LIBERTY UNIVERSITY
LIBERTY THEOLOGICAL SEMINARY

SUCCESSES TREATING SUBSTANCE USE DISORDER:

A CASE STUDY OF MINNESOTA ADULT AND TEEN CHALLENGE

A Dissertation Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

John Joseph Lenss

Liberty University, Lynchburg, VA

2024

SUCCESSES TREATING SUBSTANCE USE DISORDER:

A CASE STUDY OF MINNESOTA ADULT AND TEEN CHALLENGE

by John Joseph Lenss

A Dissertation Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

Liberty University, Lynchburg, VA

August 28, 2024

APPROVED BY:

[redacted]

Rich Sironen, Ed.D., Dissertation Supervisor

[redacted]

Melody K. Smith, Ed.D., Second Reader

ABSTRACT

Minnesota Adult and Teen Challenge (MNTC) is an addiction treatment center. The reason for this qualitative case study was to discover why clients of substance use disorder treatment programs believe that they can graduate from their program when 50% of those who start the same long-term program drop out. This case study focused on graduates from MNTC in Minneapolis, Minnesota. This study discovered the graduates' common attributes that may improve MNTC treatment center programs, which could decrease the number of people who walk away from addiction recovery programs prematurely and increase the number of those who graduate. According to MNTC records and the literature, 50% of clients in long-term recovery programs at MNTC drop out and must start over in the program before they graduate. This case study documented graduates' opinions on why they successfully completed the long-term program for the Minneapolis, Minnesota Adult and Teen Challenge (MNTC). The definition of an MNTC graduate was graduating from the program and not having a relapse for one year. The theory guiding this study was Ajzen's theory of planned behavior, which proposes that an individual's decision whether to engage in any specific behavior, such as drug or alcohol use, is predicated by their intention to engage in that behavior. Likewise, Ajzen's theory can explain a person's intention to stop substance use as a conscious behavior, which this study collected information to understand. The academic community—mainly those interested in addiction treatment and recovery programs—played a crucial role in this research, as their expertise and insights significantly contributed to understanding and improving addiction recovery programs.

Keywords: Substance use disorder, addiction recovery, treatment, long-term recovery, dropout, success rate

Dedication

I dedicate this work to my wife. None of this would be possible without her support and belief in me over the last 40 years of our marriage.

Acknowledgments

I want to acknowledge Darren Hunt, Director of Alumni Services for MNTC, and the Teen Challenge Leadership Institute Director. Darren was instrumental in connecting MNTC graduates who agreed to be interviewed for this study. Without his help, this dissertation process would have taken much longer than it did.

I would also like to thank the Teen Challenge Leadership Institute staff for allowing me to use their facilities and a secure conference room for the interviews. This meant I did not have to coordinate times and locations with the graduates, especially with the conference room just down the hall from their chapel and lecture rooms.

Table of Contents

List of Tables

List of Figures

List of Abbreviations

Minnesota Adult and Teen Challenge (MNTC)

Substance Use Disorder (SUD)

Teen Challenge Leadership Institute (TCLI)

CHAPTER ONE: RESEARCH CONCERN

Introduction

Minnesota Adult and Teen Challenge (MNTC) is an addiction treatment center with programs that run from 90 days to 13 months. The four treatment programs are Licensed Treatment, Long Term Recovery, Aftercare, and Outpatient. Fifty percent of clients in the MNTC long-term recovery program drop out and must start over in the program before graduating (MNTC, 2020). For those who complete their program and graduate from the long-term program, MNTC has a 92% success rate of graduates not relapsing for the first year after graduation. MNTC is successful with those who make it through the program. This research was designed to explore avenues for increasing the number of first-time clients graduating from the long-term program and decreasing those dropping out. MNTC's data on the graduate rates does not include any reasons for those completing their recovery program.

Chapter One contains the background information for this problem, which is detailed and demonstrates how it is universal in addiction treatment centers. The specific problem statement for this study will come in the section before the research questions; after the research questions are the assumptions and delimitations, a definition of terms, and the significance of this study—lastly, a design summary, including a description of the research samples and the sampling techniques.

Background to the Problem

According to Pastor Rich Scherber, the Founder and retired CEO of MNTC, 50% of clients who begin the long-term recovery program drop out and must start over in the program before graduating (MNTC, 2020). An initial literature search supports this same 50% dropout rate (Arnkoff et al., 2002; Chiesa et al., 2003; Clarkin & Levy, 2004; Reis & Brown, 2006; Swift

& Greenberg, 2012). This MNTC long-term recovery program was recognized as successful, with a 92% success rate of 12 months of sustained sobriety for graduates. This aligns with the biblical principles taught by Luke in his Gospel to Theophilus, which state that everything must be carefully investigated and written down for others to learn (*New American Standard Bible*, 1971/1995).[1]

This research presents avenues to increase the number of first-time clients graduating from the program and decrease the number of those dropping out before completing their program. The research problem was derived from and grounded in the study of literature that addresses the topic of clients completing substance use disorder (SUD) treatment, as well as a history of many dropping out of treatment programs before completion.

The background to the problem is as follows: In the first section of this work, the study was examined from a theological perspective and how a Christian worldview was evident in specific SUD treatment programs. Then, in the second section, the research examines the problem from a historical and sociological perspective. Both the historical and sociological perspectives examine SUD treatment historically in the United States and how those dealing with SUD affect and are affected by those being treated within the client's social support system. Finally, the paper presents a theoretical view of the background for this study, as to how some clients can complete their treatment programs while others leave substance treatment programs

---

[1] Unless otherwise noted, all quotations from and citations to the Bible are from the *New American Standard Bible* (1971/1995).

early. The last section examines several previous studies and the theories developed to treat SUD, including a detailed discussion of Ajzen's (2020) theory of planned behavior.

Theological Context for the Study

The Minnesota Adult and Teen Challenge (2020) *Annual Report* contains numerous references to the Christian faith (see also Anderson, 2021). Although MNTC has several treatment programs, only some of their programs are faith-based. However, this study focused on the 13-month long-term care program, which is faith-based, according to page 4 of MNTC's (2020) *Annual Report*. Notably, this program at MNTC was founded by a Minnesota Assemblies of God pastor (MNTC, 2020). This faith-based program opens other avenues to investigate apart from the purely psychological and sociological reasons that some clients can complete their treatment programs and others leave substance treatment programs early. Findings on clients who can complete a treatment program, as well as those who leave treatment programs before completion, may apply to secular treatment facilities.

As the Lord, Jesus Christ, commanded His followers and all future believers at the end of Matthew's Gospel, followers of Christ are to reach out to everyone so they can repent of their sins before Jesus's return. This command can be seen in Matthew 28:18-20:

> Jesus came up and spoke to them, saying, "All authority in heaven and on earth has been given to Me. Go, therefore, and make disciples of all the nations, baptizing them in the name of the Father and the Son and the Holy Spirit, teaching them to follow all that I commanded you, and behold, I am with you always, to the end of the age."

This study aimed to reach more of the lost before Jesus returns, as there was no way to know if those returning to their addictions know Jesus. This ministry was another part of returning them

to the Kingdom and following Jesus. According to MNTC's (2020) *Annual Report*, reaching the lost was a part of its mission.

Long-term MNTC program clients focus on overcoming their destructive patterns and other life issues. Before graduation, clients must have a job lined up and a room in residence for recovering people with addiction with a counseling program onsite (MNTC, 2020). After the graduation ceremony, the MNTC aftercare program continues to assist graduates and alumni in sustaining their recovery journey. Many graduates enroll in a program sponsored by MNTC—the Teen Challenge Leadership Institute (TCLI)—which provides career and life courses, apologetics, and other biblical studies. Several graduates have entered ministry positions; some have become counselors at MNTC, and others started their ministries, helping others battle addictions (MNTC, 2020). In this respect, MNTC and TCLI are helping fulfill the Great Commission by reaching out to the lost.

Paul's entire letter to the Philippians discusses how a Christian cannot be complete without connecting to other Christians spiritually and as a community member (Lowe & Lowe, 2018). The same thing happens with MNTC when this connection (both spiritual and communal) is broken by the clients leaving the program. The clients no longer have the *koinonia* they had with other clients and counselors at MNTC. This lack of community can quickly lead the client back to the unhealthy habits that landed them at MNTC in the first place. A *koinonia* community is needed to assist with spiritual and physical healing.

This researcher has had discussions with several MNTC leaders, and Luke 4:18 comes across clearly every time:

> The Spirit of the Lord is upon me because He has anointed me to bring good news to the poor. He has sent me to proclaim release to the captives and recovery of sight to the blind, to set free those oppressed.

These MNTC clients are held captive and oppressed by an addiction that has a hold on their lives, and MNTC is there to help them break free.

Historical Context for the Study

Baekeland and Lundwall (1975) claim 15 factors to predict dropping out of a program, but no factors for why those in treatment were able to complete their program and graduate. Barrett et al. (2008) performed a study years later, claiming that there are too many obstacles to determining the success of a program; as a result, it did not identify specific programs that worked versus those that had failures. There is no way to recommend implementing changes to any other program with the available data (Loveland & Driscoll, 2014).

According to the National Institutes on Drug Abuse (NIDA; 2023), which is part of the United States National Institute of Health, substance use disorder (SUD) treatment programs have existed at a local level in the United States since the 1750s. One of the more well-known national programs—Alcoholics Anonymous—was founded in 1935. Alcoholics Anonymous was examined in this study for two main reasons: it treats all types of SUD, and it is a Christian organization with similar principles to MNTC.

Sociological Context for the Study

Cleveland and Harris (2010) looked only at the addiction recovery of college students treated on campus, where these students have support from their social support system. Their conclusion, even with a small localized sample of students, was that with a social support system

of former clients, those coming out of a structured program have a higher chance of success. Those without a support system who could be related to what they experienced in treatment fell back to substance abuse. This tactic of having a social support system for people who have been through the program is the same thing programs such as Alcoholics Anonymous (2002) preach to recovering alcoholics. Knight et al. (2019) discuss women in drug treatment programs; they found that some factors that cause women to drop out early concern education level, recent arrests, and peer deviance. Other predictors that approached significance and deserve further study include marital status, number of children in treatment, child welfare involvement, cocaine use, and psychological depression.

Theoretical Context for the Study

This section identifies and discusses various theoretical literature that provides a background understanding of addiction treatment centers. SUDs are characterized by impairment caused by the recurrent use of alcohol, illicit drugs, or both. They are pervasive and endemic among American adolescents, with potentially harmful health and social consequences (Alemu et al., 2024). For example, Cordaro et al. (2012) attempted to devise a tool to monitor clients in treatment to identify some factors that would indicate they were about to drop out. He was unsuccessful, but it would be an incredibly useful tool if he had succeeded. Choi et al. (2013) discussed similar issues and provided many more factors to determine whether a client may drop out or be able to complete their treatment program. Some factors referenced in this work included age, gender, types of drug abuse, Addiction Severity Index, medical and psychiatric scores, and readiness to change.

The guiding theory for this study was the theory of planned behavior (TPB; Ajzen, 2020), as it proposes that an individual's decision whether to engage in any specific behavior,

such as drug or alcohol use, is predicated by their intention to engage in that behavior. TPB also postulates that someone has an attitude toward the behavior, which would be a subjective trait, and their perceived behavioral control over the behavior can also influence their intention to engage or disengage in that behavior. TPB was utilized to explain a person's intention to stop their substance use as a conscious behavior, which this study seeks to understand. It was also included in this study because of the versatility of application as found in the literature (Ajzen, 2020; Bhochhibhoya & Branscum, 2018; Bosnjak et al., 2020; Conner & Armitage, 1998; Davis et al., 2019; Fishbein & Ajzen, 2010; Grim & Grim, 2019; Hoffman, 2016; Sussman & Gifford, 2019; Zemore et al., 2021).

Applying TPB to this study allowed the researcher to interpret a theoretical framework for this study's commonality among those clients who completed the long-term care program. Finding this commonality may allow MNTC to modify its processes to attain more than 50% of clients graduating from the long-term program on their first attempt. Hannan et al. (2005) addressed clients who dropped out of treatment early, including how clinicians determine which clients will not finish the treatment program. They stated that those clinicians who used a formal method of monitoring their clients could determine when 85% would drop out. This research further recommended that all treatment programs use a standard client-monitoring method.

Researcher's Relationship to the Problem

This researcher was a volunteer mentor in the mentoring program at MNTC from 2020 to 2021. This mentoring program is for clients in the final six months of the long-term care program. The client is assigned a mentor by MNTC counselors to provide them with another resource that helps them ease back into society. The mentor also provides the client with someone they can relate to who is not directly involved with the program. Unfortunately, this

researcher's client dropped out of the program eight days before graduation. When this happened to the client, the researcher became interested in helping clients to graduate from the long-term care program. Coincidently, this researcher also started this doctoral program at about the same time as volunteering in mentoring in the MNTC program. This researcher focused on this doctoral program instead of mentoring another MNTC client, hoping it would help many others moving forward.

Statement of the Problem

The rationale for this study seems evident to those familiar with substance treatment programs like MNTC. This researcher started asking MNTC counselors and other employees questions and learned that MNTC, due to staffing issues, has never tracked information on their clients who complete their treatment programs versus others who leave substance treatment programs early. Performing a preliminary literature search, this researcher discovered that other treatment programs had likewise not captured this information. Contacting MNTC leadership to determine if this topic was viable for a doctoral dissertation, this researcher learned that understanding why some clients can complete their treatment programs and others leave substance treatment programs early would be valuable information to the leadership. Still, programs need the people or the budget to gather that information to track it. The MNTC Director of Men's Programs also stated that in addition to why clients leave early, he would be interested in what makes someone stay with the program to graduation, even after those clients see half their peers leaving the program (S. Stadler, personal communication, June 18, 2023).

In addition, little information in the available literature consistently defines why a client would leave any SUD recovery program early (Swift & Greenberg, 2012). Suppose the information on why some clients can complete their treatment programs and others leave

substance treatment programs early was available. In that case, this information might assist the treatment programs in modifying their procedures to help more people break their addiction (Loveland & Driscoll, 2014).

There is evidence that this is an issue being looked at by other researchers (Barrett et al., 2008; Chiesa et al., 2003; Reis et al., 2006). However, these other studies focus on psychological aspects and do not look at other stimuli that may be working to cause clients to leave (Choi et al., 2013; Cordaro et al., 2012). As MNTC's long-term care program is faith-based, this research was designed to understand these additional effects on the clients, taking more of a whole-person approach to the issue and not assuming those who graduate have a stronger faith or that every person leaves for psychological reasons only.

The profile of this study was to interview graduates from the MNTC long-term care program. MNTC has a list of alumni who have graduated from the 13-month program. Therefore, those people are more accessible to contact, as the alumni office has their contact information. However, for those graduates who left MNTC and went back to using their preferred substance and never came back, those people, unfortunately, are impossible to contact and interview, much less get the help they need to cope with their addiction.

There was a gap in the literature because past research has yet to focus on the potential reasons some clients can complete their treatment programs and others leave substance treatment programs early. In addition, previous studies were narrowly focused, and none looked at faith-based programs like MNTC (Chiesa et al., 2003; Hannan et al., 2005; Swift & Callahan, 2011). Thus, there was a need to obtain qualitative data that applied the client's perspective and voice to explain this issue in greater detail. This study evaluated the qualitative data that could lead to more clients sticking with the program through graduation.

This qualitative case study aimed to discover why some clients of substance recovery programs can complete their addiction recovery programs at MNTC in Minneapolis, Minnesota, while 50% of those who started a program at MNTC were unable to complete their treatment protocol. In addition, this researcher discovered information that may be used by treatment programs to modify procedures to help more people break their SUD.

Purpose Statement

This case study aims to understand the successful completion of the long-term program for graduates of the Minneapolis, Minnesota Adult and Teen Challenge (MNTC). This study explored demographic differences and similarities between graduates and the graduates' perceptions of why they felt they were able to complete the program while others failed. Successful completion was defined as graduating from the program and not having a relapse for one year. The theory guiding this study was TPB (Ajzen, 2020), which proposes that an individual's decision whether to engage in any specific behavior, such as drug or alcohol use, is predicated by their intention to engage in that behavior. TPB will explain a person's intention to stop their substance use as a conscious behavior that this study seeks to understand.

Research Questions

The following research questions guided this study:

RQ1 - What are the demographic differences and similarities of the graduates who completed the MNTC long-term program?

RQ2 - What are the reasons why graduates believe they successfully completed the MNTC long-term program?

RQ3 - What are the graduates' perceptions of why some fail to complete the MNTC long-term program?

This qualitative study captured the perceptions of the graduates who completed the long-term program at MNTC and assessed why they were able to finish their program. The study compared the data from the interviews and the demographics of those interviewed to identify any correlations between the interview answers and the demographics of the graduates. Much of the current literature was focused on specific substances or locations studied. Collecting demographic data may differentiate this study from previous studies on SUD treatment with similar demographics of the clients in those studies (Baekeland & Lundwall, 1975; Loveland & Driscoll, 2014; Miller, 2013).

Assumptions and Delimitations

The profile for the current study was to interview MNTC graduates. MNTC has a list of alumni who have graduated from the 13-month program, so those people are more accessible to contact. Unfortunately, graduates who left MNTC and went back to using their preferred substance and have yet to come back are impossible to contact and interview, much less get the help they need to get clean.

Research Assumptions

One research assumption assumes that completing the long-term program at MNTC without relapsing for one year was considered a success and can lead to long-term abstinence from substance abuse. Another assumption was that the TPB accurately connects the intention of those in the MNTC long-term program with behaviors concerning SUD treatments.

Delimitations of the Research Design

1. This study only looked at MNTC graduates from the Minneapolis, Minnesota location.

2. This study does not include graduates from other MNTC locations in Minnesota or any other Teen Challenge location outside Minnesota.
3. The graduates considered for this study have graduated at least one year prior to their interview and remained sober for a year.
4. No other SUD treatment programs in the Minneapolis/Saint Paul metro area, such as the Hazelden/Betty Ford Foundation or Alcoholics Anonymous, were considered for this study.

Definition of Terms

Alumni	MNTC long-term care program graduates have agreed to share their contact information with the MNTC alumni Director (MNTC, 2020).
Client	A person enrolled in the long-term care program at MNTC (MNTC, 2020).
Graduate	A former MNTC client who has completed the long-term care program and re-entered society (MNTC, 2020).
Koinonia	Holding everything in common (Erickson, 1985).
Long-term care program	This 13-month program at MNTC is the longest and most successful of the addiction recovery programs at MNTC (MNTC, 2020).
Recovered graduates	A client who dropped out of their program later returned and completed the 13-month long-term program to become a Graduate (MNTC, 2020).

Success A client who graduated from the treatment program did not relapse for at least one year after graduation (MNTC, 2020).

Significance of the Study

According to the available literature, MNTC has never tracked client demographic or experiential information, and other treatment programs have not measured this data either (Chiesa et al., 2003; Choi et al., 2013; Cordaro et al., 2012; Hannan et al., 2005; Swift & Callahan, 2011). Information on why a client would leave a treatment program early or why graduates believed they were able to complete their SUD treatment would be valuable for SUD treatment programs to modify their procedures to help more people break their addiction.

This study may apply to other treatment programs outside of MNTC. However, depending on the focus of the other programs, additional interviews would be required to determine the applicability of the MNTC findings. The literature calls for this type of personal data collection, which collects the stated reasons clients believe they were successful in completing SUD treatment, to potentially assist other treatment programs in evaluating their protocols for success in SUD treatment (Chiesa et al., 2003; Hannan et al., 2005; Swift & Callahan, 2011).

Summary of the Design

This study utilized a qualitative case study method. A case study is one of the best methods for the researcher to discover answers to the why and how questions of the process being studied (Creswell & Poth, 2018). It is also appropriate for investigating how groups and individuals deal with a social problem, such as SUD. Using a case study is a research strategy that involves determining reasons related to the research's purpose (Yin, 2018).

Graduates on the MNTC alum list were interviewed to learn their reasons for completing SUD treatment. Data was collected by interviewing graduates who have completed the long-term program. The interviews consisted of semi-structured questions (see Appendix J) to determine why the graduates believed they could complete SUD treatment.

Analyzing the data to look for themes in their answers may help MNTC and other SUD treatment programs better understand their SUD treatment program from those who have graduated. A codebook to analyze the interview data was generated to help with the later interpretation of the information. The commercial software MAXQDA (https://www.maxqda.com) and NVivo (https://my.lumivero.com) were utilized to code these interviews and look for various themes and trends in the data. At the end of this research, the conclusions and a summary will be presented to MNTC leadership.

CHAPTER TWO: LITERATURE REVIEW

Overview

This research explores avenues to increase the number of first-time clients graduating from MNTC long-term program and decrease the number of those dropping out before completing their program on their first attempt. The research problem was derived from and grounded in the study of literature that addresses the topic of clients completing substance use disorder (SUD) treatment, as well as those dropping out of treatment programs before completion. This chapter reviews the literature on SUD treatment programs. This review will provide a history of the major theories regarding treatment and summarize how these theories have changed to utilize new information from studies like this.

This review provides significant space for developing a theological and theoretical framework. It will delve into the rationale for the study and identify gaps in the literature on why some clients can complete their treatment programs, whereas others leave substance treatment programs early.

Theological Framework for the Study

A theological framework is an essential component for properly analyzing a literature review. Understanding clients' responses to questions and how they interpret situations in their lives requires a basic understanding of their background and what they think of their background. Therefore, setting a theological framework was paramount to this study.

To know God's attributes, His nature, and His will for man are essential to any theological consideration. Whether considering the client, the researcher, the MNTC staff, or the Assemblies of God church, all are affected by theology. Thus, for this study and all of God's creation, it makes sense to understand and study the Creator of the universe. How thorough one

studies God will depend on the person performing the study. No man will completely understand God, but that fact does not negate the benefit of studying Him to gain additional insight into the Creator. This type of study is called theology, which Erickson (1985) defined as:

> The discipline that strives to give a coherent statement of the doctrines of the Christian faith, based primarily upon the Scriptures, placed in the context of the culture in general, worded in a contemporary idiom, and related to issues of life." (p. 21)

The core topics used to review the theological structure of the literature review are found in the following section, including the literature resources utilized by this researcher for this effort. Within this next section, the theological framework will cover the attributes of God, sin, the reality of the fall, discipleship, and how those concepts tie in with this study.

Attributes of God

Examining the theological framework for this study was an important starting point for understanding God's attributes. This qualitative research study was needed to capture and understand each client's stated reasons and beliefs for being able to complete his or her SUD treatment. As all of humanity was designed and created by God, Who gave all men free will, starting with God's attributes may explain why some clients become MNTC graduates and others do not complete their program. This research will seek to collect the graduates' opinions on why they believe they were able to complete their SUD treatment when 50% of MNTC clients leave the program early (MNTC, 2020). These two sets of data were combined about God's attributes to determine if there was some disconnect between those clients who complete their SUD treatment programs and those clients who leave early. Combining the databases of this qualitative case study will help determine if changes are required in the program that could

decrease the percentage of clients that leave their program prematurely and increase the number of those who graduate.

Examining God's attributes was fundamental to this study as it presents the Christ-follower with the biblical standard to pursue with their life. For the pre-believer or those who have relapsed in their addiction, God's attributes provide the goals for addiction recovery clients to strive for. The attributes of God should be the goals of every human on the face of the earth, whether they are affected by SUD or not (Allen, 2015; Krause & Rainville, 2022).

