Agree
8. Religion is a very important part of my life.	1	2	3	4	5	6
9. In times of personal trouble, I turn to religion for guidance.	1	2	3	4	5	6
10. After I do something wrong, I fear God's punishment.	1	2	3	4	5	6
11. People who are evil in this world will eventually suffer in Hell.	1	2	3	4	5	6
12. Following God's commandments is important to me.	1	2	3	4	5	6
13. God knows everything a person does wrong.	1	2	3	4	5	6
14. In the end, God punishes all those who have sinned.	1	2	3	4	5	6
15. There is life after death.	1	2	3	4	5	6
16. Many people with diseases are being punished by God for their sinfulness.	1	2	3	4	5	6

APPENDIX B – Treatment Staff Treatment Philosophy Survey

	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
1. The causes of drug use vary by gender	1	2	3	4	5
2. Drug abuse by females is caused in part by gender discrimination	1	2	3	4	5
3. The causes of drug abuse vary by ethnicity	1	2	3	4	5
4. The causes of drug abuse vary by race	1	2	3	4	5
5. Drug abusers tend to associate with other drug abusers because their communities generally reject them	1	2	3	4	5
6. Negative reactions to a person's drug use by the criminal justice system increases his or her likelihood of drug abuse	1	2	3	4	5
7. When a person is labeled as a drug abuser determines how individuals and social institutions respond to him or her	1	2	3	4	5
8. Drug abusers lack respect and affection of significant others	1	2	3	4	5
9. Drug abusers do not calculate the consequences of their behavior	1	2	3	4	5
10. Drug abusers do not cope well with frustration	1	2	3	4	5
11. Drug abusers are risk prone and thrill seekers	1	2	3	4	5
12. Drug abusers have few long-term ambitions or aspirations	1	2	3	4	5

	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
13. Drug abusers have little respect for social rules or conventions	1	2	3	4	5
14. Drug abuse is concentrated in communities characterized by physical and economic decline, social disorder, and population instability	1	2	3	4	5
15. Drug abuse is a product of social disruption	1	2	3	4	5
16. Drug abuse results from generational and culture conflicts	1	2	3	4	5
17. Drug abuse occurs in communities that lack social organization	1	2	3	4	5
18. Declining neighborhoods cause drug abuse	1	2	3	4	5
19. Poverty causes drug abuse	1	2	3	4	5
20. Drug abuse is a product of substandard schools	1	2	3	4	5
21. Drug abuse is a product of substandard housing	1	2	3	4	5
22. Drug use is a learned behavior	1	2	3	4	5
23. Learning drug use is no different than learning other behaviors or skills	1	2	3	4	5
24. The longer one is exposed to stressful life events, the greater the likelihood of drug abuse	1	2	3	4	5

	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
25. Drug abuse is a response to failure to achieve positively valued goals (e.g., good job, education rewards)	1	2	3	4	5
26. Drug abusers are generally people who turn to drugs because they lack access to or have failed to achieve success using legitimate opportunities	1	2	3	4	5
27. The greater number of stressful life events, the greater the chances of drug abuse	1	2	3	4	5
28. Drug abuse is a response to negative life events or conditions (e.g., physical abuse or living in a crime-ridden neighborhood)	1	2	3	4	5
29. Drug abuse is a response to the loss of something positively valued (e.g., a job or breakup of a romantic relationship)	1	2	3	4	5
30. The more recent the stressful life event, the greater the chance of drug abuse	1	2	3	4	5
31. Drug abusers generally lack a set of pro-social values	1	2	3	4	5
32. Drug abusers generally lack effective coping skills for dealing with stresses in life	1	2	3	4	5
33. Drug abusers generally lack social skills that would help them manage their lives	1	2	3	4	5
34. Drug abusers generally lack life skills that would help them manager their lives	1	2	3	4	5
35. Drug abusers generally have a set of thought processes that facilitate their drug use (rationalizations, denial, minimizing, blaming others, etc.)	1	2	3	4	5
36. Drug abusers generally have a set of anti-social attitudes that facilitate their drug use	1	2	3	4	5

	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
37. Drug abusers generally lack the ability to feel empathy for other people	1	2	3	4	5
38. Drug abusers are generally only concerned with themselves and do not think of the consequences of their actions for other people	1	2	3	4	5
39. Drug abusers generally consider only things in the present, ignoring the future consequences of their actions	1	2	3	4	5
40. Drug abusers sometimes relapse or continue to engage in drug use because they think "going straight" is too boring and unexciting	1	2	3	4	5
41. Drug abusers often fail to see the relationship between their past patterns and current behaviors	1	2	3	4	5
42. Drub abusers often relapse or continue to use drugs because they are unaware of the things that trigger their cravings for drugs	1	2	3	4	5
43. Drug abuse is caused by the fact that the drug abuser's environment provides reinforcement for such behaviors	1	2	3	4	5
44. Drug abusers use drugs because they do not have any alternative, pro-social leisure time activities to participate in	1	2	3	4	5
45. Drug abusers generally lack emotional skills needed to cope with their lives	1	2	3	4	5
46. Drug abusers generally lack problem solving skills needed to function effectively in life	1	2	3	4	5
47. Drug abusers often relapse because they fail to acknowledge their powerlessness over the disease of addiction	1	2	3	4	5
48. Drug abusers often relapse because they fail to accept their need for a higher power	1	2	3	4	5