The primary scriptural reference for the attributes of God is found in Genesis 1:26-27, which describes how the Triune God created humanity in His image. This is not to say that humans and God are the same. Humanity is created in God's likeness (Allen, 2015; Lorberbaum, 2015). Scripture clarifies that humanity has been divinely inspired and that God has allowed man to grow and become more like God throughout humanity's life. This was part of God's plan for humanity from the beginning (Boersma, 2016; Steibel & Bergen, 2019).

Douglas et al. (2011) reported that the reader can discover that God is a spirit, a nonmaterial personal being; God is infinite in His being, wisdom, power, truth, goodness, holiness, and justice. He is eternal, and most importantly, He is unchangeable. God is known for His fellowship with His people, and God is known for His acts. God can be seen in everything on earth. The attributes listed above are to understand the qualities of what God is, not things that He does. These attributes apply to all three persons of the triune God: the Father, Son, and Holy Spirit (Erickson, 2015).

For this study, understanding how God looks at and feels about His creation—man—was crucial. God's love for man does not change due to SUD; God still desires that man be in community with Him. This section on God's attributes provides information to support the idea

that God always loves His creation. Kilner (2015) showed that humanity was created to love and seek God. For a man to not love and seek God would violate the design of humanity from God's plans, and the man or woman from experiencing spiritual growth and the spiritual fruit that is axiomatic to the sanctification process God desires humanity to go through (Wright, 2017).

God the Father

In the Old Testament, the person in the Holy Trinity mentioned the most is the Father. The Son and the Holy Spirit are in the first part of the Bible, but the Father is the primary part of the Holy Trinity in the Old Testament. In the Old Testament account of God's interaction with humanity, God the Father prepared humanity for His Son's return as a man. Therefore, Jesus was required to provide specific examples of interacting with God the Father. (Colossians 1:15; Hebrews 1:3; John 14:9; Philippians 2:67). In these New Testament verses, God shows man, through His Son, His expected way to live (Steibel & Bergen, 2019; Thomas, 2019).

Jesus is the perfect example of a man in God's vision. Man must work with the Holy Spirit to understand what God intends for man to be in a community with God. A person with SUD has fallen, and treatment programs can guide the fallen back to the Lord with the Holy Spirit's help. In the Gospel of John, the reader is told explicitly why the Holy Trinity needed to send Jesus to earth as a man. In John 3:16-17 we read that.

> God so loved the world that He gave His only Son, that whoever believes in Him should not perish but have eternal life. God did not send His Son into the world to condemn the world, but so that the world might be saved through Him.

Jesus, the Son of God

The center of Christian theology is for humans to know God and what He wants for His creation. As Christ's followers, our focus should be on the Word of God (Bible), the Imago Dei,

and how Jesus would handle various situations like SUD and the people involved in the abuse. Paul wrote to the Philippian church describing why he wanted to understand Jesus intimately. He wrote, “I may be found in Him, that I may know Him and the power of His resurrection and the fellowship of His sufferings, being conformed to His death; if somehow I may attain to the resurrection from the dead" (Philippians 3:10-11). As for the authors of books in the Bible, Paul authored more books than any other author; his devotion to studying God would be exemplary for any theology student to emulate.

The Holy Spirit

> In Romans 8:26-27, the reader has explained the role of the Holy Spirit:
>
> For we do not know how to pray as we should, but the Spirit Himself intercedes for us with groanings too deep for words, and He who searches the hearts knows what the mind of the Spirit is because He intercedes for the saints according to the will of God.

For this study, the reader needs to understand the role of the Holy Spirit, as He is part of the Holy Trinity and is present with every believer, as in 1 Corinthians 6:19: “Do you not know that your bodies are temples of the Holy Spirit, who is in you, whom you have received from God?”

Sin and the Reality of the Fall

Since Adam and Eve, man has been a sinner. Ever since the first man and woman, we are all guilty. As stated in Romans 3:23, "For all have sinned and fall short of the glory of God." However, we have a redeemer in Jesus Christ, as told in John's Gospel, John 14:6: “Jesus said to him, ‘I am the way, the truth, and the life. No one comes to the Father except through me.’”

In this study, the clients of MNTC would not be identified as ideal, practicing Christians by the world’s standard of a “Christian.” In the first letter, Paul wrote about sins that will keep someone from eternal life. In Galatians 5:19-21, God’s Word proclaims that:

> The deeds of the flesh are evident, which are sexual immorality, impurity, indecent behavior, idolatry, witchcraft, hostilities, strife, jealousy, outbursts of anger, selfish ambition, dissensions, factions, envy, drunkenness, carousing, and things like these, of which I forewarn you, just as I have forewarned you, that those who practice such things will not inherit the kingdom of God.

Sin does not mean eternal damnation for man. Even in the Old Testament, we read Lamentations 3:31-32: "For the Lord will not reject forever, for if He causes grief, then He will have compassion in proportion to His abundant mercy." From Luke's Gospel, the reader can see how Jesus responded to sinners. Luke 15:1-32 says:

> Now the tax collectors and sinners were all drawing near to hear Him. Moreover, the Pharisees and the scribes grumbled, saying, "This man receives sinners and eats with them." So, He told them this parable: "What man of you, having a hundred sheep, if he has lost one of them, does not leave the ninety-nine in the open country and go after the one that is lost until he finds it? Moreover, rejoicing, he lays it on his shoulders when he has found it."

Jesus can remove sin (Hoffman, 2016). In the book of Acts, Peter explained man's role in Acts 2:38: "Peter said to them, 'Repent and be baptized every one of you in the name of Jesus Christ for the forgiveness of your sins, and you will receive the gift of the Holy Spirit.'" There is nothing man can do to remove his sins against God, but Jesus can take away sin. In the case of the clients at MNTC, once Satan uses addiction to enter someone's life, it is exceedingly tricky, without Jesus, to extract Satan's influence from the addict's life. If that is not bad enough for the person with a SUD, Satan keeps returning repeatedly (Larson, 2019).

The reader can see the folly in trying to escape addiction without help in Matthew 12:43-45:

> Now when the unclean spirit comes out of a person, it passes through waterless places seeking rest and does not find it. Then it says, "I will return to my house from which I came," and when it comes, it finds it unoccupied, swept, and put in order. Then it goes and brings seven other spirits more wicked than itself, and they come in and live there, and the last condition of that person becomes worse than the first. That is how it will also be with this evil generation.

The final word in this study is from the final book of the Bible. In Revelation 21:4, John says that when Jesus returns, there will be no more sorrow, death, crying, or pain because believers in Christ will all be in Heaven with God. Therefore, sin and sinful actions are not forever for those who believe, and Jesus can assist the substance abuser's recovery.

Discipleship

The final topic in this theological literature review is discipleship and its importance in recovering an SUD client. MNTC, as part of the long-term program, allows clients to be partnered with a mentor in the final phases of their treatment. Whether the activity was mentoring or discipling the client, it was designed for a similar outcome. Eventually, the client can be taught to make good decisions by demonstrating those good decisions.

For the clients at MNTC, possessing a biblical understanding of discipleship as the practice of following Jesus Christ in proclaiming in word and action to and with the poor and the wicked that God loves them (Whitmore, 2019) can sustain the client when he or she does not want to continue in treatment. This aspect of SUD treatment was not only found at MNTC; other

studies have shown empirical evidence that faith-based programs work (Alcoholics Anonymous, 2002; Grim & Grim, 2019).

Managing client expectations regarding treatment effectiveness is accomplished in person with the counselor and the client, so there is immediate feedback on changes that need to be updated in the treatment program laid out for the client (Cunningham et al., 2021). James 5:11 proclaims: “We count those blessed who endured. You have heard of Job's endurance and seen the outcome of the Lord’s dealings, that the Lord is full of compassion and merciful”

Discipleship from a biblical perspective can be summarized in one commandment: love, as Jesus defined it in John 13:35 (Douglas et al., 2011; Jun, 2022). In this verse, Jesus tells His disciples to love one another. Jesus did not say only to love the other disciples; when He said one another, He referred to everyone they would meet for all eternity.

Discipleship cannot separate being from doing. Jesus called his chosen twelve “disciples,” but John the Baptist also called his followers disciples (John 1:35-37). This would be the noun portion of a disciple, but the verb portion is what the Great Commission (Matthew 28:18-20) describes. Theologically, believers in Jesus need to reach out and spread the Gospel. For those with SUD, use a disciple's noun and verb. From Matthew 28:18-20 the disciples of our Lord Jesus are called to preach the Gospel to all. However, the next step is just as important as preaching the gospel: to show pre-believers and clients of MNTC how much Jesus loves them by helping them into a treatment program to become right with God. James 2:17-26 teaches believers in Jesus that faith without works is useless; preaching the gospel to MNTC clients will not work without showing them the next steps. These actions will allow growth for the Kingdom and create more disciples with powerful stories of deliverance.

Alcoholics Anonymous and other 12-step programs utilize both a connection to a higher power and a form of discipleship to guide recovering people with SUD throughout their programs (Alcoholics Anonymous, 2002; Grim & Grim, 2019). The religion or denomination does not matter to these programs; for recovery, if someone is helping to lead the person with a SUD through the program, it is more effective than not being discipled in the program's specifics or next steps in the program (Alcoholics Anonymous, 2002; Grim & Grim, 2019).

In the Bible, Paul teaches that the main point is that someone is helping the sinner/client. For example, Romans 10:11-15 says that:

> Whoever believes in Him will not be put to shame. For there is no distinction between Jew and Greek; for the same Lord is Lord of all, abounding in riches for all who call on Him; everyone who calls on the name of the Lord will be saved. How are they to call on Him in whom they have not believed? How are they to believe in Him whom they have not heard? Moreover, how are they to hear without a preacher? However, how are they to preach unless they are sent? Just as it is written: How beautiful are the feet of those who bring the good news of good things!

Paul is essentially saying that someone needs to tell the client what to do and how great it will be to no longer be controlled by a substance.

The key is to start changing the client's life. The first step in getting over emotional stress is to look to God and talk to someone about God and the addiction issue (Alcoholics Anonymous, 2002; Dickie, 2021). The Christian counselor always involves God in discussions with the client. This provides another witness to the client, in addition to the Christian counselor or mentor, to show the client how to respond when temptation strikes. Satan is constantly looking for an opening to drive division between weaker and stronger believers, as described in 1

Peter 5:8. “Be sober-minded; be watchful. Your adversary, the devil, prowls around like a roaring lion, seeking someone to devour.”

Believers in Jesus know that Satan will say anything to open a gap in a group of Christ believers. In John's Gospel 8:44, speaking to the non-Christians, Jesus said to them:

> You are of your father, the devil, and you want to do the desires of your father. He was a murderer from the beginning and did not stand in the truth because there was no truth in him. He speaks from his nature whenever he lies because he is the father of lies.

As a client gets further into their treatment program and further from their substance-abusive lifestyle, that lifestyle will drag them back by lying about how great it used to be when they were around. That was also why the first step in any treatment program involves isolation and separation from the former, material and human influences on the client, and introduction to new positive influences in their life (Alcoholics Anonymous, 2002; Dickie, 2021).

Steibel and Bergen (2019) asserted that Christian discipleship acknowledges the importance of the body, which is required for a response to God's redemption for all of life through His son, Jesus. The client must be exposed to positive influences, such as MNTC and Christian influences. As Paul taught us in Romans 10:9, "Because, if you confess with your mouth that Jesus is Lord and believe in your heart that God raised Him from the dead, you will be saved." With Jesus and the Trinity helping the client with their SUD treatment, the client can be accessible by professing the truth that God loves and forgives them.

In this way, mentoring or “discipleship is the practice of following Jesus Christ in proclaiming in word and action to and with the poor and the wicked that God loves them” (Whitmore, 2019, p. 68). Jesus explicitly said this in one of His last sentences in the Gospel of Matthew: The Great Commission. Jesus did not discriminate or single out a particular group

when He said, “Go therefore and make disciples of all nations, baptizing them in the name of the Father and of the Son and the Holy Spirit” (Matthew 28:19). This discipling is what MNTC was called to do with the SUD clients that come to it for help in overcoming their addictions.

This theological section of the literature review evaluated God's attributes and how God wants all of humanity to be in a community with Him—even those who have fallen into addiction. The literature shows believers in Christ how all men have been affected by the fall since Adam and Eve. Jesus gives Christians the goal or image of what man should try to achieve. Believers in Christ are called to disciple all fellow men and bring them back to Jesus (see Matthew 28), no matter what state they are in now.

Theoretical Framework for the Study

To provide additional insight into the basis of this substance treatment research, one should consider the supporting literature that supports the topics and concepts of this research study. This section provides some insights into the concepts from the literature to build a reasonable argument for this study's purpose and research questions. In addition, this work includes current theories and studies found in today's literature. The theories and concepts reviewed in this framework include the theory of planned behavior (TPB); another section looks at studies documenting why some clients can complete their treatment programs and others leave substance treatment programs early. The last section reviews treatment programs incorporating Christian principles.

Theory of Planned Behavior (TPB)

An aspect encountered in this literature review was that different studies assessed alcohol problems and behaviors with different scales and measures. Also, while there were various terms related to alcohol abuse, such as binge drinking or heavy drinking, a standard definition has yet

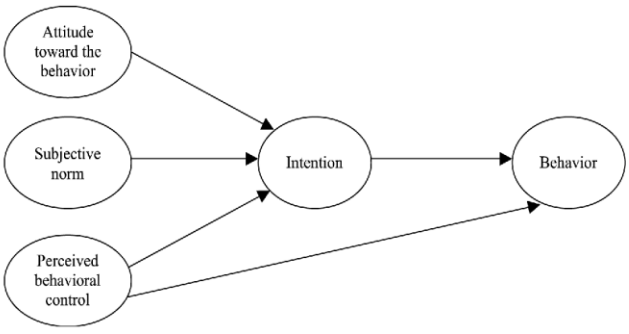
to be established. This problem goes beyond the studies in this review, as the standard definition of binge drinking varies in different countries. Without having a standard measure for binge drinking and other alcohol problems, it was difficult to compare and synthesize the outcomes reported from these studies in this review.

Description

Icek Ajzen developed TPB in 1975 (Ajzen, 2020). His theory has proven to be one of the most reliable theories for understanding why people make drastic changes in their lives and predicting these behaviors (Ajzen, 2020; Bhochhibhoya & Branscum, 2018; Bosnjak et al., 2020; Conner & Armitage, 1998; Davis et al., 2019; Fishbein & Ajzen, 2010; Grim & Grim, 2019; Hoffman, 2016; Sussman & Gifford, 2019; Zemore et al., 2021). TPB proposes that an individual's decision whether to engage in any specific behavior, such as drug or alcohol use, is predicated by their intention to engage in that behavior. TPB also postulates that someone has an attitude toward the behavior, which would be a subjective trait, and their perceived behavioral control over the behavior can also influence their intention to engage in that behavior. Ajzen developed the diagram in Figure 1 to describe the theory of planned behavior.

Figure 1

Theory of Planned Behavior



Note: From p. 27 of Kusmintarti et al. (2014).

Historical Development

Researchers have documented and expanded the TPB model for over 25 years, providing evidence and instructions for modifying the theory (Conner & Armitage, 1998). There are two methods to expand the TPB. First, TPB can be incorporated into a model of attitude and behavior relationships. The second considers the process used to set goals, such as clean living for the person with an SUD, and then charts a method to lead to goal achievement. Both changes work for substance abuse clients and can help them stick to their treatment programs (Fishbein & Ajzen, 2010; Si et al., 2020).

One of the most recent and exciting modifications to TPB comes from the integrated behavioral model (Bhochhibhoya & Branscum, 2018). The integrated behavioral model is an evolution of TPB mainly focused on motivation to change behavior. Implementing that model with TPB with the extension of the inputs adds more definition and a new source of descriptive norms. This extension is accomplished by explicitly recognizing various skills/abilities and providing a better accounting of the environment as direct predictors of the behaviors being studied (Fishbein & Ajzen, 2010).

TPB can be utilized for any study where the researcher wants to predict an expected behavior. One example of an aspect encountered in this literature review was that different studies assessed alcohol problems and behaviors with different scales and measures. One confusing point in these different alcohol studies was that there were various terms related to alcohol abuse, such as binge drinking or heavy drinking. Hence, a standard definition has yet to be established that would define alcohol abuse. This standard definition problem goes beyond the studies in this review, as the standard definition for binge drinking varies in different countries (Chen & Feeley, 2015; French & Cooke, 2012; Ross & Jackson, 2013). Without having a

standard measure for binge drinking and other alcohol problems, it was difficult to compare the outcomes reported from these studies.

Pinedo et al. (2020) examined the aspects of SUD treatment that may interest this study. Those authors used the TPB to code and analyze the data in their study—a methodology similar to that used in this study. They also gathered information from interviews, which needed to be transcribed and coded to identify themes in the data. Specifically, their study analyzed the effects of race and ethnicity and how this may affect women in SUD treatment programs. The current study was not intended to focus on race, ethnicity, and gender, as Pinedo et al. did; however, this could be the focus of a future study.

The various TPB research foci are included in this literature review for two reasons. First, they show how TPB can be used regardless of the substance being abused. Second, they demonstrate that this study will require standard definitions to understand why some clients can complete their treatment programs and others leave them early.

Seminal Research

TPB was essential for researchers who need to predict, understand, and eventually change clients' behavior, using an empirically validated theoretical framework. One reason many researchers like to use the TPB, particularly in social science studies, was that the TPB was focused not only on the behaviors, but also on the determinants of those behaviors and how they affect each other. Another reason researchers prefer to use the TPB (Fishbein & Ajzen, 2010; Zemore et al., 2021) was because all the established tools have already been developed. These tools measure and collect the theoretical data that a study requires. Lastly, TPB is a structured model with nearly 50 years of application, providing a framework for examining the behavior's determinants (Ajzen, 2020).

The least complicated explanation of TPB, which was arguably the most frequently cited explanation of human behavior, is that it is simple. The theory proposes basic constructs: influence, intentions, and intentions that influence action. The three base components leading to intention and action are attitudes toward a behavior, subjective norms, and perceived control over the behavior studied (Sussman & Gifford, 2019).

Strengths and Weaknesses

A strength of TPB was that the behavior achieved depends on the client's motivation or intention to achieve the behavior and the client's perceived ability to control the behavior. The theory maintains that three core components—attitude, subjective norms, and perceived behavioral control—shape an individual's behavioral intentions (Ajzen, 2020). The main problem with TPB is that it needs to explain sufficient variability in the behavior. As such, it is a psychological theory that links an addict's beliefs to behavior, requiring variability in dealing with human emotions (Abad et al., 2019; Neale et al., 2015).

Davis et al. (2019) presented an example from the literature closer to this study with MNTC. They conducted a study that involved 18-25-year-old adults at an elevated risk for prescription drug misuse. Their study looked at injured college athletes who were provided pain medication as part of their treatment. However, after physical healing, those participants continued to use these prescription opioids. Their study used TPB to identify the salient beliefs that the students had about continuing this behavior.

Biblical/Theological Critique

Even though TPB, as initially proposed, does not support a biblical worldview, it was included in this project for two reasons. First, it is the most prevalent theory in the literature (Bosnjak et al., 2020; Conner & Armitage, 1998; Zemore et al., 2021). Secondly, other

researchers discussed in later sections have modified TPB by adding a Christian worldview (Grim & Grim, 2019; Hoffman, 2016).

Conclusions for this Research on TPB

While studying clients who graduated from SUD treatment and those who left their treatment program before completion, some researchers discovered that by modifying TPB, they could predict which clients would leave treatment programs before completion (Davis et al., 2019; Pinedo et al., 2020; Zemore et al., 2021). Their detailed reviews provided this researcher with tools that can be used to gather similar data for a dissertation. One of those tools was called the barriers to retention scale. This 19-item tool was correlated with treatment completion and predicted treatment completion using a multivariate analysis with an internal reliability of 0.88. Zemore et al. (2021) provided suggestions for future research sections, which included the concepts of changing substances being abused and asking if recovery was possible without total abstinence from the substance being abused.

A study on adolescent SUD demonstrated the versatility of utilizing TPB in Iran. In this case study, the researchers were looking at TPB to plan and implement prevention programs among adolescents before they became substance abusers (Abad et al., 2019). Neale et al. (2015) researched SUD treatment programs, interviewing clients to understand their views of the services they were provided in their treatment program and how these treatment service providers viewed their services. This was similar to customer satisfaction surveys, which this researcher was familiar with. After this research is complete, this researcher plans to share the information with the leadership at MNTC.

Utilizing the tools in this literature search for this researcher's study, data from MNTC can be compared to these other studies to significantly add to the knowledge base of why some

clients can complete their treatment programs, whereas others leave substance treatment programs early. Some of those tools include the reason for leaving the treatment questionnaire (Ball et al., 2006) and the barriers to retention scale (Zemore et al., 2021).

Related Literature

Subtopics in the related literature include treatment protocols in the United States and the theories supporting those protocols. Of course, SUD is a global problem, but this section will focus mainly on literature from the United States. The following subsection will examine getting someone started in an SUD treatment program. The criteria required for a treatment program are the type of protocols and available treatment options.

Grit Theory

Angela Duckworth (2016), a professor of psychology, developed a theory on how some people successfully achieve their goals, which she calls “grit.” Grit was initially developed to understand why some United States Military Academy cadets make it through the program, but many wash out. The Army was interested in understanding how to get more cadets to stay with its program. Duckworth determined that two components determine grit: passion and perseverance. She also designed the grit scale (see Appendix I) to measure how much grit someone has, with ten simple questions.

Grit theory was utilized in this study in two main ways. The first was to understand the questions to ask and evaluate whether passion and perseverance are factors in graduates' reasons for believing they were able to complete their SUD treatment program. The second was to gather information on MNTC’s use of goal setting and the effectiveness of those goals in assisting the graduates in completing their treatment.

Description

Grit can be described as the combination of passion and perseverance that allows people to achieve their goals (Duckworth, 2016). The perseverance component of grit can be described as having a long-term goal and keeping the hope that this goal is achievable, that achieving that goal will improve our future, and that tomorrow will be better whether that goal is completing SUD treatment for life, not depending on various substances or drugs to get through life, or, in the case of West Pointers, getting through “Beast Barracks” (cadet basic training) and eventually become an officer in the U.S. Army.

Duckworth (2016) found that those with grit also show a passion for what they do. They are purposeful in what they do and realize that they will have to change and improve to achieve goals, but when they reach their goals, the journey to get there will be worth it. Their passion shines through in their actions and makes it possible for them to persevere through the adversity of achieving their goals.

The challenges they face along the way make them more robust, and just like the famous motivational saying, "That which does not kill me makes me stronger," people with grit make their world a better place and themselves better people. These people tend to be sober, clear-thinking people whom others will follow since they have demonstrated that they can focus on a goal more prolonged than most.

Historical Development

The U.S. Military Academy leadership contracted Duckworth to help it understand the cadets. The leadership had two goals: To understand why someone would qualify to get into West Point only to drop out in the summer before classes started after spending so much energy to get in. The second goal that the leadership had was to develop some form of test or screen to

predict which cadets would drop out and who would stay in the program. The tool Duckworth developed was called the grit scale (Duckworth, 2016, pp. 55-56; see Appendix K).

Since that initial work, numerous studies have been started to measure grit, and additional tools have been developed to understand who may succeed in their goals and who may not. The grit scale tool is simple to implement and was part of the focus of this study. Other tools found in the literature include the values in the action classification system (Peterson & Seligman, 2004), the eleven-character strengths needed for better-controlling SUD (Huang & Smedema, 2023), and the reason for leaving the treatment questionnaire (Ball et al., 2006).

Seminal Research

Quinn et al. (2022) developed a follow-up study that utilized grit in reducing SUD, showed promise in reducing dependency, and showed that the subjects in the study demonstrated less depression and anxiety compared to the control group. Their study examined utilizing what the authors called the Grit Wellbeing and Self-regulation Program. The participants were provided treatment for SUD, with their grit levels measured at the beginning of the program and after treatment (Quinn et al., 2022). This researcher's study does not look to duplicate their effort; however, grit was used in SUD treatment, which may help predict which MNTC clients will complete their treatment.

Huang and Smedema (2023) identified character strengths that can help the client be in a position to control SUD. Many programs stress the primary goal of abstinence for treating SUD. This study has realized that by assisting the clients to better their character and their inherent manner for dealing with treatment, this type of psychological intervention has reduced relapse rates after treatment by nearly 50% from those who only attempted abstinence from SUD.

Biblical/Theological Critique

It is easy to understand how Grit is biblical by breaking into its components of passion and perseverance. There are too many instances of passion in the Bible to list here, but one would be Jesus. He was so passionate about man that He came to earth and sacrificed Himself for our sins. Alternatively, as John 15:13 states, “Greater love has no one than this, that one lay down his life for his friends.“ The other component of grit, perseverance, can be seen in James 5:11: “We count those blessed who endured. You have heard of Job's endurance and seen the outcome of the Lord’s dealings, that the Lord is full of compassion and merciful.” Conclusion: Grit is a biblical concept.

Conclusions for this Research on Grit

Grit is applied to this study in numerous ways to understand the traits that the graduates of MNTC exhibit, their passion for getting clean, and their perseverance in a 13-month program that grows to a lifelong new way of life without SUD. Grit can even be utilized to understand the entire philosophy of MNTC and other SUD treatment programs. From the literature, it was evident to this researcher that these programs have a passion for helping those with SUD overcome their addictions. MNTC has saved clients with SUD for over 30 years, a short time compared to eternity. However, as a Christian organization, it will do what it does until Jesus returns: save souls from the enemy and guide them back to the Lord.

Treatments in the Related Literature

Getting Started in Treatment

In any given year of a study of addiction in the United States, 90% to 95% of drug and alcohol abusers do not get into a treatment or self-help program. Therefore, the first goal of any substance abuser seeking treatment is to get engaged in a treatment program (Landau et al.,

2004). This was where TPB came into the equation. One must first address a patient's motivation to change to get into a treatment program. This motivation to change must happen while working with the patient to keep them from abusing more substances. The patient needs incentives for abstinence, developing techniques to resist the substance being abused, replacing the substance-using activities with more constructive and rewarding activities, assisting the patient in improving problem-solving skills, and facilitating better interpersonal relationships (Calhoun, 2009).

Many times, coercion is used to get the patient into treatment. This can come in many forms, some from family members, friends, employers, health care professionals, and other noncriminal justice agencies. Legal pressure to enter treatment through the criminal justice system is not the only source of coercion (Calhoun, 2009).

For 45% of the clients at MNTC, the coercion to enter an SUD program came through legal pressure from the courts (Calhoun, 2009). This pressure can take on many different forms. For example, in some ways, courts coerce someone into SUD treatment. It can be as simple as a recommendation to receive treatment through the criminal justice system. As part of a plea agreement after a conviction, the client may also have the option of having legal sanctions deferred during treatment, the jail sentence reduced, or the sentence entirely lifted. Alternatively, courts may make treatment a requirement, sending inmates involuntarily to a prison treatment program (Calhoun, 2009).

Types of Treatment Protocols

This subsection looks at different treatment protocols. Before that discussion, some definitions need to be established. First, no one treatment works for every person for every substance being abused (Dodgen, 2004). Second, the available literature has yet to agree on

effective treatment. Everyone involved in the process would like to view total cessation or drug use as that definition, but treatment providers recognize that it is unrealistic (Sealock, 2011). Furthermore, regarding residential treatment, such as provided by MNTC, the methodological problems and implementation of treatment are full of inconsistencies and issues that make that data inconclusive (Hannan et al., 2005).

Based on the criteria of clients' completing their treatment programs, most treatments for addictions fail; this includes long-term residential programs (O'Keefe, 2020). The relapse rates are reported to be between 40 to 60%. MNTC reports a 50% relapse rate (Anderson, 2021). The actual rates are likely even higher, as it was impossible to follow up with relapsed long-term patients and alcoholics since they are cognitively incapable of participating in long-term studies. Dodgen (2004) refers to drug abuse as a chronic relapsing disorder. One remedy he proposed to prevent relapse into prior behavior was to extend the treatment for as long as possible to keep the client involved with the treatment facility.

SUD treatment may be specialized treatment with one main goal: to stop substance use. Treatment was primarily talking therapy, such as counseling and psychotherapy; in addition, medications may be employed to manage detoxification from some drugs and to treat coexisting psychological or medical conditions (Dodgen, 2004; Hystad & Wangensteen, 2022; Sealock, 2011). No matter where or how often the treatment is, talking to the client is a critical component (Alcoholics Anonymous, 2002; Dodgen, 2004).

Since more effective SUD treatment is needed, studies are constantly launched to gather additional data (Heitmann et al., 2021). Therefore, this researcher's study falls into the category

of gathering additional data for the growing base of literature. Those treating SUD rarely have an accurate test to determine if progress is being made with the patient. They may have data from a questionnaire or an interview, but they have nothing that will predict a patient's behavior 100% of the time (Hannan et al., 2005).

One new tool in a study to gather this data was attentional bias modification, a component of the intervention of bringing a person with a SUD into a treatment program. However, in a Dutch study, the findings provided no support for the hypothesis that adding attentional bias modification intervention to an ongoing study contributed to positive treatment outcomes in those patients diagnosed with alcohol or cannabis use disorders (Heitmann et al., 2021).

One definition of an effective treatment is that the patient can achieve abstinence. In that case, the treatment emphasis moves to other areas of the patient's life that may need repair from their former SUD lifestyle. These include coping skills, decision-making skills, emotional state, and relationships with friends and family (Dodgen, 2004). No matter the treatment, the likelihood is that treatment will be a long-term process, with relapses that require multiple interventions and long-term, vigilant monitoring (Hystad & Wangensteen, 2022; Sealock, 2011). Stanton (2004) suggested that the follow-up sessions should last two to six months after the initial treatment.

Many branches of medicine use various lab tests to monitor patients' treatment responses and determine when treatment sessions should be changed to less frequent meetings (Hystad & Wangensteen, 2022). For example, a person with diabetes will have their blood sugar checked regularly, and then the medication dosage will be modified depending on how their body responds. The goal for the person with diabetes is, like a substance abuser, to stop all treatment

because the therapy, along with behavior changes, has worked. This change in treatment would not allow them to stop testing but to stop or curtail treatment.

Twelve-step programs such as Alcoholics Anonymous, Narcotics Anonymous, and others have focused on providing a place where someone with SUD could connect with peers going through the same issues (Alcoholics Anonymous, 2002). Such programs focus on topics like abstinence and spirituality and not as much on changing the client's thoughts as cognitive behavioral treatments historically have focused. Studies have shown that many people with SUD suffer from psychological issues, and having a higher power to pray to or meditate on helps them alleviate this type of stress. This is especially true when they cannot communicate with another person with SUD (Gilbert, 2022; Hai et al., 2021).

According to those who have completed a program, SUD recovery protocols regularly show that a spiritual focus is essential. The literature is clear about the most prevalent drug treatment protocol: Twelve-step programs have memberships in the millions in the United States for juvenile and adult participants (Alcoholics Anonymous, 2002; Gilbert, 2022; Sealock, 2011).

Criteria for Treatment Providers

Several sources, including the U.S. National Institute of Health (NIH), have called for minimum criteria for working with people with SUD. While the NIH recognizes many treatment options for patients—including behavioral therapies, counseling, medication, psychosocial therapies, and inpatient and outpatient services—there is no comprehensive list of training for the different treatments (Cherry, 2013; Papamalis, 2020). Some SUD treatments— such as utilizing medication for treatment—are governed

by the Federal Drug Administration and Department of Enforcement Administration; however, there needs to be a comprehensive oversight.

Recovery from misuse was highly effective when the therapists had extensive training in addiction recovery and hypnotherapy. Qualitative data (not quantitative) substantiates this claim due to the number of variables involved in gathering the data (O'Keefe, 2020). Where treatment takes place impacts the requirements and effectiveness of the treatment. Options include inpatient hospitals, outpatient clinics, therapeutic communities, and for-profit, nonprofit, private, and public facilities (Fisher, 2009). Many treatment programs were never designed to evaluate the treatment's effectiveness for the client objectively once treatment commenced. Unfortunately, this also reduces the control over the different variables that would affect the results that the patient is experiencing.

The type of treatment also affects the staff's training. Some specialized treatments require specialized training with supervision and periodic recertification to deliver the proper level of care (Osilla & Stern, 2019). In addition, the client may request certain features, which could also affect the training required. For example, the demographics of the therapist or the type of psychotherapy will affect who can work with the patient (Arnkoff et al., 2002).

Papamalis (2020) focused on factors contributing to clients completing their SUD treatment program. They discovered little literature that captured the factors allowing clients to be successful in SUD treatment programs. Their study, as with numerous other studies, aimed to attempt to build a model to predict which clients may succeed and which would not (Baekeland & Lundwall, 1975; Loveland & Driscoll, 2014; Miller, 2013).

The patient should expect to complete an assessment and receive a treatment plan that the counselor can review periodically. These should be included early in the process and include

structured goals for determining progress with the treatment. Treatment is different for each client and needs to be customized to their motivation to change their behavior and problem severity (Osilla & Stern, 2019).

Treatment Protocols

Understanding the various applications of treatment protocols could help explain why some clients can complete their treatment programs, and others leave substance treatment programs early. Low graduate rates constitute a significant problem that treatment programs encounter (National Institute on Drug Abuse, 2014). This dropping-out does not include the damage to the client when they relapse. If treatment programs learn why clients drop out, they could respond to their client's needs and proactively change the therapy based on the data presented (Mee-Lee et al., 2010; Papamalis, 2020).

Bukten et al. (2014) conducted a study focused on opioid SUD treatment, attempting to identify factors that may be used to build a model that could predict which indicators may point to a successful transition into an opioid maintenance program. Their study was conducted in Norway. However, the methods and techniques used for data analysis apply to the present study.

Hans and Hiller (2013) conducted a study to determine the effectiveness of individuals and groups using outpatient cognitive-behavioral therapy (CBT), which incorporates several techniques to focus attention on developing skills to solve problems. It utilizes a constructive, not destructive, viewpoint for investigating drug use to be productive in helping the substance abuser. It teaches substance abusers to resist the substances they are addicted to, even in the face of pressure from friends and family and other internal and external pressures to relapse (Sealock, 2011).

Choi et al. (2013) focused mainly on quantitative information and looked at clients who left treatment after only 30 days. The point of their study was to attempt to identify which trends the clients who left the program may have had in common. The factors recorded were age, substance abuse, gender, psychiatric scores based on standard tests, etc. Utilizing individual CBT should allow relapse rates to improve, keeping more clients in therapy and getting help for longer durations (Hans & Hiller, 2013).

Recent literature shows a trend of addiction treatment therapies moving toward outcome-informed, client-directed approaches. These approaches use real-time data monitoring to change treatments (Mee-Lee et al., 2010). One reason for this change is to keep clients in therapy longer, as there is a correlation between those who stay in treatment long enough to realize the benefits of the treatment (Alcoholics Anonymous, 2002; National Institute on Drug Abuse, 2014).

Another factor that could keep clients in the programs longer was if they understood more about the program before they entered the system. Reis and Brown (2006) looked at providing new clients with a video of instructional material on what they should expect in the treatment process. National Institute on Drug Abuse (2016) focused on getting more substance abusers out of the court system and into treatment. Its theory was that people are not getting the treatment they need because the criminal justice system does not know about all the options open to a substance abuser.

SUD Treatment Literature

This section focuses on the primary SUD treatment therapies and the data location so researchers can find this data for future studies. Government grants fund many studies on SUD, and the data is accessible to the public.

Ormbostad et al. (2021) examined SUD clients' perspectives to understand why they dropped out of their SUD treatment programs. Their study did not use interviews but surveys to gather information from a residential treatment program. Interestingly, their study demonstrated that in some cases, those who dropped out of their SUD treatment program never had any intention of completing the program. This researcher had one personal experience at MNTC that attests to this, in which one particular client had been sent to MNTC from the court system instead of going to prison. His court order required him to be in treatment for one year. He eventually worked his way into the MNTC long-term program, which is 13 months long. Days after his first anniversary of joining MNTC and just eight days before graduation, he walked away from the program without repercussions from the courts.

Springer and Bedi (2021) introduced to this researcher the research protocol known as the enhanced critical incident technique, which is used to identify critical events that cause a behavior change. In this study, this would be leaving SUD treatment before completion. Using interviews, Spring and Bedi asked men from Canada and the United States why they left counseling and if there were factors that would have made them stay to complete the treatment program. The critical incidents were identified from the transcribed interviews using coding techniques to confirm these critical incidents.

Cognitive-behavioral therapy (CBT) has previously been discussed in this literature review. CBT incorporates several techniques to focus attention on developing skills to solve problems. It utilizes a constructive, not destructive, viewpoint for investigating drug use to be productive in helping the substance abuser. CBT teaches substance abusers to resist the

substances they are addicted to, even in the face of pressure from friends and family and other internal and external pressures to relapse (Sealock, 2011).

Reading the literature on substance treatment, one can see that much of the data are variable and far from impressive. Data that could help treatment programs require more rigor and control to facilitate treatment strategies and approach changes. Simply telling someone to abstain from alcohol and drugs is not easy for the person with a SUD. Winters (2018) showed that adolescents had relapse rates in the first year in the range of 40-60%. The specific type of treatment did not matter; the relapse rates were the same. According to NIDA (2023), the methodologies of 12-step facilitation, motivational enhancement approaches, community reinforcement, therapeutic community, medication, CBT-like, or family-based treatments such as discussed in Winters (2018) all have the same relapse rate.

NIDA is a federal agency that serves as the government's center for research on drug abuse and addiction. Its primary role in the United States is to ask fundamental questions about drug abuse. As such, it was the first agency consulted for this project's SUD information. NIDA seeks to understand how substances affect the body and brain so that it can develop new prevention approaches and treatments (Padwa & Cunningham, 2014).

The next government agency, Drug Abuse Reporting Program, took the NIDA information and developed a study to determine the effect of community-based SUD nationally. This 20-year study gathered data from 44,000 people admitted to 52 federally supported treatment agencies between 1969 and 1989, with follow-up interviews conducted six and 12 years after the original admission dates to the treatment facility (Boslaugh, 2011).

The prospective treatment outcome was a subsequent study examining SUD treatment (Boslaugh, 2011). This study collected data from 11,750 clients and examined persons treated in

10 U.S. cities between 1979 and 1981. One other source for data on SUD treatment in the United States was the Office of Applied Studies of Substance Abuse and Mental Health Services Administration, which focused on the treatment and consequences of SUD (Boslaugh, 2011).

Boslaugh (2011) detailed additional data from the drug abuse treatment outcome studies that ran from 1990 to 1993. That study was also funded through NIDA and involved over 10,000 adults in 11 cities. Another program, summarized by Boslaugh, was derived from the judicial system's arrestee abuse monitoring program. Data from that study was collected over 17 years, from 1987 to 2003. From the program name, the reader can tell this data involved recently arrested people.

Stitzer (2009) discussed the clinical trials network, which started in 1999. Its purpose was to share information on promising practices in community treatment programs based on data, not anecdotal, between researchers and the programs and to promote findings based on evidence-based practices.

The combined pharmacotherapies and behavioral interventions, or Project COMBINE, looked at the effects of medication and counseling in treating alcohol addiction (Mee-Lee et al., 2010). The consolidated framework for implementation research was unique in that it was designed to look at efficiencies in implementing treatment programs for drug and alcohol abusers. The information looked at the factors in implementing the process, including external and organizational factors (Louie et al., 2021). An interesting recent study from Teplin et al. (2021) concluded that those abusing substances and experiencing behavioral disorders "were more common among non-Hispanic White youths than Hispanic and Black youths" (p. 2).

Hwang et al. (2020) offered a different perspective on those leaving treatment after referral by the court system. Their study examined court records, looking for those re-offenders. It identified a three-fold increase in re-offending for those who left their SUD treatment programs before completing their treatment. Even though their study did not explore why some clients remained in their respective programs until completion, it also did not identify the reasons some participants left their treatment early.

Another attempt to develop a model to predict those likely to drop out of SUD treatment was conducted by Andersson et al. (2018). Their data was concerned with demographics, psychological profiles of the clients, and which substance was being abused, to determine if there was some correlation with those who dropped out of treatment. No correlation was observed, so they were not able to produce a model to predict which clients succeed and which are destined to fail.

Şimşek et al. (2019) took a similar study approach to this researcher's to identify why clients leave SUD treatment early. Their study had the goal not to develop a predictive model, but to understand the reasons why some clients stay with the program and others leave SUD treatment early, then feed this information back to the treatment centers in Turkey so those centers could make changes to their programs, in the hopes of helping more people with SUD. Their study was unique in that one of the factors tracked how many treatment sessions the client completed before they left, along with basic demographic information on the clients.

Juvenile Treatment Studies

These works are included in this literature review to show recent research on the different substances treated in various facilities. They are included mainly for the methodology for gathering and analyzing data. Meyer et al. (2018) used acceptance and commitment therapy,

which is a psychological therapy using empathy and mindfulness to reach the client. Like most addiction recovery programs, acceptance and commitment therapy, as reported by Meyer et al., requires clients to continue practicing mindfulness techniques for the rest of their lives. Unfortunately, the tool used by such therapy could not predict who would complete the treatment. Rather, Meyer et al. discovered that the only way clients were to show improvement was to regularly contact the therapist and avoid the psychological triggers that would cause them to relapse.

Pfund et al. (2021) focused on gambling and gambling addiction as opposed to SUD. However, much of their treatment protocol was similar to those employed in SUD treatment programs, since in reality, programs like MNTC deal with all types of addictions, including pornography, nicotine, substance abuse, and anything that can be put in place as a false idol to be worshipped or addicted to. Psychologically, the treatment protocols are similar, no matter what was being abused. The first step is to break the immediate abuse, then substitute something else for the client to focus on—something like Jesus—and lastly, to change the daily habits and stay away from the original thing being abused. Then, in order to maintain the gains in that client's life from not needing that substance, a lifestyle change must be made to make it easier for the client to focus on the new thing and not backslide (Pfund et al., 2021).

Visnovsky et al. (2022) examined alcohol as an abused substance, utilizing Lesch's typology for alcohol abuse, which is based on a longitudinal prospective study on patients with an alcohol addiction. Their year-long study analyzed psychiatric and psychosocial treatments. The levels in the Lesch study refer to levels of dependency on alcohol for the subjects (Visnovsky et al., 2022). However, this researcher found in the present study that there was no difference in

recovery rates between individuals in the different Lesch levels. Nevertheless, Lesch's typology and background helped this researcher better understand the clients at MNTC.

Parts of an article by Ball et al. (2006) are helpful for this researcher's project, as that article provides a reference and example of gathering and analyzing data. This paper was a qualitative case study, just as this researcher's study plan and the interview questions can be modified to collect the qualitative data needed. Ball et al. collected data from the perspective of clients who dropped out of the program. However, they provided a unique perspective on data that was much more challenging to obtain. The tool they developed was called the Reason for Leaving Treatment Questionaire. It consists of 28 true or false questions regarding why the client left the program, and could be modified to provide this researcher with information. This researcher's study was designed to determine similar factors in the Reason for Leaving Treatment Questionaire for MNTC so that its findings may be applied at other Teen Challenge centers in the United States and worldwide.

Viewing research on both juvenile and adult residential treatment efficiencies was unreliable. These studies are full of implementation issues and methodological problems. Unsurprisingly, they have shown more positive outcomes when clients stick with the treatment for a long time (Alcoholics Anonymous, 2002; Sealock, 2011). Alemu et al. (2024) demonstrated many relapses when clients fail to complete their programs; they also discovered that of those juveniles with a drug abuse problem, only about 10% receive treatment.

MNTC sponsors a program that goes to middle- and high-schools to teach about the dangers of drugs and SUD. There have been numerous studies on the prevalence of drugs and the percentage of those graduating from high school who have tried drugs (Abad et al., 2019; Anderson, 2021; Davis et al., 2019; Miller, 2013; Papamalis, 2020; Wisdom, 2009). Teter et al.

(2020) specifically looked at prescription stimulants among high school students and correlated that with academic performance. Considering the news reports that are prevalent near the end of the school year reporting overdoses of teenagers, this type of study was not a surprise. What was shocking was the amount of prescriptions for stimulants that are prescribed to children. The number of illegal or non-prescription stimulants, including over-the-counter drugs, makes this type of study more important to share with young people (Kilmer et al., 2021).

Miller (2013) analyzed teenagers in the Arizona Teen Challenge residential program. This type of research was another example of those looking at the Teen Challenge programs and their success rates. In particular, Miller attempted to ascertain whether adding Christian principles to SUD treatment programs was a significant benefit. Her quantitative study used surveys through the mail and only had a 17% return rate, which translated to a sample size of 34, and the calculated ideal sample size was 153. The data she collected was exciting information about the group's demographics in Arizona. However, there was no statistically significant sample size to base conclusions and extrapolate them to other populations.

As with adults in the judicial system for drug-related crimes, youths may not know the help available to them from drug court. Fulgham (2020) found that minor substance abusers from the suburbs had a higher graduation rate than those youth from the inner city; one speculation was that parental involvement was higher in the suburbs. Motivational enhancement therapy assumes that adolescents want to understand why they have a drug problem, so then they can find their motivation to stop using. The Adolescent Community Reinforcement Approach teaches the consequences of using drugs by establishing clear goals for the counseling sessions (Wisdom, 2009). These goals are then tracked to completion. The Matrix Model was initially developed in the 1980s to study

SUD, with cocaine as the substance being studied (Obert et al., 2000). Within the Matrix Model, juveniles were exposed to structured information, relapse prevention, and what to do when he or she needed a contingency. Clients learned motivational enhancement to continue their treatment and family involvement in their program, and they also learn to use a 12-step program such as that in Alcoholics Anonymous to treat their SUD.

Different SUD treatment programs must collect more information to determine which steps precipitated the relapse, otherwise rendering comparison mute between treatment programs (Wisdom, 2009). Numerous therapy models are successful with juveniles regarding abstinence or reduced drug use. The Minnesota Model was started by the Hazelden Betty Ford clinic in Minnesota (Wisdom, 2009). It is based on Alcoholics Anonymous's 12 steps, and serves as the basis for most of these therapies. The Minnesota Model views SUD as a disease model of addiction, and the only solution is lifetime abstinence (Wisdom, 2009). In addition, the Minnesota Model uses several factors found in MNTC, such as recovering people with a SUD as counselors, availability of aftercare counselors, and mandatory group meetings for a new client when the program starts.

In cognitive behavioral therapy, juveniles are taught techniques to refuse drugs and stay away from the friends that are using them by developing new friends (Wisdom, 2009). They are also taught coping mechanisms and problem-solving. This therapy relies on the juvenile's family for support and strength while in treatment.

The last therapy for this literature review was multidimensional family therapy, which links the parents and the juvenile by building alliances links between the two and opening a communication channel (Wisdom, 2009). Also openly discussed are the parents' and juveniles'

concerns about the treatment process, such as conflicts and having positive interactions, trust, and hope for the future (Wisdom, 2009).

This researcher's closing comment on juvenile treatment studies is to note that an obstacle to helping juveniles was getting permission from various groups (e.g., parents, teachers, and social workers) before collecting any data. Research was needed to evaluate the best approach of actively involving parents to help their children who are not motivated to get into treatment—explaining to parents that getting their child treatment will promote recovery.

Treatment Programs Incorporating Christian Principles

This section of the literature review provides examples of various SUD treatment programs that have incorporated some faith-based elements into the therapy of their clients (Alcoholics Anonymous, 2002; Dickie, 2021; Grim & Grim, 2019; Hoffman, 2016; Krause & Rainville, 2022). This researcher utilized or customized the strategies and methodologies for possible implementation at MNTC. This section contains many features that were implemented as part of this study. This researcher believes that with a thorough review of this section, various methods to decrease dropout rates and increase the graduate rates at MNTC were identified for trial in Minneapolis.

The following literature took a different approach to implementing Christian principles. For example, Grim and Grim (2019) utilized the congregation facilities for the location to perform their treatment program. Hoffman (2016) purposefully studied holding SUD treatment programs off the church property, at a separate location. Dickie (2021) discussed showing God's love right where the client is. There are advantages and disadvantages to each of these ideas.

Grim and Grim (2019) included several statistics, facts, and exciting conclusions that apply to this study. For a sample from their article, 73% of SUD treatment programs in the United States have a spirituality-based element. They also defined spirituality as an openness to God or a place where someone can experience love and a sense of purpose. The last exciting statistic came from a survey on MNTC (Owen et al., 2007). Similar to the one in this study, their survey reached out to graduates from MNTC to reveal the top two factors in the graduates maintaining sobriety. Those two factors were reported as staying connected to God (58%) and family (34%).

Like much of the literature in this section, when these authors talk about faith and God, they are careful to be non-denominational and even go so far as not to call out any Christian terms. For example, one statistic on addiction prevention provided by Grim and Grim (2019) says that most scientific studies show faith was a positive factor in treatment. This researcher's topic concerns MNTC, a treatment facility founded by and adhering to the doctrines of the Assemblies of God church. Therefore, MNTC fits Grim and Grim's (2019) faith-based parameters, but this researcher's research questions probed for more specific answers than just faith-based ones.

Hoffman (2016) noted observations contradicting this researcher's experiences with MNTC. One outcome of his study was to find that for pre-adults, there are faith-based programs to help them with SUD, but once someone is an adult, they are not exposed to any programs that might prevent SUD. Hoffman's location is in Ohio, and this research was conducted in Minnesota, so the different states may operate Teen Challenge differently concerning admissions.

Hoffman (2016) also observed that programs like Celebrate Recovery, Salvation Army Adult Rehabilitation Centers, and Teen Challenge would be utilized more if adults knew about faith-based early intervention programs. He referred to structured programs to help adults, not just scheduling time with a pastor. Similar to Alcoholics Anonymous meetings that meet in most churches, he posited that there should be structured programs for early intervention. After establishing these early intervention programs, the second step he recommended was to communicate the existence of such programs to those who can help, like attorneys, court officers, and social workers. Notably, Hoffman was a pastor responsible for setting up a program at his church in Ohio.

Dickie (2021) discussed an ancient way of learning the Bible and claimed that this method was helpful for addiction recovery, evangelism, and discipleship. This technique relates to a Jewish custom and method for teaching and remembering Bible stories. Before the Bible was written, all the stories were passed verbally from generation to generation. Dickie proposed that when a person has to act out a story to tell it, they must first understand how the person who wrote it was feeling at the time they wrote the story in order to act out that story appropriately.

This methodology described by Dickie (2001) becomes effective when people not in the story ask questions of the person telling it. This technique was helpful for SUD treatment because the abuser must now understand how their actions affect all those around them and everyone they interact with when they are in character. The realization of the levels of trauma for all involved would be used for reconciliation.

Krause and Rainville (2022) studied the drinking habits of military veterans. Their conclusions agreed with Grim and Grim (2019): adding God to the recovery and treatment equation suits the client and helps them with the treatment process. Waters (2019) brought up a

topic that has not been discussed: since SUD is defined in the *Diagnostic Statistical Manual of Mental Health Disorders* as a mental disorder, then why are SUD addictions treated as a crime?

Chavez (2021) looked at pastors leaving their positions in churches in Texas. At first, her paper may seem different from this study, but it was pertinent to the present study for two reasons. Chavez's research looked at pastors leaving to understand why many MNTC graduates work in ministry; some of the information may apply to both the MNTC dropouts and the pastors leaving. She also discussed various demands and stressors that cause ministry burnout. The MNTC graduates likewise experience stressors, including contact with the outside world and the apparent pull to indulge in the substance abuse that caused these clients to end up in MNTC in the first place. Lastly, she highlighted the fact that many pastors leave ministry due to limited time for spiritual and self-care, which can have applications for SUD users, too.

Courtois and Steinberg (2021) examined factors involving clergy abuse of people they are counseling. This was related to the current study; MNTC has separate men's and women's programs. For the long-term clients, men and women live in different locations. However, there are times when all the clients are together for various events. Courtois and Steinberg concluded that no definitive data indicates that an interaction between the sexes was an issue. However, that was not the main reason for referencing their work. This study evaluated the effects of this sin and all the ancillary parties, including clients' family members, and seeks to provide examples of assistance offered to all affected by corruption.

Summary of Related Literature

The literature shows that SUD is a global problem spanning all age groups. Although not one single substance was abused, this problem was just as prevalent in men as it was in women. There are many protocols and treatment plans, none of which work for every afflicted person.

Unfortunately, for those seeking treatment, finding the treatment that will work for them was not guaranteed. Still, at least there are many locations and treatments where they can identify the treatment option that helps them with their addiction.

Rationale for Study and Gap in the Literature

The current literature shows numerous studies on SUD treatment programs and protocols (Papamalis, 2020; Wisdom, 2009). Researchers have implemented many theories to identify the best theory or methodology to assist those with addiction. Unfortunately, no data indicate a single theory that works for all those addicted to a substance. As researchers cannot identify a universal method to help those seeking help, there has been little to no research on why some clients can complete their treatment programs or why many of those starting treatment programs leave substance treatment programs early.

The literature shows a gap in understanding why clients feel they can complete their SUD treatment programs. If the reasons for graduating versus leaving SUD treatment could be discovered, more clients could be helped proactively. Understanding why clients believe they can complete their treatment programs is necessary so changes can be implemented to increase the number of people completing their programs.

Profile of this Study

A qualitative case study was needed to capture why MNTC graduates believe they could complete their programs when historically 50% of those who enter SUD treatment programs leave their programs early (Creswell & Poth, 2018). This qualitative study was designed to capture the perceptions of the graduates who completed the long-term program at MNTC and ascertain why they were able to finish their programs. This study compared data from the

interviews and the demographics of those interviewed to identify any correlations between the interview answers and the demographic surveys of the graduates.

CHAPTER THREE: RESEARCH METHODOLOGY

This study utilized a qualitative case study methodology. A case study is one of the best methods for the researcher to discover answers to the why and how questions of the process being studied. A case study is also appropriate for investigating how groups and individuals deal with a social problem such as SUD. This approach was used as a research strategy that involved determining reasons related to the research's purpose (Yin, 2018). This chapter will detail the research design and explain the steps to conduct, collect, and analyze the data.

This chapter presents the research design, including the problem, purpose statement, and research questions. The setting and participants are also presented in the research design. Next, the researcher's role in this study and the ethical considerations detailed by the Liberty University (2023) Institutional Review Board are discussed. Finally, the data collection methods, instruments, and analysis are examined.

Research Design Synopsis

The Problem

Bohler (2023) noted that: "According to 2021 data from the National Survey on Drug Use and Health, 16.5% of the United States population over the age of 12 meet the criteria for a SUD" (p. v; see also Substance Abuse and Mental Health Services Administration, 2022). Supporting this data was a Know The Truth survey, which is used by the MNTC substance-use prevention program (Anderson, 2021). In 2020, the Know the Truth survey was completed by just under 4,000 students about addictive substances, and found that 34% of the high school students who responded reported using addictive substances in the past year (Anderson, 2021). Anderson focused specifically on those clients who have completed their program out of the Minneapolis, Minnesota, location and remained sober for at least one year.

MNTC has a 92% success rate of graduates from its long-term program not relapsing in the first year out of the program. Anderson's (2021) study explored avenues for increasing the number of first-time clients graduating from the program and decreasing those dropping out in the program's first six months since, currently, half of the clients who enroll in a SUD treatment program drop out before completing their program.

Purpose Statement

This case study was designed to understand the successful completion of the long-term program for graduates of MNTC. It explored demographic differences and similarities between graduates and the graduates' perceptions of why they felt they were able to complete the program while others failed. Successful completion was defined as graduating from the program and not having a relapse for one year. The theory guiding this study was Ajzen's (2020) Theory of Planned Behavior (TPB), which proposes that an individual's decision whether to engage in any specific behavior, such as drug or alcohol use, is predicated by their intention to engage in that behavior. TPB explains a person's intention to stop their substance use as a conscious behavior that this study seeks to understand.

Research Questions

The following research questions guided this study:

RQ1 - What are the demographic differences and similarities of the graduates who completed the MNTC long-term program?

RQ2 - What are the reasons why graduates believe they successfully completed the MNTC long-term program?

RQ3 - What are the graduates' perceptions of why some fail to complete the MNTC long-term program?

This qualitative study captured the perceptions of the graduates who completed the long-term program at MNTC and analyzed why they could finish their program. It compared the data from the interviews and the demographics of those interviewed to identify any correlations between the interview answers and the demographics of the graduates. Much of the literature was centered around specific substances or locations studied. Collecting demographic data may allow this study to be linked to other data.

Research Design and Methodology

Recent research by Carter (2020), Frelin (2015), and McDonald (2023) identified specific aspects of the case study methodology used in this study. As this researcher has identified, there needs to be more information from clients who have graduated from an SUD treatment program to help program leadership change their programs. Thus, a qualitative case study was the only logical methodology to collect this data type (Creswell & Creswell, 2023; Schwandt, 2007; Seidman, 2019; Yin, 2018). Yin explained that the reason for utilizing a qualitative case study is that a researcher wants to understand the essential conditions that relate to the study. This study was designed to understand the conditions or why some clients of MNTC can graduate and others fail to complete their treatment programs.

A qualitative case study was an appropriate method for this study because face-to-face interviews were primarily used as the source of information to collect pertinent information from the graduates (Creswell & Creswell, 2023; Schwandt, 2007; Seidman, 2019; Yin, 2018). These recorded interview data included facial expressions, voice inflection, and the graduates' verbal answers. These additional factors provided the researcher with indications of the sincerity of the verbal responses.

Closed- and open-ended questions (see Appendix J) were used during the interview to uncover additional information not found in other methods, such as a written questionnaire. Depending on the answer, the researcher could ask the graduates clarifying questions. The open-ended questions were designed not to be answered with a one or two-word answer.

Utilizing interviews for case-study research is commonplace in today's society for many different topics. People are used to being asked for their opinions about all sorts of things (Schwandt, 2007). In this case study, the sample was from graduates of one program with a 92% success rate in helping clients with substance use disorder. The subjects of this study are intimately familiar with the SUD treatment they have received. However, according to the literature, this information has yet to be previously captured.

Setting

The setting for this qualitative case study was MNTC, located in Minneapolis, Minnesota. MNTC was chosen for this study mainly because of the high success rate in treating those with SUD. For those who complete their program and graduate from the long-term program, MNTC has a 92% success rate for the first year out of the program so as not to relapse. However, 50% of clients in the long-term recovery program at MNTC drop out and must start over in the program before they graduate (MNTC, 2020). Sometimes, the clients leave the program and are never seen again. The literature supports this same 50% dropout rate (Arnkoff et al., 2002; Chiesa et al., 2003; Clarkin & Levy, 2004; Garfield, 1994; Reis & Brown, 2006; Swift & Greenberg, 2012). This research explored avenues for increasing the number of first-time clients graduating from the program and decreasing the number of those dropping out in the program's first six months (see Anderson, 2021).

This study focused specifically on those clients who have completed their program out of the Minneapolis, Minnesota location. This study utilized multiple data sources, including MNTC documentation, graduate interviews, and field notes (Creswell & Creswell, 2023). Convenience sampling was used to choose the MNTC graduates for interviews.

Pastor Rich Scherber, Founder of MNTC, is a pastor in the Assemblies of God church. From a leadership perspective, MNTC utilizes a team-based approach with a Christian worldview. The teams' approach was optimal for removing organizational barriers, focusing on clients, and helping them cope with SUD. Many employees believe in Jesus Christ, but that is not a requirement to work at MNTC.

Participants

The sampling type for this study was a convenience sample (Schwandt, 2007). Convenience sampling is, as the name suggests, usually the chosen sampling method because it is fast and easy to find information samples (Leedy & Ormrod, 2019). However, for this study, convenience sampling was chosen because, as with any addiction, the clients may stay in SUD and not want to contribute to this study. Given the nature of those afflicted with SUD, without convenience sampling, the amount of information may not be able to be collected.

The MNTC alumni director states that over 6,000 have graduated from the Minneapolis campus alone in the past 30 years (D. Hunt, personal communication, January 5, 2023). When the graduates leave the program, they provide contact information to the program, but there is currently no budget to follow up with those alumni and keep their information accurate. With over 30 years of graduates, it is likely that some have passed away or moved and changed their contact information without updating the administration at MNTC. When this researcher interviewed the alumni director, he estimated that 20-50% of those in the alumni directory have

current information in the alumni database. From this discussion with the alumni director, convenience sampling was the only logical answer to gathering information for this study (D. Hunt, personal communication, January 5, 2023). Future funding at MNTC will hopefully become available to update the alumni directory.

The prospective study participants were contacted in several ways to identify their willingness to participate in this study. This researcher had met numerous graduates in previous ministry work and has their contact information. However, none of those graduates were contacted, and the researcher does not believe they know anything about this study. Prospective study participants were contacted by phone (see Appendix H) or email (see Appendix F), depending on the current contact information available to this researcher. Others attend this researcher's church and may have been contacted in person (see Appendix G). As an alternative to those methods, this researcher contacted the pastor of Riverview Church (Appendix B), with the pastor offering to let this researcher speak on a Sunday afternoon during the main service (see Appendix G).

The sample size for this study was 16 interviews. To preserve anonymity, each graduate was identified in the reports only as a number, 1 through 16, during data gathering. Those 16 were then assigned a pseudonym for documentation purposes in this research. Names of the participants and other identifying information are not recorded or transcribed. The participants in the study are all over 18 years old and received and agreed to consent forms before any data gathering (see Appendix I). A demographic survey was obtained from those interviewed to answer Research Question 1.

The specific interview questions were vetted in a separate pilot test. These questions can be found in Appendix J. The software program that assisted in the analysis was NVivo (https://my.lumivero.com).

Fifteen interviews were conducted in a conference room at MNTC (see Appendix D) in Minneapolis, and one additional interview was conducted in a coffee shop to accommodate the graduate's work schedule. Riverview Church was a recent church planted by an instructor at the Teen Challenge Leadership Institute (TCLI) who saw a need for the graduates to attend a church where they would not be judged based on their past. Many of those interviewed attend church at Riverview. TCLI was a training program that some graduates participated in after graduating from MNTC. TCLI programs help graduates to reengage with society.

Role of the Researcher

This qualitative case study utilized multiple data sources, including MNTC documentation, MNTC graduate interviews, and field notes. Face-to-face, in-person interviews provided the researcher with unfiltered views of the graduates and their opinions of why they believed they were successful when others were not (Creswell & Creswell, 2023; Creswell & Poth, 2018).

This researcher was involved in several areas of this study. He began by selecting graduates for interviews, asking questions, and generating notes. He then presented and collected the various release forms from the graduates before conducting any interviews.

This researcher was involved in the volunteer mentoring program at MNTC in 2020 and 2021. None of the potential subjects of this study were mentored by this researcher, whose only client-mentee dropped out of the program eight days before his graduation. This mentoring program is for clients in the final six months of the long-term care program. During mentoring,

each client is assigned a mentor by MNTC counselors to provide them with another resource that helps them ease back into society. The mentor also provides the client with someone they can relate to who was not directly involved with the program. Coincidently, this researcher also started this doctoral program at about the same time as serving as a mentor in the MNTC program. When the client this researcher mentored dropped out of the MNTC program, this researcher became interested in helping additional clients graduate from the long-term care program.

Ethical Considerations

The subjects of this study were provided with applicable confidentiality and legal documents (see Appendix I), which were identified by the Institutional Review Board (IRB) before any data-gathering activities, such as personal interviews. This researcher collected these signed documents and stored them according to IRB guidelines.

To protect subject confidentiality, graduates were identified only by 1-16 in all study documentation. Demographic information of those interviewed was gathered, but no other personal information was used in this study.

The IRB approval process at Liberty University (2023) was as follows: After completing the research prospectus and a video conference with the dissertation supervisor, this researcher applied for review and approval by the Liberty University IRB (see Appendix A). Before gathering any information, the IRB approved all instruments (interviews and questions) used to gather data from MNTC graduates. After IRB approval, this researcher began pilot-testing the interview questions and the process to gather the data needed for this study.

Any adjustments to the process, as laid out in this prospectus, were first cleared through the dissertation supervisor. This researcher will retain all raw data from the interviews and data analysis for five years following graduation.

Data Collection Methods and Instruments

The primary data collection method was personal interviews. The questions asked during the interviews were structured to make the graduates comfortable providing their information and opinions by establishing a rapport before delving into intimate information about their treatment for SUD (Creswell & Creswell, 2023; Creswell & Poth, 2018). Questions for these interviews can be found in Appendix J. Notes from the interviews and observations of the graduates were also collected for analysis.

The interview questions were designed to provide sufficient information to answer all three research questions. A pilot test was conducted with three MNTC graduates known to the researcher for feedback on the questions and the delivery of those questions. No one from the pilot test group was included in the study. As Yin (2018) explained, interviewing requires two parts: asking good questions and being a good listener.

Collection Methods

Personal interviews were audio-recorded, and the researcher also used notes from those interviews. The interview questions are semi-structured and structured to elicit a response, not just a yes or no answer. Demographic data was collected during the interview to assist in the analysis of this study (Creswell & Creswell, 2023; Schwandt, 2007).

This type of data collection for research has recently been successfully demonstrated in three accepted studies by Carter (2020), Frelin (2015), and McDonald (2023). In each of these studies, the primary data collection method was precisely what this researcher was proposing.

Individual interviews with subjects were chosen from a convenience sample of those who met their particular study's criteria. The literature also supports this methodology, which utilizes personal interviews, notes, and demographic data (Bohler, 2023; Carter, 2020).

Instruments and Protocols

All information was collected and stored to be accessed for future review. Interview recordings were transcribed using MAXQDA (https://www.maxqda.com), a commercially available software. The interviews were recorded for two reasons. The first reason was to ensure that all information was present. The second reason was to capture the answers for replay to clarify the client's responses to the questions.

Previous researchers have identified that gathering and processing interview data has numerous potential problems, and this study remained mindful of those potential issues while gathering data (Hannan et al., 2005). Most potential problems were related to the memory of those being interviewed. Recalling events from memory was another reason to record the interviews and store that information. Human memory is imperfect; depending on the time that has elapsed since graduation, the answers to an interviewer may change. In addition to the amount of time since graduation, other factors must be accounted for by those interviewed. These additional factors include any personal bias of the graduate and the interviewer concerning politics, anxiety, anger, and other emotional states that the subject was experiencing when the interview was conducted (Leedy & Ormrod, 2019; Patton, 2015).

To supplement the recording data from the interviews, this researcher took notes during the interviews, which were analyzed along with the interview transcription. The interview had seven open-ended questions. The plan was for individual face-to-face interviews, which were anticipated to take 20-30 minutes (Creswell & Creswell, 2023).

The data analysis process for a qualitative case study was straightforward; this case will follow the analysis steps laid out in the text of Creswell and Creswell (2018). The first step involved the transcription of the recorded interview data. After transcription and verification that the transcription was correct, various textual analysis tools were used to transcribe the audio data and to identify common themes and patterns among the interview subjects and their responses to the questions (Patton, 2015; Schwandt, 2007).

The next step after transcription was to combine interview data with the notes from the interviews and then combine all of this information with the demographic documentation acquired during the interview. After combining all this information, the data must be winnowed into manageable pieces. The next step was to review the data to ensure it made sense, fill in any gaps, and sort it by type. This was the first time all data was viewed as a complete set. Before the next step, this data review was needed to feed the information to computer software.

NVivo software (https://my.lumivero.com) organized the data using codes and categories. Computer software was used for coding because codes may need to be changed based on the data being run through the program. A computer can rerun the data much faster than a person, and all of this coded information can be stored for later comparison and sorting.

The final step in the analysis was to determine the optimal method for presenting this information in a manner that would make sense to those interested in this study. Everything that the coding process discovers may not be of interest to all those reading this study. Some information from the analysis may indicate a future study topic outside this study's current topic.

The interview questions were developed using a question topic statement table, which is included in Table 1 below:

Table 1

Question Topic Statements

Research Question	Sub-Topic	Survey Statement
RQ1: Demographically, are there similarities with the graduates in the study?	Family	Childhood home?
		Current home?
		Religious/Church affiliation?
		Siblings?
		Are others in your family using the same substance?
	Substance Abused	Crack
		Meth
		Speed
		Alcohol
		Other
		Did you relapse?
		How long of a time use?
	Treatment	MNTC house/location/outpatient
		MNTC Mentor?
		How did you learn about MNTC?
		Age at graduation?
RQ2: What themes can be traced to the graduate's stated reasons for feeling they were able to complete their SUD treatment at MNTC?	Interactions with former friends from the abuse phase of the client's life.	My friends do not use as much as I do.
		My family is not affected by substance use disorder.
		My family and friends will not know how to help me.
		The people that I used to associate with still use.
		My friends and I have lots of fun together.
	More robust physically to handle withdrawal	This is no different from any other hangover.
		I work out all the time.
		I take supplements.
		I drink lots of water every day.
	Made new friends only with people in the program	People in the program will keep me from backsliding.
		People in the program can relate to me.
		People in the program know how to help me.
		People in the program care for me, and I care for them.
RQ3: What do graduates from MNTC feel are the differences between those who graduate and those who drop out of the MNTC long-term care program before completion?	The attitude of others who dropped out.	My family and friends can help me with the treatment.
		I am stronger than others who have been here.
		I can do this on my own and do not need MNTC.
		I know better than the MNTC counselors.
	The behaviors of those who dropped out.	Getting high will help my progress.
		I can go out with my old friends.
		I still get high, but not with the same substance.
	Do not have to change their friends and family contacts	I still communicate with my boyfriend/girlfriend.
		A "family member" is in treatment, and other friends keep us connected.
		Every time they get a pass off campus, they go home.

The pilot study, conducted using the interview questions before the interviews, validated the method and identified no inherent gaps in the data collection.

Interviews

Logistically, the interviews took place in two locations. A conference room at MNTC and a conference room at a coffee house on a Sunday afternoon. These locations were chosen as they had low background noise to make for better audio recording, with a time limit of 30 minutes per interview (Creswell & Creswell, 2023; Creswell & Poth, 2018; Leedy & Ormond, 2019; Schwandt, 2007)

The purpose of a personal interview, instead of a survey, was to capture what the graduate believes about the SUD treatment process at MNTC in the graduate's own words. Interviews were semi-structured with open-ended and closed questions (see Appendix J). The questions were grouped chronologically based on the graduate's experiences with SUD. These questions were designed to uncover the graduate's life before MNTC, their perception of MNTC and their treatment process, and lastly, how their life has changed since graduating from MNTC (Seidman, 2019).

Similar types of information were also gathered and used as detailed in Alcoholics Anonymous's (2002) *Big Book*, which was initially written in 1939. This general technique for treating SUD was a process that has been introduced previously. However, the attitudes of those who have completed a program have yet to be documented in the literature.

Document Analysis

Documents for this study were from three sources: notes from the personal interviews, transcriptions from the personal interviews, and any documentation available from MNTC (Schwandt, 2007). As stated earlier in a discussion with the MNTC Alumni Director, only a little information exists on the people in the program as MNTC needs the budget for that type of

activity. There was a possibility that additional information could be provided by MNTC leadership.

The documents were analyzed using the two-cycle coding method described by Saldana (2021). This researcher kept a code book during all coding activities to track the codes used during the analysis. The first coding cycle utilized attribute coding for basic information from the interview setting. Structural coding breaks down the documents so that concept coding can identify the main ideas; metaphor and verbal exchange coding look for patterns from the transcriptions (Saldana, 2021).

Second-cycle coding was implemented to assist in creating a model diagram of the responses and other information presented for analysis. This part of the document analysis was focused on developing groups based on the information presented. Second-cycle coding included pattern, longitudinal, elaborative, and focused coding. These operations can be carried out quickly with software. Multiple iterations will break the information, and then the data are rebuilt into groups and subgroups for further analysis.

Conclusions from this analysis can be identified by theoretical coding and ordering and reordering the information until clear themes are evident from the data (Miles et al., 2020; Saldana, 2021). This researcher thematically analyzed the information to look for key points and themes from the content of documents, interview transcripts, and publications. With the NVivo software, this grouping of information into categories consolidated the ideas and themes from the coding phase of document analysis. The software also allowed for a graphical representation of the collected information, which may identify additional patterns for the researcher and readers. Conclusions about the information's complexity, network effects, and any domino effects that one part of the data had on the other parts.

Procedures

This researcher secured the IRB's approval before any pilot testing or data gathering (see Appendix A). In addition to IRB approval, and before proceeding with the study, a file structure system and database had already been established to sort and segregate the data and show what data or data types are missing as data collection progresses. The interview audio data was transcribed with commercial software from MAXQDA before storing that information with the other data (Leedy & Ormond, 2019; Yin, 2018). All data was stored electronically for easy grouping and regrouping as the analysis proceeds. The data is safeguarded with both biometrical and multiple physical security features.

Data Analysis

During the analysis phase, visual representations of the data in graphs and flowcharts were utilized to assist in identifying key points and themes (Yin, 2018). One methodology for data analysis was the data analysis spiral (Creswell & Creswell, 2023; Leedy & Ormond, 2019), which has four basic steps. First, organize the data so it can be broken into smaller groups. Second, look over the entire dataset to see what macro groupings may be present. Third, identify those specific themes or subcategories. Lastly, determine how to integrate and summarize the data in a way that conveys the relationships to those who may be interested in this study.

Analysis Methods

The data analysis method followed a similar pattern defined by previously mentioned researchers (Carter, 2020; Frelin, 2015; McDonald, 2023):

1. Transcribe all interview data. Use commercial software and then read the transcriptions to ensure they were transcribed correctly compared to the interview notes. This may require going back to the audio recording.

2. Organize all data electronically using the filing system already put in place for this study.
3. Code the data with MAXQDA 2020 (Saldana, 2021). A commercial software package provides initial codes, allowing custom coding to refine the analysis.
4. The software will identify themes, patterns, and relationships between the interviewees and other data. A different commercial software package, NVivo, was used for this. This is the same software Carter (2020) and McDonald (2023) used from the NVivo website: https://lumivero.com/products/nvivo. NVivo allows qualitative researchers to organize, analyze, and visualize their data, finding the patterns it contains.
5. This step involves validating the data. This is accomplished by returning to some graduates, the MNTC leadership or the person/people in the pilot to clarify what they previously said in discussions with the researcher (Leedy & Ormond, 2019; Schwandt, 2007).
6. Summarize the data understandably to those using this study. This would include other researchers who wish to expand these techniques to other SUD treatment programs and the MNTC leadership so that they could determine if changes should be made to their program to allow more clients to be helped.

Trustworthiness

Trustworthiness is the standard in qualitative research. One reason for that statement that applies to this study is the data sources. This researcher has participated in quantitative studies in the past, which require a statistically significant sample size to be valid. However, a statistically significant sample size is impractical in qualitative studies like this one. The sheer number of

interviews that would be required could take many months, maybe even years, and that was if that many graduates of MNTC could even be found; many fewer would agree to be interviewed. As discussed above, according to the MNTC Alumni director, only 20-50% have provided accurate and current contact information to locate them quickly.

The trustworthiness of this qualitative study was evaluated by looking at four subcategories. Those subcategories that comprise trustworthiness are discussed in the following pages. The subcategories are credibility, dependability, confirmability, and transferability (Leedy & Ormond, 2019).

Credibility

Credibility concerns how accurately this study's findings will relate to reality. As part of the credibility assessment, this researcher must be assured that the interviewed graduate was telling the truth about their experiences at MNTC (Schwandt, 2007). The corollary to this statement was that this researcher wrote down and understood what the graduate meant to say, which was captured in the study.

Credibility is critical if this study is to provide believable findings and results (Leedy & Ormond, 2019). For this reason, the IRB-approved protocols defined for data gathering and analysis were followed precisely. Credibility was another reason for the in-person interviews to gather data. Note-taking during the interviews will provide credibility; if there was some reason that this researcher believed the graduate was not being entirely truthful, additional questions could be asked.

The credibility of this study’s findings can be tested and verified if these individual findings can be seen in multiple graduate responses. Before publishing any findings from this study, the other interview responses were checked to verify the findings. A caution to the

credibility of this study was that the reader should be aware that findings from this study may not apply to programs outside of MNTC. The techniques and some of the questions may apply to other SUD treatment programs, and any similarity to the findings from this study should not diminish the credibility and trustworthiness of this study of MNTC.

Dependability

The dependability of a study details how well the researcher laid out the line of questioning to gather the appropriate data. Dependability asks if the questions are in a logical order if the questions are traceable back to the research questions, and if all questions were documented (Schwandt, 2007). In other words, was the study documented and repeatable with the documentation? The last part of dependability that applies to this study was the ability of the study to account for and handle outliers from the questioning. For example, if the line of questioning did not account for a theme evident partway through the graduates who agreed to be interviewed. Was the study sufficiently dependable to handle these data collection or analysis deviations? (Leedy & Ormond, 2019).

This study was designed to analyze all data as it was presented and look for themes and key points that need additional questions in the interviews. With sufficient explanation, the findings should detail all the questions to allow readers to replicate this study for themselves or a different SUD treatment organization.

Confirmability

To verify trustworthiness, confirmability may sound similar to the credibility of the data, as already discussed. Confirmability is more straightforward to demonstrate than credibility as long as there is a link between the data, interpretations of the data, and the study's findings (i.e., no undocumented data was used in the study; Schwandt, 2007). Whatever conclusions from the

study are based on actual data collected, and the data collection process was not subject to questioning (Leedy & Ormond, 2019).

As this researcher is a trained quality process auditor, having an audit or paper trail to link findings to data was a mandatory methodology. Throughout the research process, all claims or assumptions were supported by data of some form; claims without data were not used in this study. If, at some point after publishing the study, someone would like to verify the data, that data can be made available to them.

Transferability

The final piece of demonstrating trustworthiness for this study was transferability. Transferability is not mandatory for qualitative research, but it is desirable. Transferability refers to the research process and even some findings. Are these transferable to other case studies about a similar topic? (Leedy & Ormond, 2019; Schwandt, 2007).

In this study, some of the demographic questions to the graduates may be transferable to other studies. Interview questions may be transferable but different from the methodologies implemented by various SUD treatment programs. When discussing findings from this research with other programs, findings from this study are not anticipated to be transferable—not even between Christian organizations like MNTC, Alcoholics Anonymous, or Addicts Anonymous. However, program developers at other SUD treatment programs should be able to take the concepts and generalized findings from this study to evaluate if particular findings could benefit another program.

Chapter Summary

This chapter discussed the methodology used for a qualitative case study design to uncover the stated reasons for some people to complete substance use disorder treatment at the

Minneapolis, Minnesota, location of MNTC. The approach for this study was for those graduates who participated in this study to share their lived experiences and express in their own words how they feel they were able to complete their treatment program. The convenience sample of 16 graduates was based mainly on the researcher's ability to contact participants for an in-person interview of 13 questions. Coding of the transcripts from those interviews was compared to notes from the interviews, and after coding was complete, themes and critical points were generated from each graduate's perspective.

CHAPTER FOUR: ANALYSIS OF FINDINGS

Overview

This case study aimed to understand the successful completion of the long-term program for graduates of the Minneapolis, Minnesota Adult and Teen Challenge (MNTC). This study explored demographic differences and similarities between graduates and the graduates' perceptions of why they felt they were able to complete the program while others failed. Successful completion was generally defined as graduating from the program and not having a relapse for one year. The theory guiding this study—Ajzen's (2020) theory of planned behavior (TPB)—was paramount as it proposes that an individual's decision whether to engage in any specific behavior, such as drug or alcohol use, is predicated by their intention to engage in that behavior. TPB explains a person's intention to stop their substance use as a conscious behavior that this study seeks to understand.

This chapter presents the results of the data analysis. It begins by describing the method of collecting the data and what was measured during the interviews for the case study. Next, it provides the demographics of the graduates and summaries of their responses to the interview questions (see Appendix J). The third focus of this chapter will be on the data analysis and findings from that analysis. The chapter closes with an evaluation of the case study design for this research.

Compilation Protocol and Measures

The case study method, known for its effectiveness in uncovering the "why" and "how" of the process under study (Creswell & Poth, 2018), was particularly suitable for investigating how groups and individuals cope with social issues like substance use disorder. This research

strategy was instrumental in determining reasons that align with the research's purpose (Yin, 2018).

Graduates on the MNTC alumni list were meticulously interviewed to understand their reasons for completing SUD treatment. The data collection process was comprehensive, involving interviews with graduates who have completed the long-term program. The interviews were conducted using structured semi-structured questions (see Appendix J) designed to elicit the graduates' beliefs about their ability to complete SUD treatment. The questions found in Appendix J were carefully developed to gather information to answer the three research questions.

The following pages will present the research and interview questions designed to gather data for each research question. Interview question 13, "Is there anything else that you would like to add?" was designed to allow the graduates to express any thoughts relevant to this study. Thus, their comments from question 13 could apply to RQ2 or RQ3.

RQ1: "What are the demographic differences and similarities of the graduates who completed the MNTC long-term program?" The comments for this research question were derived from interview questions 1, 2, 3, 4, 5, 7, 9, and 12.

RQ2: "What are the reasons why graduates believe they completed the MNTC long-term program?" The comments for this research question were derived from interview questions 6, 8, 10, 11, and 13.

RQ3: "What are the graduates' perceptions of why some fail to complete the MNTC long-term program?" The comments for this research question came from interview questions 5a and 13.

To ensure the confidentiality of the graduates, pseudonyms were assigned to them (see Table 2). The pseudonyms, including Alan, Bill, Charlie, Deb, Erica, Fred, Gerald, Howard, John, Kyle, Larry, Mark, Nathan, Olivia, Pete, and Ruth, were used throughout the research process to protect their identities.

Data from the 16 interviews amounted to 199 minutes of recorded dialog with the graduates. The recordings varied from six to 34 minutes, 10 being 10 minutes or less. Along with the audio recording, this researcher also captured 55 pages of handwritten notes from the interviews. The recordings were transcribed using the MAXQDA software. The graduates' names were pseudonymized to preserve anonymity; see Table 2 below:

Table 2

Graduates' Pseudonyms

Interview #	Pseudonym
1	Alan
2	Bill
3	Charlie
4	Deb
5	Erica
6	Fred
7	Gerald
8	Howard
9	John
10	Kyle
11	Larry
12	Mark
13	Nathan
14	Olivia
15	Pete
16	Ruth

This research was poised to significantly enhance the understanding of SUD treatment programs at MNTC and other institutions. A codebook was generated to analyze the interview

data, facilitating the later interpretation of the information. Commercial software MAXQDA and NVivo were utilized to code these interviews and identify various themes and trends in the data. The conclusions and a summary of this research will be presented to MNTC leadership, providing valuable insights for the future of SUD treatment programs.

Demographic and Sample Data

RQ1 - Demographics of the Graduates Interviewed

A summary of this study's demographics is presented before individual responses are discussed. The four women and 12 men ranged in age from 32 to 51, averaging 41. The women were closer in age at 36, 37, 40, and 41, with an average of 39. Though this study—involving the Minnesota Adult and Teen Challenge—only involved adult participants, future studies could focus on teens within the program instead.

The majority of those interviewed were abusing multiple substances during their life before coming to MNTC. Most of them started with alcohol or cigarettes and moved to less socially acceptable substances like cocaine, heroin, fentanyl, and methamphetamines. MNTC does work with many different types of substances that can be abused; thus, the variety of answers was not unexpected by this researcher.

All those interviewed came from Minnesota, mainly from the Minneapolis/Saint Paul metro area. After graduating from MNTC, nearly all participants chose to live in the Minneapolis/Saint Paul metro area—another exciting piece of data involved question 7 (see Appendix J) about emotional maturity. The two who said they did not grow in emotional maturity were graduates over 50 years old when they graduated from MNTC. Regarding the mentoring question, number 11 from the interviews, all of the graduates in this study would have had a mentor, except for extenuating circumstances for two, such as Larry being on furlough

from jail to attend MNTC. His furlough prevented him from going out of the building with a mentor.

The next section of this study includes detailed demographic data and comments from MNTC graduates. Alan came to MNTC after attempting 12 other programs to get help with his alcohol addiction. Alan did not backslide (question 5, Appendix J) after entering MNTC; however, in further discussion with Alan, he mentioned that all 12 of these other programs were secular and did not speak of Jesus or how He would want someone with SUD to live their life for the Kingdom. Even though Alan was 40 years old when he entered MNTC, he had been abusing alcohol for 15 years, by his estimate.

Before coming to MNTC, Alan lived in a Minneapolis/Saint Paul suburb. When Alan first realized that he needed to get help with his addiction, he was living in another state, where he attended secular treatment programs. Alan stated that he did have a mentor when he was in the long-term program, and he still stays in touch with him. Alan also said his emotional maturity was higher at graduation than when he started the program.

Bill's situation was similar to Alan, who came to MNTC to treat his alcohol addiction. Bill was 37 when he entered the MNTC long-term SUD treatment program, and he estimated that he had been drinking for 12 years prior to coming to MNTC. Like Alan, Bill lived in different cities, but just before entering MNTC, he lived in a smaller town in Minnesota, not in the Minneapolis/Saint Paul metro area.

Bill grew up and lived outside of the Minneapolis/Saint Paul metro area, attending various SUD treatment programs in different cities nearby where he was living. He was living in that area after his divorce, and that was when he started drinking more. He had a job during the day and was drinking every night, and as he said, he believed that he was able to maintain his

lifestyle. His family disagreed with his SUD assessment, and through legal means, they were able to force him into seeking treatment. That was when he came to MNTC after the local SUD treatment failed him.

Bill never had the mentor experience that others at MNTC were afforded, due mainly to stipulations with the court system that placed him in MNTC. Just like Alan, Bill thought that he had grown in emotional maturity while getting sober (question 7, Appendix J). Bill answered no to the backsliding question at MNTC (question 5, Appendix J).

Charlie came to MNTC at the age of 38 to treat his addiction to opiates, methamphetamines, and fentanyl. Charlie has had an SUD for 19 years. Charlie had been living around the Minneapolis/Saint Paul area before coming to MNTC, more to the point that he was homeless in the Minneapolis/Saint Paul area, sleeping in garages, basements, and anywhere he could find.

Charlie backslid once after he started the MNTC long-term program (question 5, Appendix J). This infraction added three months' worth of additional treatment sessions to his long-term program. The infraction occurred early in his treatment, and they made him start over, but he did not leave the campus. Charlie believes that he grew in emotional maturity while attending MNTC (question 7, Appendix J). He did have a mentor, and he still talks to him regularly. Like most of those interviewed for this study, Charlie works at MNTC, helping guide and mentor clients as they work through the program to sober living.

Deb came to MNTC for the last time at the age of 40 to treat her addiction to cocaine and alcohol. Deb had attempted other MNTC programs, and it was not until entering the MNTC long-term program that she attained the sobriety she was seeking. One comment she made about not moving to harder drugs was that the cocaine that she was abusing was due to her boyfriend

and his abuse. She mentioned that after breaking up with him, she stopped her regular use of cocaine but started drinking more and started to seek help with her SUD for alcohol. Deb had had SUD a part of her life for ten years when she started abusing cocaine with her boyfriend at the time, who had a cocaine problem.

Deb did backslide the first couple of times that she started with the treatment programs at MNTC (question 5, Appendix J). She backslid twice and had to start over each time after being removed from campus for 30 days. She lived and started doing drugs outside of the Minneapolis/Saint Paul metro area prior to coming to MNTC. Deb did have a mentor during the program but no longer spoke with her. Deb believed that she grew in emotional maturity while at MNTC (question 7, Appendix J).

Erica came to MNTC at the age of 43 to treat her addiction to alcohol and methamphetamines. Erica has had SUD as part of her life for 30 years; she started abusing various substances at age 14. Before coming to MNTC, Erica was dealing with her SUD outside of the Minneapolis/Saint Paul metro area. Erica tried numerous other programs before coming to MNTC but did not backslide after starting the long-term program (question 5, Appendix J).

Like the younger people in this study, Erica felt that she grew in emotional maturity while in treatment (question 7, Appendix J). While in the program, she had a mentor who still talks to her.

Fred came to MNTC at the age of 50 to treat his addiction to methamphetamines or, as he put it, “any upper that he could get his hands on.” Fred has had SUD as part of his life for 45 years; he commented that he has been abusing uppers for his entire life. When Fred came to MNTC, he lived outside the Minneapolis/Saint Paul metro area. Fred did make it through the

MNTC long-term program on his first attempt. He attributed this to attempting to get sober in 12 other programs prior to coming to MNTC.

Fred did not think he had grown emotionally at MNTC (question 7, Appendix J). He mentioned that he had been through enough life to know what he wanted, and that was to get sober, not work on his emotions. Fred did have a mentor in the program, but he no longer talks to him. The mentor has not reached out since graduation, and Fred does not know what happened to him.

Gerald started at MNTC at the age of 32 to treat his addiction to methamphetamines. Gerald has had SUD a part of his life for the previous ten years. Gerald did admit to some periods of sobriety while on parole, but that was a condition of his parole. He started as a smoker, then moved up to alcohol, which, as he said, led to marijuana and eventually methamphetamines.

When Gerald came to MNTC, he lived in the Minneapolis/Saint Paul metro area. However, Gerald grew up and did most of his substance abuse in the Minneapolis/Saint Paul metro area. Gerald backslid once while in the long-term program (question 5, Appendix J). He believes that he grew emotionally mature (question 7, Appendix J) and had a mentor while in the program. He talks to his mentor but not regularly.

Howard came to MNTC at the age of 38 to treat his addiction to methamphetamines. Howard has had SUD as part of his life for 25 years. Prior to the methamphetamine addiction, Howard experimented with alcohol, marijuana, and cocaine. However, he came to MNTC to rid his life of the methamphetamine addiction that was controlling everything about his life.

Howard grew up and spent most of his time abusing substances outside of the Minneapolis/Saint Paul metro area. Howard did not backslide in the long-term program (question

5, Appendix J), which he attributes to attempting other programs that were much shorter than the 13-month long-term program he graduated from. Howard thinks he matured emotionally in the program (question 7, Appendix J). He had a mentor while in the long-term program, and they continued to meet until the mentor went home to be with Lord. Shortly after losing his MNTC mentor, Howard was introduced to another gentleman who agreed to mentor him outside the official MNTC mentoring program. They still meet regularly.

John came to MNTC at the age of 33 to treat his addiction to methamphetamines. John has had SUD as part of his life for 20 years. Like many in this study, John started with alcohol at age 13, then moved to marijuana and cocaine. He had an interesting comment about when he tried cocaine, where he said that it allowed him to drink more. That cocaine would wake him up from his drunken stupor to the point that he believed he was able to drive a car. However, when he started methamphetamine, that was when his life went out of control to the point that he eventually sought help with his SUD.

John was living in the Minneapolis/Saint Paul metro area when he came to MNTC to get help with SUD. He backslid once in the long-term program and had to start the 13-month program all over again from Day One (question 5, Appendix J). John had a mentor in the program, and they still talk regularly. He believes the MNTC program helped him emotionally mature (question 7, Appendix J).

Kyle was the third oldest person in the study when he came to MNTC at the age of 48 to treat his addiction to heroin and fentanyl. Kyle has had SUD as part of his life for 38 years, the second longest of those interviewed for this study. Kyle stated he had tried the whole gamut of substances that could be abused, but when he finally came to MNTC, it was for heroin and fentanyl SUD. Kyle did not backslide while in the long-term program(question 5, Appendix J).

Kyle lived outside the Minneapolis/Saint Paul metro area before coming to MNTC for help. He attributes MNTC to helping him grow in emotional maturity (question 7, Appendix J). Kyle had a mentor in the long-term program, and they still communicate.

Larry arrived at MNTC at the age of 42 to treat his addiction to fentanyl and methamphetamines. Larry started his SUD journey with alcohol, then cocaine, and continued with the harder drugs until he got to methamphetamines and fentanyl. Larry estimated that SUD has been part of his life for 35 years. When asked if he was using substances at seven years old (42 minus 35), he said yes, that he was sneaking beers from his father as a child.

When Larry came to MNTC, he lived in the Minneapolis/Saint Paul metro area. He had a mentor while in the program and still speaks with him. Larry also believes that he grew emotionally mature (question 7, Appendix J) while in MNTC and did not backslide in the long-term program (question 5, Appendix J).

Mark, at age 47, also came to MNTC for SUD treatment for methamphetamine. Mark had been abusing various substances for 32 years, from the time he was 15. He sought SUD treatment from six other treatment programs prior to MNTC. When Mark came to MNTC, he lived in the Minneapolis/Saint Paul metro area.

Mark did not backslide while at MNTC, as with the previous programs he attempted prior to MNTC (question 5, Appendix J). He did have a mentor, but they no longer communicate. Mark believes he came out of MNTC more emotionally mature than when he entered the program (question 7, Appendix J). He attributed his emotional growth to the MNTC culture and held himself accountable for his actions.

Nathan came to MNTC at the age of 46 to treat his addiction to methamphetamines. Nathan has had SUD as part of his life for 33 years. Before coming to MNTC, Nathan lived in

the Minneapolis/Saint Paul metro area. Nathan was in MNTC as part of a plea agreement with the courts, and thus, he did not backslide, or he would have gone to prison (question 5, Appendix J). For those in the program from the courts like Nathan, if you leave the program, there is an immediate warrant out for you, and you will go to direct prison for violating parole—creating more incentive not to backslide on top of getting sober.

Nathan stated that he had several mentors while in the program and still communicates with one of them today. He said being in MNTC made him mature emotionally (question 7, Appendix J).

Olivia arrived at MNTC at the age of 36 to treat her addiction to methamphetamines. Olivia has had SUD as part of her life for 24 years. Prior to MNTC, Olivia had experimented with many different substances over 24 years, and she struggled with SUD, starting with alcohol and marijuana as a teenager and for most of her adult life until she tried methamphetamines. To get off of methamphetamines, she came to MNTC for help.

Before coming to MNTC, Olivia lived in the Minneapolis/Saint Paul metro area. She proudly stated that while in the long-term program, she did not backslide and made it through on the first try (question 5, Appendix J). She did have a mentor, and they still meet regularly. Olivia considers her mentor to be one of her best friends.

Pete, the oldest person in this study, came to MNTC at the age of 51 to treat his addiction to methamphetamines. Pete has had SUD as part of his life for 36 years. Pete completed the long-term program without backsliding (question 5, Appendix J). Pete was the other person not to have a mentor while in the program; due to stipulations in his probation, he was not allowed to leave the property without violating parole.

Before coming to MNTC, Pete lived in the Minneapolis/Saint Paul metro area. As was already discussed, the only two graduates who did not believe they matured emotionally were over 50. That means Pete, at 51, and Fred, at 50, were the only two who responded negatively to the growing emotional maturity question (question 7, Appendix J).

Ruth came to MNTC at the age of 35 to treat her addiction to heroin, fentanyl, and methamphetamines. Ruth has had SUD as part of her life off and on since she was 21. Ruth believed that she was a functional adult even when using heroin and fentanyl, but when she discovered methamphetamines, this was where her life took a turn. She was addicted to methamphetamines for three years prior to seeking help at MNTC.

Ruth lived in the Minneapolis/Saint Paul metro area before coming to MNTC. She completed the long-term program without backsliding (question 5, Appendix J). Ruth felt that she matured emotionally while in SUD treatment at MNTC (question 7, Appendix J). She did not have a formal mentor while in SUD treatment, but seeing the benefit of others who did have a mentor, she had one after graduating from MNTC.

Observations from the demographic data included that the oldest and youngest women in the study have demographics similar to men's. Erica was 43 years old when she came to MNTC for treatment for alcohol and methamphetamine SUD. Erica had SUD for 30 years and tried to overcome her addiction by trying 12 other treatment programs prior to MNTC. Ruth was 35 when she came to MNTC. She was a mother to four children and estimated that she had been abusing for 13 years total. Ruth's SUD did include some of the most problematic drugs in this study: heroin, fentanyl, and methamphetamines.

Men of note in the study include Larry, Howard, and Fred. The typical demographic with these three was their graduated drug use to more problematic substances until they came to

MNTC for help. Fred's answers were unique, explaining why he took longer to attend MNTC. He stated that he had to wait for parole after serving five years in prison for some of his actions while high on uppers. Fred had been abusing drugs for 40 years and graduated from MNTC at the age of 51.

Both of the men who were over 50 years old (Pete and Fred) said that they did not feel that SUD treatment allowed them to grow in emotional maturity. Everyone in the study under 50 did feel that they came out of treatment more emotionally mature (question 7, Appendix J). As commented on earlier about the age of the participants, all of them were over 30 years old.

RQ2 - Why Were Graduates Able to Complete SUD Treatment?

This next section looks at two areas. The first are the responses to questions 6 and 13 on why participants believed they could complete SUD treatment when 50% of those who started a treatment program never completed it. The second area concerns how faith in Jesus helped the participants be able to complete the long-term program at MNTC. These responses were to question 8 during the interviews. Following are responses to questions 6 and 13 (Appendix J). As this researcher has had previous interactions with other MNTC graduates working in ministry positions, question 6 asked for three reasons they believed they could graduate. Had the question been asked for just one reason, this researcher anticipated that the answer from everyone in the study would be that God changed them and allowed them to graduate. Thus, the question asked for three reasons, not just one.

Alan started right off by saying that his number one reason for being able to complete SUD treatment was God. Then, to provide some context to his reasoning for his answer, he added that he had attempted to get sober in 12 other treatments prior to coming to MNTC. Alan added that all of the other treatment programs he attempted were all secular. He also added that

he was a strong-willed person and thought that he could figure out sobriety with just a little help from these other programs. Eventually, after 12 attempts, Alan realized willpower was insufficient to tackle SUD.

His second reason for completing SUD treatment at MNTC was that he was desperate. The desperation seems evident after going through 12 programs; he wanted to get sober and was willing to keep trying. In his response to this question, he said that "he had used everything up"; he did not know where to turn and did not have anyone else to rely on.

The last reason Alan gave, which this researcher did not anticipate, was the MNTC community. The community provided new friends who were going through the same thing that Alan was and gave examples of success in sobriety. The community provided empathy for what he was going through to reach sobriety and counselors who had found the program successful. Alan bought into the community so much that he cut all ties with his former friends, who, in all likelihood, were keeping him from sobriety.

At the end of answering this question, Alan asked to change the priority of his answers. God first, community second, and desperation third, in that order.

Bill's number one reason for being able to graduate from MNTC was also God, and he added more to his response with his written word in the Bible. Being raised in a Christian home, he knew what he should do, but while using drugs, he did not follow God's Word. At MNTC, he needed to have a clear mind to hear God, which translated into getting sober if he was going to let God help him. The next step after getting sober was for him to be more like the *Imago Dei* and, indeed, follow Jesus.

Bill's second answer to how he managed to get through the long-term program was to have an earthly tangible goal to work towards. In his case, that meant leaving a legacy for his

children, nephews, and other family members. He wanted them to be proud of him and be someone they could admire. This meant that Bill would need to change everything about his SUD life, and he would find the conviction to work through the process to get better. Bill would use the teachings from his parents, friends, and the Bible to accomplish this earthly goal and show him an example of what he could be.

Bill's third reason for sticking to the program to graduation was the community and the friendships he made with the other men in it. He made the analogy of people who experience war and the bonds formed under that intense pressure. In both cases, these coping mechanisms help us navigate the pressure and keep us alive in the battles that we are in. SUD kills people just as much as war does, so this is something that must be taken seriously if we want to live. Discussing addiction battles happens every day in treatment, and having someone to talk to and who understands what you are going through, as well as having someone to lead you through the trials and tribulations, was how to survive and even thrive in treatment.

In summary, Bill was able to graduate from the long-term program because of God, having tangible goals to work towards, and the MNTC community.

Charlie's reason for completing the long-term SUD treatment program at MNTC was to restore his family. Before MNTC, no one talked to him. His brother married while Charlie was high, and no one wanted him to be there, so they did not even tell him about the wedding. Charlie had not talked to his mother for over three years before coming to MNTC. However, once Charlie started treatment, they started to talk to him. This made Charlie want to know more about what he had been missing in his family.

The second reason Charlie believed he could complete the long-term MNTC program was the community there. Charlie was an introvert and not willing to open up to people and ask

for help. Charlie realized that nearly everyone in the community has had SUD issues, and they have empathy for people coming in, just as Jesus did with sinners. They do not care about your past; they focus and get you to focus on your sober future and what that may look like. The turning point for Charlie was realizing that nearly all of the staff had the same addictions, and they were able to overcome those addictions and now work at MNTC to help others overcome their addictions. The community cares enough about you that even if you mess up, they are there to catch you and help you get right back into the program, just like they did. Like the saying from sales training, your customers do not care how much you know until they can see how much you care.

The final point for Charlie's reasoning for being able to complete the long-term program was God. Charlie found his faith in Jesus in MNTC. Thus, he wanted to keep that feeling and be with other people who had the same feelings of being close to the creator of the universe.

In summary, Charlie's reasons for being able to complete the MNTC long-term SUD treatment are a restoration to his family, the community's care for each other, and finally, God.

Deb provided hope for change in her life through Jesus. She was raised to be a Christian and felt that coming into MNTC and allowing God back into her life was what allowed her to complete SUD treatment. She commented that MNTC was like coming home to something she knew. MNTC provided tools that aligned with her Christian values; even though her SUD may have obscured those values, the Christian values were still in her soul.

Deb's second motivation to complete the treatment came from her son. She was a single mom and did not want her son to be taken away while she was getting help for her addiction. During a sober time, she realized that she already had a support network with her family that could take care of her son without sending him to some agency to keep him. This was when she

realized she could come to MNTC, stay for the long-term program, and get the needed help. She was motivated to get better, and this was the last part of the puzzle to let her do whatever it took to get into SUD treatment.

In summary, Deb's reasons for being able to complete the MNTC long-term SUD treatment centered around family, including her renewed relationship with her heavenly family and acting like a child of God and not a rebellious child who caused problems. This relationship with God and a realization that her earthly family was also willing to help her become a better person and mother to her son were catalysts for her success. In Deb's case, everything came back to God and acting like He would want her to act.

Erica got right to the point about why she was able to complete the MNTC long-term program: She stopped worshiping false idols and put Jesus first in her life. After discussing how important having the correct focus is, Erica listed two other reasons for being able to complete the program.

The first reason, after God, was that MNTC was a year-long program that could be longer if needed. Coming to MNTC gave Erica a sense of security, knowing she would not be kicked out after a set amount of time. Her SUD treatment would take a year or more, but a calendar would not determine her progress, but rather by how well she was coping with sobriety and not being high.

The final point Erica made, which she could not stress enough during the interview, was that it was all women in her treatment. Very few men worked with the women to help them heal from SUD. Erica knew that she had other women supporting and encouraging her, and if she was having an issue, it would be another woman with whom she could talk the problem through. As she pointed out, women relate to other women much differently than men, and women relate

well to each other. Put differently, she needed an entire year with other women going through this addiction battle together, discussing personal stuff going on in their lives, and she felt she needed a full year of talking to other women to get through this program.

In summary, Erica's reason for being able to complete the MNTC long-term SUD treatment was putting God first in her life, having a full year of treatment, and going through this type of treatment with other women.

Fred stated that God was his main reason for being able to complete SUD treatment. More specifically, God wanted him to change, get sober, and work in the ministry that God had set aside for him to work in. However, he needed to get sober before starting that ministry.

Fred's second reason was that he was tired of living a life of addiction. In his words, "he needed to change" from the lifestyle he led for his entire life to one with purpose. He felt that his inner being was telling him to stop living like he had been for his whole life.

In summary, Fred provided only two reasons for being able to complete the MNTC long-term SUD treatment: that God called him to a higher purpose and put on his heart that it was time for a change to something productive instead of destructive.

Gerald believes that God was intentional about whom He called to MNTC and made the decisions in Gerald's life to bring him to MNTC. Things do not just happen with God; He was intentional, and there was a purpose for what He does, even if we do not understand the motivation for it initially. So, the number one reason for Gerald was God.

Earlier in this paper, Gerald's legal issues were identified as a motivating factor for completing the MNTC long-term program. When he entered MNTC, Gerald still had pending charges, and at the time of the interview, he still had two pending charges. Gerald was hopeful that with God's help and his completion of the MNTC program, those charges would not involve

more jail time. However, Gerald understands what he did and accepts responsibility for the outcome of the two outstanding charges. Gerald hoped his last reason for completing the program would influence the courts, and they would see that he had changed. His final reason for being able to complete the program was the community and the support that everyone in the community, from the counselors to the clients in MNTC, provides to all the clients.

In summary, Gerald's reasons for being able to complete the MNTC long-term SUD treatment are God's and God's plan for his life after MNTC, Gerald's motivation for staying out of prison, and the MNTC community support throughout the program.

Howard's main reason for being able to complete the long-term program was Jesus. Jesus influences everything in this program, including getting those with SUD into the long-term program. This leads directly to Howard's second reason for completing treatment: the time this program takes and the fact that your treatment was not calendar-based. Clients can stay longer than 13 months if that is what they need to do. The program was designed for 13 months, but that was not a hard date; it was just an estimate based on over 30 years of teaching those with SUD how to live without those substances.

The last reason Howard mentioned was a combination of others discussed: God and community. Howard pointed out that having God on your side creates hope that you can improve. That was coupled with the MNTC community, which was made up of people who have gone through the program and are now living productive lives, and you have hope that you can achieve sobriety just like they did. With the community as it is, clients see examples of success every day right in front of them, and those examples encourage the clients to keep after the program so that the client can succeed just as the staff did—a compelling testimony of the program's strength.

To summarize, Howard's reasons for being able to complete the MNTC long-term SUD treatment are God, the length of time spent in the program, and the community around the clients who demonstrate success from SUD every day.

John stated that he felt the main reason he completed the long-term program was to change his life. He wanted to hold his head high and make his mother proud. His mother was the one who pushed him to get into MNTC and get help, which in turn made him feel obligated to show her he could change from a drug addict to someone she could be proud of. He pointed out that his mother was also a graduate of MNTC, so she knew firsthand what it could do, and she wanted that for her son. These thoughts of pride welled inside him and made him believe he could do it.

John said his second reason for sticking with the program was similar to the first, but he wanted his three children to look up to their father instead of trying to make his mother proud of him. His daughters are 16 and 13, and a son was 9. John's father was not around when he was growing up, and he did not want his children to go through what he went through.

In MNTC, John started to study the Bible. His third reason for completing the SUD treatment was to be the man God created him to be. The more he developed a relationship with God, the more he understood how God could love a drug addict like himself.

In summary, John's reason for being able to complete the MNTC long-term SUD treatment was a yearning to make his mother and his family proud of him. He wanted them to hold their heads up and want to see him. His last reason, which ties into the first two, came from the Bible and understanding what God wanted from him and that God would help him get what he wanted with his family, just as God wanted him to be a vibrant part of His family.

As previous graduates have stated, Kyle had many of the same reasons for being able to complete SUD treatment. Jesus wanted Kyle to succeed so Kyle could help grow the Kingdom as part of God's family. Over the 13 months of the long-term program, Kyle would come to understand more about Jesus and the Kingdom, but the bottom line was that Jesus wanted him to complete SUD treatment.

Kyle's second stated reason was another that has been expressed in this study: he wanted to be a better father and role model for his children. This wanting to be better for his children flows directly to his remaining reason for completing the treatments, which was to be more than just a drug addict. He wanted to make a difference in the world in a good way.

To summarize, Kyle's reasons for being able to complete the MNTC long-term SUD treatment are that God wanted him to work for the betterment of the Kingdom, restoration to his children, and finally, to be a better person in the world to affect those around him positively.

Larry said that God was a big part of completing the long-term program. God showed Larry the hard times and taught him to deal with disappointment and leave the bad stuff alone. Larry learned how to pray about what was going on in his life and to trust that god understood what was happening to Larry and that He had a plan, even if Larry did not understand that plan.

The second reason that Larry believes he could complete his SUD treatment is his determination. When he wants to see change, he has been able to stick with the program and persevere until he reaches his goal. Beating SUD was a big goal when most of his life to this point revolved around finding drugs and staying high. Nevertheless, as he said in the interview, he was determined to change and do something different with his life.

For Larry's last reason for completing SUD treatment, he started to say love and the MNTC community until he realized that they are not exclusive, not at MNTC. The community

has a strong influence because they do everything with love. Everyone was either going through what you are going through, or they have done it. Thus, everyone has empathy for everyone and shows love to anyone willing to follow the program and try to improve. As Larry said, initially, as a client, you do not realize that all this caring and love was genuine, but once you understand how the community gets behind the clients, it becomes obvious.

In summary, Larry's reasons for being able to complete the MNTC long-term SUD treatment are as follows: First, God was leading everyone through the program. His second reason was Larry's sheer willpower to finish what he set out to do—finally, the community and how they love and support one another.

Mark was ready to make a change. Like many addiction recovery programs, the most significant gains happen when the client is at their lowest. It was very similar to the Christian faith in that most believers will say that they came to Jesus when they were at their lowest and did not know how to turn: I was ready; I was finished and at my lowest point. Mark was at his lowest when he came to MNTC.

Mark's second reason was that he was a military veteran and considered himself good at following rules. He does not question everything that has been asked of him. However, Mark could see a sense of structure in MNTC and did not have it as someone with SUD. The next thing MNTC did was teach Mark how to use the tools he would need to get sober and remain sober, once again, similar to the military.

Mark's last reason was almost counter to his second. The military teaches success through conformance to rules or commands, which Mark was good at. However, he said his third reason for completing the long-term program was a willingness to be different. For a military analogy, think of special forces versus the regular army. Special forces use tactics that are

different from those of regular troops. In SUD treatment, when everyone you know was constantly looking to get high, as Mark was before MNTC, now Mark wanted to learn techniques and be different from those he was used to being around.

To summarize, Mark's reasons for being able to complete the MNTC long-term SUD treatment are that he wanted to make a change, but he did not know how. MNTC showed Mark a system and structure to help him reach his goal of sobriety; all that he would need to do was act and be unlike the people he was used to being around and use his new tools to get to where he wanted to be, which was sober.

Nathan's first reason why he could complete the SUD treatment was similar to others. He wants to be a good role model and father to his child, wife, and family. He wants them to be proud of him instead of wondering what his SUD will make him do next.

Nathan's second reason was that after being an addict for most of his life, he was ready to change. He may not have known precisely how to change, so he came to MNTC to learn how to change. Nathan's last reason for completing the long-term program was God: understanding why God would want a drug addict to come into the Kingdom. As Nathan learned more about God's character, he understood what to do next: get sober.

In summary, Nathan's reasons for being able to complete the MNTC long-term SUD treatment are a restoration to his family and making them proud of him; he was ready to change his lifestyle for the better, and finally, God.

Olivia's main reason for being able to complete the long-term program was God. She did not know God or anything about Jesus when she enrolled in the long-term program. Indeed, a regular person that you could have a relationship with. As she said in her interview, everything changed for her on her journey to sobriety when she understood it was about a relationship.

Her second reason was that it was a long-term program. You are not kicked out after several days or months have passed. You stay in the program until you are ready to leave. She had been to other programs and felt there was never enough time to understand and implement everything they taught.

In summary, Olivia only had two reasons for being able to complete the MNTC long-term SUD treatment; the first was God and developing a relationship with Him, and the second was the amount of time spent learning how to deal with SUD issues.

Pete's primary reason was God, and he stopped there and pointed out that there was no other reason. Everything else will take care of itself if you have Jesus. Pete exclaimed that he spent most of his life not wanting to be sober, but once he met Jesus, he had a new purpose and goal in life, and it was not getting high.

Like the other parents interviewed, Pete's secondary reason was to be there for his child—to be the parent they deserve to have, not the parent they are embarrassed to be around.

Similar to Olivia, Pete only stated two reasons for being able to complete the MNTC long-term SUD treatment: God got a hold of Pete and showed him a better plan for not only his salvation but that of his family. Pete's second reason ties to the first. Pete is a father and wants his child to know what it is like to have a godly father here on earth.

Ruth said that she could complete the MNTC long-term SUD treatment because of the community. The first reason was the love and support of the MNTC employees and how they help everyone who comes to the program. Her second reason was her family, who, like the MNTC community, demonstrated their love and support as she tried to shake the SUD addiction.

The last reason Ruth chose the program was its length—not too long but not too short. Like some others, Ruth considers the Teen Challenge Leadership Institute (TCLI) another 13-

month extension of the long-term program. No one has to stay for TCLI, but Ruth believes that everyone should and that MNTC should look into opening additional TCLI locations.

To summarize Ruth's responses, she was able to complete treatment because of the MNTC community loving all the clients that come to the program, the lover of her family when she was going through the program, and the fact that the 13 months might seem like a long time. However, she would like it to be longer.

The graduates' reasons for why they believe they were able to succeed in completing their SUD treatment are summarized in Tables 3 and 4 below:

Table 3

Reasons Graduates Were Able to Complete Treatment

Graduate	Response
Alan	God. I have been to 12 other treatments. Moreover, they were all secular, and that was I would always come out and do my own will. I was in desperation. The community was probably the most essential factor. I stayed here the most because of the guys I was surrounded by.
Bill	The number one reason is God's written word; His wording shows those truths with a clear mind. The first step is getting sober. What do you want to leave behind for your future kids or nephews who you do have? Do you want to be someone your parents are proud of? You are a brother of which your sister is proud. Be proud, be who you are, and be the uncle your nephews can be proud of.
Charlie	The restoration with my family. Community: Almost everyone on the staff had been in the program before me. Teen Challenge just made me feel comfortable. I have never felt like that before. I found my faith here, which is a big part of why I completed this.
Erica	I put Jesus first over myself.

Graduate	Response
	I needed that whole year to get through treatment. The separation of men and women. I had the support of other women; it was good that I had another female to work with.
Fred	God wanted me to get sober. I needed to change. I am 52 and tired of living this life I have lived my whole life. To make a better family and be at peace. To find peace and hope and a purpose.
Gerald	Number one is God. The most prominent evidence of God's presence is that I watch guys repeatedly return who do not get it and then see them finally get it. The community sets this teen challenge apart from everything else: the community it builds. When I saw the staff were all made up of program graduates, that inspired a lot of hope, encouragement, and buy-in. When you are going through the program, you are going, wow. You look for the worst stories and are like, well, that guy had this, that, and the other thing going on, and he still made it. And I can, too.
Howard	Jesus. The length of time for the long-term program. Another reason was hope. So many people here worked for the program, came through the program, and had years of sobriety.
Larry	God. I was determined to change my life and do something different than what I had been doing all my life. Love and community all in one. Because of the love that they show you here, it feels disingenuous at first until you realize it is real love. You realize these people love me. They care for me. That is part of the community.
Mark	A willingness to be different for the first time. The love shown to me by the entire community, especially the empathy from the staff. The length of the program. I needed more than 60 days to get sober.
Ruth	Jesus. The love and support of the Teen Challenge employees and my family.

Graduate	Response
	The program's length and the option to come to TCLI but have another year-long option if you choose were game changers. I had never been in a program where I had that time.

Table 4

Reasons Graduates Were Able to Complete Treatment from Question 13

Graduate	Response
Bill	Its two most significant successes are that Christ is in the program and the time it invests in people. The advantage is that MNTC can invest in a person for up to a year and sometimes more. Some people take longer, but they stick with them. If someone is willing to look at God in Christ and what He did for them, you have this one thing at the center of your program, and that is not Christ-like; it is Christ. As someone who has been to six different stints in treatment and three different programs, I know that Jesus has been the difference. I knew right away at the beginning that this was a year-long program.
Charlie	I think the big piece of it was the community.
Erica	The year-long program is so important, and I came into this program surrendered.
Larry	Their aftercare and athletic program. If you come here once, you will be considered an alumnus. So they have many alumni events that reach out to people and say, "We are doing an event." We were hoping you could come in so we can check on you, see how you are doing, and reconnect you with the community.

How did their faith in Jesus affect their completion of SUD treatment? (question 8, Appendix J). The responses from the graduates on how faith influenced their ability to complete treatment may sound like the interviewees testified to their belief in Jesus. These responses were not coached to come out this way. However, this researcher has witnessed many MNTC graduates in churches or Christian men's groups speaking about how Jesus saved their lives. So,

if it sounds like they are preaching, this is how they talk about their zealousness for Jesus and what He had done in their lives.

Alan explained how his faith influenced his ability to complete SUD treatment by describing how his faith gave him a purpose. He explained that he needed that guidance to overcome all the obstacles he encountered in a year-long program. He kept his focus on God and felt that God put him in MNTC for a reason: to help others through SUD treatment. Without the purpose reiterated through his faith, he felt he would have been sidetracked and possibly not have completed the program.

Alan mentioned a secondary reason for my success: the faith community in MNTC and how they act as a community of believers. This was similar to the Apostles in the Book of Acts, who shared everything for the common good, and no one was lacking. This community was so instrumental in Alan's treatment that he has taken a job with MNTC to continue to help others coming into the program.

Alan talked about how his faith put things in perspective. The smaller picture of life was successfully navigating SUD treatment. He spoke of how this smaller-picture view fits the big picture and prepares for the kingdom of God. When the Holy Spirit imparted this knowledge to him, he realized that even when he does not see the small changes, they are still happening because of his faithfulness to do what the Lord wants of him.

Bill also stressed that the fact that MNTC was Christ-centered and not just faith-based was a considerable factor in its success. Having Christ and the length of the program allow clients like himself to understand and see examples of their faith and how it can be used for good. These statements come back to the community and how many staff members are program graduates and can empathize with the new clients.

Bill had one more comment about faith and MNTC. He said that if someone with SUD was willing to look at God in Christ and what Jesus did for the client by dying on the cross, then why could the client not complete the long-term program? He then tied this together with the time element of the long-term program by saying that he has seen people who take longer to self-evaluate and understand their faith and tie their faith to sobriety.

Charlie used a story to explain faith's impact on his ability to complete the training. He was on an outreach to people experiencing homelessness and met a person who told him that he was thinking of committing suicide. Charlie kept talking to him and turned the conversation to explain that God loves everyone. Sometimes, we are tested, and some character flaws may emerge. However, if you meet someone struggling with life, you can help them because you have faith. This same faith was in the MNTC community; that was how clients are turned into graduates by having faith. Faith permeates the MNTC community, and it allows everyone in the community to do more than they imagined they could do.

To finish the story about the man Charlie met on outreach, Charlie offered to bring him back to MNTC and help him get started and get some help. The man thanked Charlie but was not ready to surrender and come with him to MNTC. He also was no longer contemplating suicide.

Deb talked about how her faith eventually allowed her to trust that God genuinely had a plan for her, which involved her son coming to MNTC. Hearing this from God gave Deb peace she had not experienced before. Deb's son did come to MNTC, which was now another testimony that Deb uses to describe how faith helps those needing SUD treatment. Deb also points out that faith teaches that sometimes we have to wait for God's time to be correct, not that she did not want her son to be in MNTC as soon as possible, but she needed to wait.

Erica talked about how she used to put her faith in worldly things but always ended up with a disappointing outcome. Our Faith in Jesus tells us that He will not forsake us and works for all things good. Faith in Jesus was the only thing that has consistently worked out in her favor. Through her faith, she understands that god has a goal for her and, even though this was a year-long program, He would give her the resilience to stick with it until the end. Her faith allowed her to continue to believe that even during the trials and tribulations of SUD treatment over a year.

Fred used his faith when real life came after him to get him to quit the program and return to the world. His faith showed him how to deal with his perception of what the world was telling him versus what God was telling him. God was telling him to stick to the program, get sober, and then move on into God's world for the next season of life.

Gerald provided an analogy of driving a car down a road to describe faith. Because of free will, we have some latitude when driving on the road. However, God will only let us get so far out of the lane before there are consequences. Our faith explains this to us in a manner we can understand. There are consequences when we cross over the limits God has set for us, whether speeding or some other driving law. However, with faith, we can recognize when we go outside the limits, such as testing the rules at MNTC, and God brings us back to his protective fold. Gerald provided examples of times he tested the limits, but he attributes his faith to returning him to where God wants him to be. His faith increased when Gerald realized this situation, and he returned to the program.

Faith has allowed Gerald to not only graduate but change his entire lifestyle. He broke generational curses and understood where those stumbling blocks were so they could be avoided. His faith has given him a larger view of his life, his children, and where God wants him to be.

His final comment about his faith was profound and his recovery from SUD: “I think it was still a reason I am sober today.”

Howard talked about how he initially felt that he did not have enough faith or was lacking in some areas. He said that when he got to MNTC, there would be meetings where the other members would talk about how they felt the Holy Spirit in the room. Howard did not feel that but wanted to experience it as they seemed to be progressing in the program faster than he thought he was progressing. His faith drove him to seek guidance from the Bible in a prayer closet until, one day, it became natural for him, and he understood what others were experiencing with the Holy Spirit.

After this, he noticed the Lord showing up in different ways that he had not seen in his life experiences. Howard kept praying in his prayer closet and understanding more of what the Lord had intended for him. The Lord wanted him to take his faith home and proclaim it to others, similar to Jesus' final commissioning in Matthew’s Gospel.

Howard has taken his faith home, led various church groups, and taught others how MNTC has affected him and how he can help others with SUD treatments.

John. After getting to MNTC and realizing the presence of God throughout the buildings and program, John hoped that his faith would grow so that he could “feel God in my heart.” His faith showed him how to forgive and move on. In particular, John forgave himself and the mother of his children, who also forgave him for what he had done to her. By understanding forgiveness, he was allowed to focus on God and healing within the SUD treatment process of MNTC. His main takeaway from the forgiveness was that “God does not judge you based on your past. He judges you based on your future.”

By clearing away all of the traumas in his heart, he made room for God to come in and work on him to make him a better man moving forward after MNTC. However, first, he had to graduate to demonstrate to himself that he was a changed man. John attributes the MNTC community and aftercare programs to his long-term sobriety and freedom from addiction.

Kyle initially said, "I am a Marine." Nevertheless, they said something this researcher, who knows many Marines, was unprepared for. Kyle started talking about surrendering to God. In this researcher's past, he could not think of a single Marine who discussed surrender. However, in this case, Kyle was saying that he did not know where to turn; he was out of options and decided to trust his faith and let God heal him of not only SUD but everything that Kyle used to hold on to—family, dogs, possessions, dignity, etc.

After putting his faith in God to work, he started to see a light at the end of the tunnel to resolve the issues he was experiencing in his life and that it could be better. He realized that God was real and that nothing was too complicated for Him. Kyle said that realization was scary at first, but then he began to use it to his advantage and let God take over everything in his life, including getting him free from addiction.

Larry says that his faith strengthened him and let him know that what he was going through in the long-term program was worth it because he was worth it. When he came to MNTC, Larry was having issues doubting his self-worth, and his faith let him know that God thought he was worth saving, which was why God led him to MNTC. In summary, Larry's faith helped him understand what God thought of him, which matured him as a person by opening his eyes to realize who he was in God's eyes.

Mark’s faith made him realize he was a new creation born again to do great things in the Kingdom. The fact that he could say he was born again has stuck with him as a man and defines his life going forward.

Nathan uses his faith to understand the principles found in the Bible and how to apply those principles to situations that he finds himself in, such as the long-term SUD treatment at MNTC. He also uses the Bible's principles mainly in situations involving others. As he said, the Bible contains proven methods for any situation. Nathan also said that the Bible and its teachings have given him a purpose that he did not have when he was trying to get high and did not care about anything else.

Olivia said that her faith changed her as a person, right to her core being. Her faith changed her character; now, she wants to continue to do better each day and work on herself instead of her destructive tendencies from SUD. She feels that she has a purpose and is growing into the type of person that she is supposed to be: a daughter of the living God. She wants to bring other people into the Kingdom and tell them everything she can about God and why this life was so much better than her old life of getting high.

Olivia wants to help others discover God, and for any others who struggle with SUD, she wants them to understand that God was our counselor, our teacher, and everything that comes with SUD needs to beat it. She admitted that in SUD treatment, it was vital to have people trained to help people through treatment who have gone to school. However, God was the only one who would always be present when everything else was completed, so He needed to be included in SUD treatment.

Pete concluded that being a drug addict was not a long-term life plan and decided that if he were going to make something of himself, he would need help. He also realized that not

everyone has faith once he got into MNTC. He concludes that faith provides a vision of what God wants for us, which is more than the short-term goal of sobriety. Those without faith leave the program but return because they have lost sight of God and His plans for them. After this revelation, Pete decided that he needed to make sure he kept God in his program so he could get sober and live a longer life.

Ruth discovered that with faith, she could understand the love and forgiveness of God. This led her to forgive herself and those around her. She also realized that without forgiveness in her heart, this was what made her continue to abuse drugs and keep going back to the streets to find the next high.

Table 5

How Faith Influenced Graduates' Ability to Complete Treatment

Graduate	Response
Alan	God had called me to be here, complete treatment, and help others.
Bill	It is about what we do along the way and how we influence others. I have an opportunity every day to impact whoever I touch for Jesus.
Charlie	C.S. Lewis has that point where he says that if Christianity is not authentic, it is unimportant. However, if Christianity is accurate, then it is of extreme importance.
Erica	It is always disappointing not to put my faith in worldly things. Believing that Christ works all things for good has helped me get through treatment.
Howard	I remember hearing people who had been here longer than me talk about the presence of God in specific meetings. I was in those same meetings, and I did not feel it. I wanted to feel God, so I stayed until I could experience God’s presence like they did.
Larry	God told me I was worth it, showing me that God was real.
Ruth	When I finally understood, God's unconditional love and forgiveness led me to forgiveness of myself and others, which I think unforgiveness always kept me stuck and going back to the streets.

RQ3 - Why do Some Fail to Complete SUD Treatment?

The open-ended questions and responses concerning why the graduates felt they failed initially (question 8, Appendix J) were all based on the personal experiences of the graduates before completing their SUD treatment at MNTC. Some responses describe why they failed at other facilities. Most interviewees believed they could succeed at MNTC because of the aftercare plans. These plans—often considered insufficient in the other treatment facilities they tried—significantly affected their success.

Alan kept a relationship with a woman outside of MNTC, even though that was discouraged by his new core support group at MNTC, due to the risks of relapse when associating with those from one's past. He decided he already knew God and did not need to be preached to; one day, he decided that he had been sober for five months, and a job was waiting, so he was leaving the program to get back to life. The relationship was with a woman who struggled with her addiction and kept it hidden from him initially. He left MNTC to help her but did not know as much as he thought and fell back to using himself. In summary, outside of relationships, he thought he knew God to the point that he was cured of SUD and a job called for him.

Bill grew up believing that if you out-think, work out, and prepare, there is nothing you cannot accomplish. In other words, he already knew how to get over SUD if he wanted to. Bill also mentioned having an authority problem and did not like anyone telling him he could not do something like drink. He had that under control, and those telling him to stop drinking did not know him well enough to make that judgment.

With that mindset, Bill set out to prove others wrong about his addictions because he was not going to let others tell him what to do. He switched careers, got a new job, and thought that if

he threw himself into his work, he could outwork his addiction. He tried some programs to get help with SUD, but eventually, he realized that he was wrong about his assumptions about his way of treating his growing addictions.

Charlie is similar to Bill because he thought he could treat himself. Even when Charlie was in treatment programs, he struggled with their way of treating his addiction. Charlie thought that he knew better. Thus, Charlie kept looking for the program that had the way he thought treatment should be done. He was looking for a do-it-yourself program and kept trying the next one that he heard about, not taking time to research what he should be doing, just assuming he knew the best way to get sober.

Erica was going to other programs and MNTC, too, because she was trying to please other people in her life who thought she needed to be in a treatment program. Alternatively, as Erica said, “I did not have a huge desire to stay sober until I came here.” She had the wrong motivation to get sober. She even said that while in treatment, the people she was trying to please would quit hassling her until they found out she was not going anymore, and then it would start again.

Fred learned that many other programs do not have a valid accountability program, so when he would leave the other programs, there was little to no contact with that program to see if he needed additional help or just a wellness check-in. There was no accountability during the program or after leaving.

Gerald did not know a good program from a bad one, so he would attempt something and then move on to the next program. He did not have guidance from anyone to help him make decisions.

Howard did not understand the programs and could not tell when he was supposed to be done. That added to the fact that his boss liked his work, and when Howard would not show up, the boss would be supportive of him seeking help and reminding Howard that they had a job to do when he was done with treatment.

John left other programs because, as he said, I "just was not ready to stop getting high." He had little motivation but not the value system to reinforce the motivation enough to get him sober. He said that he wanted to change at some point, but those other programs were not coming up at a time when he was open to getting sober.

Olivia tried and completed an inpatient that did have an aftercare program, so two months later, she was using substances again. Then, it took time to get into the subsequent inpatient, but the same thing happened: there was no aftercare, and she backslid within a month (question 5, Appendix J).

Ruth tried other programs and came to the same conclusion as Olivia: the need for a solid aftercare plan leads back to SUD.

The responses in Table 6 were all personal experiences of the graduates prior to completing their SUD treatment at MNTC. Some responses describe why they failed at other facilities, such as the response from Ruth. All 16 believe they succeeded at MNTC because the aftercare plans were insufficient at the other treatment facilities they tried.

Table 6

Reasons Graduates Were Previously Unable to Complete Treatment

Graduate	Response
Alan	I still had a toxic relationship with a woman outside of here. I decided I knew God. There was a job waiting for me.
Bill	I have always been able to get things done by myself. Who is to tell you cannot have a drink? You can outwork the addiction.
Charlie	I felt like I had it. I think I just got to the point where I felt comfortable staying.
Erica	I was doing treatment to please other people. I did not have a huge desire to stay sober.
Fred	There is no umbrella of brotherhood to keep you accountable as there is at MNTC.
Gerald	I did not know any better yet.
Howard	I was supposed to go back to work. I probably did nine treatments before Teen Challenge. It takes over thirty, sixty, ninety days to deal with it. The most significant difference was Teen Challenge's Christ-centered approach, which was absent from other programs I was involved with. I think that is how long you were discipled at MNTC.
Ruth	Not having a solid aftercare plan.

The responses in Table 7 were all personal experiences of the graduates prior to completing their SUD treatment at MNTC. Some responses describe why they failed at other facilities, such as the response from graduates Deb and Ruth. All 16 believe they succeeded at MNTC because the aftercare plans were insufficient at the other treatment facilities they tried.

Table 7

Reasons Graduates Were Unable to Complete Treatment from Question 13

Graduate	Response
Bill	As someone who has been to six different stints in treatment and three different programs, that has been the difference; I knew right away at the beginning that this would be a year-long program.
Fred	The only thing that needs to be added is that we need to learn to live in the real world rather than this umbrella, where we are still being served food, catered to, and pampered, and all these people are poor.
Howard	I tell people the church is the best aftercare plan.

Additional data collected outside the interview included asking the graduates to take the Grit Scale (see Appendix K) to provide additional correlation data to explain why they completed their treatment program. The Grit Scale measures passion and perseverance, ranging from one to five. The higher the score, the more passion and perseverance. The 16 data points from the MNTC graduates ranged from 3.1 to 4.7, with a mean of 3.9.

Grit combines passion and perseverance, allowing people to achieve their goals, such as getting sober. The perseverance aspect of the Grit Scale was described as having a long-term goal and keeping the hope that this goal was achievable, i.e., sobriety. People with a higher Grit score also show a passion for their work or, in the case of MNTC graduates, a zealousness for getting sober (Duckworth, 2016). A higher average Grit score of 3.9 for people who graduated from SUD treatment was expected.

Table 8

Summary of Grit Scale Data

Pseudonym	Grit Score	Comments
Alan	4.8	The grittiest of the MNTC graduates.
Bill	4.4	Nearly perfect for his perseverance in keeping with his treatment program and deep passion for getting sober.
Charlie	4.3	
Deb	3.5	Lower than the group average but consistent with the scores of the other female graduates interviewed.
Erica	3.2	
Fred	3.2	
Gerald	3.4	
Howard	4.3	
John	4.7	He was the second youngest person in the study.
Kyle	3.1	This is the lowest score of anyone in the study.
Larry	3.4	
Mark	3.8	
Nathan	4.5	He attributed this higher score to his legal issues and his determination not to return to jail.
Olivia	4.0	
Pete	4.2	
Ruth	4.1	
Mean	**3.9**	Scores can range from 1.0 to 5.0

Many responses to the last question, ‘Is there anything you want to add?’ mention TCLI. While TCLI was not a part of this study, it was an option that some MNTC graduates qualified for at the end of their treatment program. These responses regarding TCLI were left in this study to highlight the hope and optimism that some graduates believe the program helps them stay sober, paving the way for potential future studies on its impact.

Data Analysis and Findings

RQ1 - Demographic Differences and Similarities

Analysis of the demographic data from this study does not indicate any themes or correlations with graduates. Demographically, there are more similarities than differences between the 16 graduates. The similarities are logically consistent with the graduates. For example, many come from the Minneapolis/Saint Paul metro area. Even though there are other facilities around Minnesota, it would make sense to go to a treatment facility near where one lives or, in many cases, near the court that sent you to MNTC. All of them have stayed in the metro area after graduation, which can be explained by their familiarization with the area and their new sober friendships.

This researcher chose these demographic categories based on prior knowledge of working in ministry with other MNTC graduates and knowing what they had been through. These categories were validated in the pilot testing as something that MNTC leadership would be interested in understanding (S. Stadler, personal communication, June 18, 2023). When someone arrives at MNTC, these demographic areas are captured during admission. However, MNTC does not have the resources to do a comparison study of admission data with those who graduate from the long-term program.

RQ2 - Why Were Some Graduates Able to Succeed?

The responses from the graduates on how faith influenced their ability to complete treatment may sound like the interviewees testified to their belief in Jesus. These responses were not coached to come out this way. However, this researcher has witnessed many MNTC graduates in churches or men’s groups speaking about how Jesus saved their lives. So, if it

sounds like they are preaching, this is how they talk about their zealousness for Jesus and what He had done in their lives.

Four themes emerge in the data analysis of the graduate interviews: Jesus is present in the program, the staff's empathy for the clients, the critical support of aftercare programs, and the length of time in treatment.

Jesus is Present

The central theme in the graduates' words can be summed up with only two quotes, as these stand out as representative of the interviews—for example, when Howard said, "Jesus was present here," or Gerald compared MNTC to other programs: "Number one reason was God. I have been to 12 other treatments. They were all secular." Those who stick with their program can see the *Imago Dei* and know what they need to do to break free of their addiction. As stated earlier in Luke 4:18, Jesus came to set the captives free, in this case, free from SUD and addiction.

The feeling that Jesus was present and the graduates wanting to experience Him and have a personal relationship with Him made them want to stay with the program. Ruth summed it up nicely: "When I finally understood, God's unconditional love and forgiveness led me to forgiveness of myself and others, which I think unforgiveness always kept me stuck and going back to the streets." Again, with Howard on why Jesus kept him in MNTC:

> I remember hearing people who had been here longer than me talk about the presence of God in specific meetings. I was in those same meetings, and I did not feel it. I wanted to feel God's presence until I could experience it like they did.

Staff Empathy

A second theme was that the staff can genuinely empathize with the clients because nearly all are graduates of the same program. As Charlie stated, “Community: Almost everyone on the staff had been in the program before me. Teen Challenge just made me feel comfortable. I have never felt like that before.” They know precisely what they are going through, and the presence of graduates on the staff gives hope to those still struggling.

Erica also mentioned another subtopic in this theme: “The separation of men and women. I had the support of other women; it was good that I had another female to work with.” She had been to other treatment programs that did not have many women working on staff, and she added, “You get support from the community you build with people who genuinely care about you.” Having women who had been through what she was going through was different from the other SUD treatment programs that she had attempted, and she believes this was one reason that MNTC was successful in treating women like herself.

Aftercare Program

The last two themes are tightly coupled with the aftercare programs with MNTC and the fact that this program was 13 months long and, if needed, even longer. TCLI must be mentioned as a part of the aftercare program. The graduates viewed TCLI as a needed part of aftercare for those who qualify. Even though TCLI was not designed to be a part of this study, it must be mentioned as part of the reason the graduates believe they were able to complete their treatment.

Outside of TCLI, MNTC has other aftercare programs that encourage graduates to participate. Graduates who request to be included are added to the alumni list, and invited to various events and activities. These activities include softball games, getting jobs at MNTC, helping with the annual gala (MNTC’s primary fundraiser), picnics, working at local churches

and ministries in various capacities, and numerous athletic events around the Twin Cities metro area. Just prior to the interviews starting, some of the graduates interviewed took a trip 300 miles away to a new satellite location in Green Bay, Wisconsin, to help that facility build housing.

As part of the MNTC graduation process, a potential graduate must have a job, have identified sober housing, and be signed up to attend some external or internal counseling before leaving the MNTC facilities. Two churches have recently opened in the Minneapolis/Saint Paul suburbs, explicitly catering to MNTC graduates. Graduates are not required to attend these churches but are encouraged to join a church where they can get additional counseling help if needed. The pastor of one of the churches was a TCLI instructor, so the graduates have seen him around the building and are familiar with him.

Time in the Program

Several interviewees emphasized the flexibility of the year-long program, stating, “The year-long program was so important.” Another comment also pointed out that MNTC does not have a set time limit after a client must leave. “The advantage was that MNTC can invest in a person for up to a year and sometimes more. Some people take longer, but they stick with them.” Ruth viewed TCLI as “having another year-long option if you choose to do that; that was a game changer for me. I had never been in a program where I had that time.”

Howard stated it differently than the other programs he had been to: “It takes more than 30, 60, 90 days to deal with it.” Other programs were based on moving people into and out of their programs at set times, not when the client was ready to move on. The graduates pointed out this as a reason for failing at those programs.

RQ3 - Graduates' Perceptions of Why Some Fail

Not surprisingly, nearly every reason the graduates gave for why some clients fail in SUD treatment programs was the opposite of why they believed they could complete the long-term program at MNTC—starting with the profound belief in Jesus's involvement in the program. Some programs say they are based on biblical principles but do not examine the Bible to see what it says about overcoming something like SUD. Graduates of those programs do not predominately staff other programs, so the counselors cannot emphasize as well as the MNTC staff.

As with the previous research question, four themes emerge in the data analysis of the graduate interviews: Jesus was not present in other programs, and treatment staff was more concerned with pushing people through the program instead of developing them as sober members of society. Third, other programs need to be longer to allow for the development of good habits to replace the destructive habits that clients enter their programs with. Lastly, there was a crucial need for effective aftercare programs and for holding graduates accountable after leaving for the real world.

Not Christ-Focused

Bible-based and faith-based programs do not have the same focus as Christ-focused or Christ-centered programs. With other programs that are not Christ-focused, the staff likewise need to reinforce that Jesus wants them saved, and the first step to being saved is being sober to understand the benefits of being saved. This means that clients need help understanding why they want to be sober. As stated by Alan, "As someone who has been to six different stints in treatment and three different programs, Jesus has been the difference." Gerald said, "The most

significant difference was Teen Challenge's Christ-centered approach, which did not exist in other programs I was involved with."

With the lack of focus on Jesus in the treatment of SUD, then too early in the treatment process, many clients believe that they understand how to stay sober and that they do not need to stay there any longer and can leave. In reality, they are not ready to reenter society. There was little to no aftercare program, and it was not long-term; it lasted only a few months, and then you were put back on the street to fend for yourself. Without this knowledge of Jesus and the expectations of following him, this can lead to false hope, and as Alan said, "I decided I knew God, so I left that program."

Staff Empathy was Missing

Other programs' staff cannot relate to what their clients are going through, much less what they need to hear from them as role models for sobriety and how to get there. The clients cannot relate to the staff, and thus, "There was no umbrella of brotherhood to keep you accountable as there was at MNTC," as Fred stated. The staff's inability to demonstrate empathy to the clients led to distrust of what the staff was telling the clients. Then the clients start to believe things, as Bill stated, "Who was to tell you that you cannot have a drink?" and "Why should I follow this program? These guys do not know what I am going through or how to get me where I need to be, which is sober."

Length of Program

Several graduates commented that they needed a longer time to get sober and implement changes to their lives to keep them sober. As someone who had been in other SUD treatment programs, Howard succinctly said, "It takes more than 30, 60, 90 days to deal with it." What MNTC has found was that there was no correct amount of time that works for every person to

turn their life to sobriety. However, as Bill stated, “The advantage was that MNTC can invest in a person for up to a year and sometimes more. Some people take longer, but they stick with them.”

Howard combined the themes of the length of time in the program and staff empathy when he said, “ I think the difference was in how long you are discipled at MNTC.” This determines how long someone needs to stay in the program because it is a discipling process to sobriety. You need someone demonstrating sobriety, and then having the staff able to answer questions and provide knowledge can take longer for some people. Nevertheless, 14 of the 16 who were interviewed for this study agreed that anything less than a year was not enough time to change the abusive habits that had been built up for a decade or more before coming to MNTC.

Aftercare Programs are Lacking

Ruth identified one reason for backsliding at previous programs: "Not having a solid aftercare plan.” An active aftercare program would have someone contact you to see how you are doing before you have urges to return to the substances that ruined your life in the first place. Other programs will tell you that if you feel you are about to backslide, you should call a sponsor, who is not a trained counselor but may be able to talk you out of abuse. Other programs will tell you to find a meeting to commiserate with others. However, all of these are assuming that those affected with SUD can tell when they need help. This may mean they do not get help for long periods, as opposed to regular positive reinforcement from a regularly occurring aftercare program.

As previously mentioned, some churches in the Minneapolis/Saint Paul suburbs cater to MNTC graduates, making them feel welcome and not like outcasts from society. As MNTC is a Christ-centered program, Howard has said, “The church, I always tell people that it was the best

aftercare plan"; something like a structured aftercare program with regular touchpoints for graduates.

Relevant Theories for this Study

As discussed in the previous section concerning TPB and grit, clients leave treatment because they want to and do not see a reason to continue treatment. Those who graduate understand the reasons to get sober and have decided to work within the SUD treatment system to attain the sobriety goal. TPB would have them plan to attend SUD treatment for a while until it looks like they tried and then leave the program. Their plan was never to get better, to make someone else happy that they attended. They have no passion (grit) for getting sober, nor do they want to take the time to persevere and complete their SUD treatment. Grit can be used to understand the entire philosophy of MNTC and other SUD treatment programs. It was evident to this researcher that these programs have a passion for helping those with SUD overcome their addictions.

Evaluation of the Research Design

This study utilized a qualitative case study method and accomplished the purpose of this study, which was to understand the successful completion of the long-term program for graduates of the Minneapolis, Minnesota Adult and Teen Challenge. Two MNTC graduates and one MNTC leader confirmed the design's trustworthiness, confirmed their answers to interview questions, and identified initial themes. The validation of the research strategy through these discussions was a key step in ensuring the study's credibility and relevance to the research's purpose (Yin, 2018).

The study also explored demographic differences and similarities between the graduates, providing a correlation to the previous studies of Andersson et al. (2018) and Hannan et al.

(2005). Most important for the contributing literature were the graduates' perceptions of why they felt they could complete the program while others failed. This type of information is not found in the precedent literature. Lastly, findings from this qualitative case study were consistent with related studies utilizing TPB (Ajzen, 2020; Bhochhibhoya & Branscum, 2018; Bosnjak et al., 2020; Conner & Armitage, 1998; Davis et al., 2019; Fishbein & Ajzen, 2010; Grim & Grim, 2019; Hoffman, 2016; Sussman & Gifford, 2019; Zemore et al., 2021).

The interviews were open to any graduate who met the criteria. However, the sampling could have been more random instead of a convenience sample. Only two of those interviewed were unknown to the researcher, and the first two graduates to be interviewed recruited the remaining 14. However, due to time constraints and HIPAA laws, having the graduates recruited by others in MNTC was the most expedient manner to obtain the convenience sample needed.

This chapter presented the compilation protocol, sampling demographics, data analysis procedures, research findings, and evaluation of the research design. Findings from this qualitative case study approach were consistent with related studies utilizing TPB. Chapter 5 will discuss the implications of these findings for MNTC and SUD-treatment facilities with similar Christian-based curricula.

CHAPTER FIVE: CONCLUSIONS

Overview

The primary purpose of this study was to document and understand the stated reasons that allow the successful completion of substance use disorder (SUD) treatment. Another purpose was to understand some of the reasons that 50% of those who start a SUD treatment program fail to complete their treatment.

This last chapter summarizes the entire study, including the research conclusions, implications, and applications to SUD treatment. The following section will also detail this study's limitations and suggest future research. Finally, the chapter will close with a summary of the research.

Research Purpose

This case study aimed to understand the successful completion of the long-term program for graduates of the Minneapolis, Minnesota Adult and Teen Challenge (MNTC). This study explored demographic differences and similarities between graduates and the graduates' perceptions of why they felt they were able to complete the program while others failed. The theory guiding this study was Ajzen's (2020) TPB, which proposes that an individual's decision whether to engage in any specific behavior, such as drug or alcohol use, is predicated by their intention to engage in that behavior. TPB explains a person's intention to stop their substance use as a conscious behavior that this study seeks to understand.

Research Questions

The following research questions guided this study:

RQ1 - What are the demographic differences and similarities of the graduates who completed the MNTC long-term program?

RQ2 - What are the reasons why graduates believe they successfully completed the MNTC long-term program?

RQ3 - What are the graduates' perceptions of why some fail to complete the MNTC long-term program?

Research Conclusions, Implications, and Applications

This study did not reveal a demographic correlation between the sixteen MNTC graduates who were the subjects of this research. However, the graduates' stated perceptions of why they were able to graduate from the long-term program revealed several similarities in experience. Four reasons for success stand out from the study. Also, the areas that the graduates feel contributed to someone dropping out of SUD treatment were discovered to be identically opposite to the reasons they gave for being able to complete treatment.

Successful completion of their SUD treatment was attributed to how much Jesus and His teachings affected them while in the MNTC program. Staff empathy with those in the program, the aftercare programs, and the length of time for the 13-month, long-term program were all seen as contributing factors to success. The research's conclusions are addressed as follows.

RQ1 Conclusions: Demographics

Andersson et al. (2018) and Hannan et al. (2005) came to the same conclusion as this research: There was no correlation between demographics and successful SUD treatment. Not having any correlation makes developing a model to predict who will succeed and who will fail unpractical. Like Andersson et al. and Hannan et al., this study does not present demographic data that can predict who will graduate from long-term SUD treatment and who will not.

Even the first step for a client to enter treatment affects their motivation for coming to treatment. For example, those coming to MNTC from the courts are motivated to complete a set

amount of time in treatment to avoid further jail time. When these clients came to MNTC, their goal was not necessarily to get sober. Thus, the data collected from them was skewed compared to someone who did not come from the courts. For example, Fred came to MNTC at age 50, partly because he spent the previous five years in prison. MNTC was part of his probation and early release from prison.

TPB also applies to demographic data. Most of the graduates interviewed reported SUD for decades before coming to MNTC. Something in their lives changed to make them want to stop abusing substances and decide to get help.

RQ2 Conclusions: Why Graduates Believe They Succeeded

This research discovered four specific areas that set MNTC apart from other SUD treatments according to the graduates' reasons. First, Jesus is part of the program, not just faith-based but Christ-centered. The second is staff empathy. Many of the staff are graduates of the same program and had similar experiences that allow them to relate to clients coming to MNTC who cannot learn by just reading about it. Third is the aftercare program at MNTC, and finally, the long-term program is not time-bound; instead, the amount of time is based on the client and whether they are ready to reenter the world. The following paragraphs detail what the graduates believe makes MNTC's long-term program successful.

Jesus in the Program

This researcher expected MNTC graduates to credit Jesus with their sobriety. Every graduate interviewed talked about how they accepted Jesus into their lives and overcame their SUD by studying what Jesus wants of them. All 16 of them believe that they were put in MNTC not just to get sober but to grow in their faith, give their testimony to pre-believers, and fulfill the Great Commission.

On the MNTC campus and in groups off-site, there are official and unofficial Bible studies every single day of the week. These studies are not just reading the Bible but studying what Jesus wants of his followers, including those recovering from SUD. They study the *Imago Dei* and God's attributes; they do not just read the Bible. The goal of these studies is to determine their current situation in a SUD treatment program and for God to expect them to act as His children in a fallen world. During these studies, they also learn how to disciple others who are going through the same process as they are.

Staff Empathy

While MNTC employs some staff with professional credentials, most of the staff who interact with clients most of the time in the programs are graduates. Hiring graduates of the program has two effects on those going through SUD treatment. First, the staff empathizes with the clients since they have been through the same program. Second, the staff provides a real-life example of someone who has completed the program. Staff who have been through not only the treatment program but also have similar personal SUD experiences cannot be duplicated by taking a class. The staff know exactly what the clients are going through since they have lived it.

Aftercare

Graduates and MNTC supporters are invited to all MNTC events, whether playing on a softball team or attending performances of the MNTC choir. As with the staff empathy, this provides another touchpoint for those going through the program to interact with graduates, mentors, and counselors. One requirement of graduating from the program is to have continued SUD counseling arranged after leaving the MNTC facilities.

This methodology becomes effective by having people not in the story ask questions of the person telling it. This technique was helpful for SUD treatment because the abuser must now

understand how their actions affect all those around them and everyone they interact with when they are in character. The realization of the levels of trauma for all involved would be used for reconciliation.

Time in the Program

Many SUD treatment programs, including some programs at MNTC, are time-dependent: 30, 60, or 90 days long. These types of programs are based on funding rather than client-needs-based. After the scheduled time, the client is removed from the program to fend for themselves. MNTC's long-term program is planned for 13 months, though the 13-month time is just an estimate given by the amount of treatment planned. However, if the staff does not believe the client is ready to return to the world, the client can stay longer.

RQ3 Conclusions: Perceptions of Why Some Fail to Complete

The graduates' responses to why they failed in previous SUD treatment attempts are nearly precisely opposite of their stated reasons for the MNTC program's success. The MNTC graduates stated four reasons for failure, which will be discussed in the following pages.

Other Programs are not Christ-focused but Faith-Based

A Christ-focused program allows the graduates to understand why it is essential to complete SUD treatment. Completing treatment allows them to strive to be more like Jesus and help others, fulfilling the Great Commission. Christ-focused clients are not simply in the program for secular approval or to satisfy some court order to keep them out of prison; they are to be more like *Imago Dei*, and that is why they should want to complete SUD treatment.

Faith-based programs may work for some by helping clients connect to a higher power. However, as the MNTC graduates emphasized, those programs differ from pursuing a personal relationship with Jesus in Christ-based programs like MNTC's.

Lack of Staff Empathy

For those programs that recruit staff from healthcare, working in a SUD treatment facility can be just a job, no different from working in a nursing home or hospital in those positions that do not require a particular degree to have the position. These staff may try to empathize with clients, but it is a paycheck; they do not know what the clients are experiencing.

However, some staff require training and professional certifications, and some treatments require specialized training with supervision and periodic recertification to deliver the proper level of care (Osilla & Stern, 2019). Even though there was no list of those who require training (Papamalis, 2020), there are professions, such as those who write prescriptions, that the FDA and DEA govern for oversight. Certain facilities may require specific credentials, but having a license does not translate into empathy for your clients.

Length of Programs

Everyone was seeking treatment, and the timeline for treating each individual differed. However, generalizations can be made, and from this research and the quotes from the participants, we can see that quicker was not better. A longer timeframe was beneficial for many participants, especially when they knew MNTC would not kick them out after a specific number of days of treatment.

Aftercare Lacking

Studies have proven that SUD treatment is a long-term process and continues after leaving a treatment facility (Hystad & Wangensteen, 2022; Sealock, 2011). People with an addiction are never cured, as Alcoholics Anonymous teaches, one day at a time. Aftercare programs must be in place for someone to stay sober long-term.

TPB applies to understand the motivation for someone to remain in SUD treatment, including the aftercare program; it can also motivate someone to leave a program. For those who do not want to get better and want to avoid jail time, no amount of treatment will help those who do not want to be helped (Ajzen, 2020; Bhochhibhoya & Branscum, 2018; Bosnjak et al., 2020; Conner & Armitage, 1998; Davis et al., 2019; Fishbein & Ajzen, 2010; Grim & Grim, 2019; Hoffman, 2016; Sussman & Gifford, 2019; Zemore et al., 2021).

Research Limitations

This study was limited to those who had successfully graduated from MNTC's long-term SUD treatment since those participants were easy to locate. Those who fail to graduate from MNTC (for various unknown reasons) are problematic to contact, as many have severed contact with MNTC and, therefore, are challenging to locate.

These program graduates may not have had the exact reasons for dropping out of a program as those who left and never returned to sobriety. For example, someone sent to SUD treatment from the courts may only remain in the program to avoid additional prison time, not necessarily to be treated for SUD. This was a different motivation to stay with a program than those interviewed for this study. Though two of those interviewed for this study initially came to MNTC instead of going to jail, after they got to MNTC, various factors like the Holy Spirit and the intervention of the staff convinced them that they could achieve sobriety and help others.

Further Research

One area for further research would be a purely quantitative demographic study of graduates of an SUD treatment program to determine if there was any correlation between populations. A larger sample size would be required for a strictly demographic study, so the findings are statistically significant. A suggested sample size for this type of study would be 300

participants. However, a power analysis, as defined in Creswell and Creswell (2018), would determine the proper sample size for this type of study.

Another area of research would be simply redoing this study with a larger sample size, possibly ten times as large. This would allow for the validation of this study, and if the sample were large enough to create a statistically significant study, it would be helpful in the literature. This could be accomplished by having ten additional interviewers ask questions. If the desire was to utilize MNTC as a future focus, as already mentioned in this paper, the alumni list has thousands of names. That should allow sufficient potential participants. If using a different program, it would be wise to utilize their alumni list whenever available. Using these types of lists can present HIPAA challenges with sharing information.

A further research topic would be to develop a model/tool/questionnaire/interview that could predict each client's behaviors to predict if he or she will be successful in a SUD treatment program. This type of study design could be based on previous attempts (Ball et al., 2006; Zemore et al., 2021) with modifications. Before beginning this type of study, the first step was to define the study's outcome and target audience. Previous researchers have attempted to define a model to predict success or failure in treatment. Part of this study would be understanding previous work and why none have resulted in a valid model. Before launching a new study, it would be prudent to analyze previous studies to determine what had already been done to develop a model and understand why those models fail to predict an outcome in SUD treatment.

Instead of a qualitative study, another future research would be a quantitative study of solutions from a literature search, applying tools already developed to add to the literature. It focused on why some clients complete their SUD treatment programs and others fail to complete their programs. Two tools in particular that could be utilized are the Barriers to Retention Scale

(Zemore et al., 2021) and the Reason for Leaving Treatment Questionnaire (Ball et al., 2006). This type of study would have sub-studies to identify the pros and cons of both tools and any others found in a literature search. All these would aim to develop a super-tool using parts of all previous tools/studies.

One area of further research would involve either a qualitative or quantitative study to uncover additional data from those who have dropped out of SUD treatment, which would be helpful. Whether that data was demographic, Grit Scale data, or interview data, any of it would make for an exciting correlation study. The challenge will be identifying participants and collecting their data, especially if they have yet to be sober. There are two potential solutions for identifying test subjects. First, social media postings with a link to an anonymous survey tool to capture the data. This will require some advertising to direct the correct people to social media. Second, provide a flyer/link to all admitted to any treatment facility, maybe an app on their phone, so they could participate at some future point when they leave their respective programs. Once again, the data gathering site would need anonymity so potential participants do not feel they are being tracked. No matter which marketing method is used to identify test subjects, a low response rate is expected.

For someone wishing to pursue a study with the Grit Scale, one could develop a quantitative study to determine if scores change as treatment progresses. This type of data would interest the programs to indicate areas for improvement in their processes. Have clients fill one out when they enter a program and every month after that. A different rationale for this study would be to see trends as the treatment progresses and if there was a time/score that may predict someone was about to leave the program. A Grit Scale study might indicate whether those entering an SUD treatment program will succeed. Recall that Grit was initially developed to help

the U.S. Army determine the likelihood that an individual entering the U.S. Military Academy would likely remain in the program.

Further research would involve a quantitative study using the Grit Scale on incoming clients and developing a tracking system to correlate graduation rates with Grit scores. This differs from the proposed study above, which only looks at correlating graduation with grit scores. The most significant benefit of this type of study would be the tracking system, which would look at many different demographic factors of those in SUD treatment programs.

Another study using the Grit Scale would involve a quantitative study with a larger sample size, which could be conducted to examine whether there was a correlation between the grit score and the age of graduates and clients entering the program. Another area might be the grit score taken upon entering the program, which can be compared to the graduates' grit scores post-treatment. Since grit measures perseverance, it is easy enough to see that someone who completes a 13-month-long program exhibits perseverance. Such a study could also examine age and other demographics that might be interesting.

Lastly, further research could redo this study but change the sampling criteria to only look at graduates under 20. This is called the Minnesota Adult and Teen Challenge, after all. This type of study would allow for its validation. It may also correlate to the older sample size, identifying the names of graduates using the MNTC alumni list (or using a different program, utilizing their alumni list if it exists). Using these types of lists can present HIPAA challenges with sharing information.

Summary

This research contributed to the SUD treatment literature in the two categories. First, it confirmed previous studies (Andersson et al., 2018; Hannon et al., 2005) that no correlation

exists between demographic data and successful or unsuccessful SUD treatment programs. Second, this study demonstrated that a successful program like MNTC includes at least three elements: a Christ-centered approach to treatment, staff who regularly interacts with clients and demonstrates genuine empathy to the clients, and lastly, is not time-bound for treatment and includes an extensive aftercare program.

For example, consider the client this researcher was assigned to mentor before beginning this research. That client was not in the program for any reason other than a court order to attend 12 months of treatment or go to prison. His motivation was not to stay sober or learn to follow Jesus. He was there to avoid prison time. When his one year in the program was up, he walked away; this was just eight days before graduation. According to his social media, he returned to using substances with the group he was with before jail. Even though he talked to this researcher (his mentor) about his discussions with the MNTC staff, it was all an act. This gentleman is one example of someone who abused the SUD treatment resources at MNTC to avoid jail time. However, by focusing on those with a motive of getting sober, 92% of those who complete the long-term program remain sober (MNTC, 2020).

This research contributes to the research literature on the effectiveness of SUD programs. While the success rate may never reach 100%, the data shows that when done right, SUD-treatment programs (such as MNTC) can assist many in recovery to move forward with a productive life.

REFERENCES

Abad., S. S. M. M., Sadeghi, S., Jadgal, M. S., Yooshany, N., Atabay, R. A., Movahed, E., & Alizadeh, S. (2019). Application of the theory of planned behavior to predict drug abuse-related behaviors among adolescents. *Tolooebehdasht Journal*, *18*(2), 1-11. https://doi.org/10.18502/tbj.v18i2.1259

Alcoholics Anonymous. (2002). *Alcoholics Anonymous big book* (4th ed.).

Alemu, B. T., Baydoun, H. A., Olayinka, O., & Treadwell, R. M. (2024). Substance use disorders among adolescents in the United States: 2000-2019. *Southern Medical Journal*, *117*(2), 80-87. https://doi.org/10.14423/SMJ.0000000000001655

Allen, L. M. (2015). *Graduates' perceptions on how "Teen Challenge Alberta" influenced them: A grounded theory study* [Doctoral thesis, University of Calgary]. https://prism.ucalgary.ca/server/api/core/bitstreams/7a61fcdf-76c0-47a4-b8ad-b0327bd15ced/content

Anderson, T. (2021, July 28). *Know the truth student survey finds substance use remains high* [Press release]. Adult & Teen Challenge. https://www.mntc.org/wp-content/uploads/2021/09/KTT-School-Recap_2020-2021.pdf

Andersson, H. W., Steinsbekk, A., Walderhaug, E., Otterholt, E., & Nordfjærn, T. (2018). Predictors of dropout from inpatient substance use treatment: A prospective cohort study. *Substance Abuse: Research and Treatment*, 12, 1-10. https://doi.org/10.1177/1178221818760551

Arnkoff, D. B., Glass, C. R., & Shapiro, S. J. (2002). Expectations and preferences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work*: *Therapist contributions and*

responsiveness to patients (pp. 335-356). Oxford University Press. https://psycnet.apa.org/record/2003-02805-000

Ajzen, I. (2020). The theory of planned behavior: Frequently asked questions. *Human Behavior and Emerging Technologies*, *2*(4), 314-324. https://doi.org/10.1002/hbe2.195

Baekeland, F., & Lundwall, L. (1975). Dropping out of treatment: A critical review. *Psychological Bulletin*, *82*(5), 738-783. http://doi.org/10.1037/h0077132

Ball, S. A., Carroll, K. M., Canning-Ball, M., & Rounsaville, B. J. (2006). Reasons for dropout from drug abuse treatment: Symptoms, personality, and motivation. *Addictive Behaviors*, *31*(2), 320-330. https://doi.org/10.1016/j.addbeh.2005.05.013

Barrett, M. S., Chua, W.-J., Crits-Christoph, P., Gibbons, M. B., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training*, *45*(2), 247-267. http://doi.org/10.1037/0033-3204.45.2.247

Bhochhibhoya, A., & Branscum, P. (2018). The application of the theory of planned behavior and the integrative behavioral model toward predicting and understanding alcohol-related behaviors. *Journal of Alcohol and Drug Education*, *62*(2), 39-63. https://www.jstor.org/stable/48511451

Boersma, G. P. (2016). *Augustine's early theology of image: A study in developing pro-Nicene theology*. Oxford University Press.

Bohler, R. M. (2023). *Perceived need and unmet treatment need among adults with alcohol and drug use disorders in the United States: Examining the treatment gap to inform a more robust continuum of care* (Publication No. 30573376) [Doctoral dissertation, Brandeis University]. ProQuest Dissertations & Theses Global.

Boslaugh, S. (2011). Data collection systems. In M. Kleiman & J. Hawdon (Eds.), *Encyclopedia of drug policy: "The war on drugs" past, present, and future*. SAGE Publications.

Bosnjak, M., Ajzen, I., & Schmidt, P. (2020). The theory of planned behavior: Selected recent advances and applications. *Europe's Journal of Psychology*, *16*(3), 352-356. https://doi.org/10.5964/ejop.v16i3.3107

Bukten, A., Skurtveit, S., Waal, H., & Clausen, T. (2014). Factors associated with dropout among patients in opioid maintenance treatment (OMT) and predictors of re-entry. A national registry-based study. *Addictive Behaviors*, *39*(10), 1504-1509. https://doi.org/10.1016/j.addbeh.2014.05.007

Calhoun, S. B. (2009). Coercion and treatment. In G. L. Fisher & N. A. Roget (Eds.), *Encyclopedia of substance abuse prevention, treatment, and recovery* (p. 202). SAGE Publications. https://doi.org/10.4135/9781412964500

Carter, P. T. (2020). *Exploring practices pastoral leaders use to retain millennial parishioners* [Doctoral dissertation, Walden University]. https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=11373&context=dissertations

Chavez, B. C. (2021). *Lived experiences of Assemblies of God pastors regarding leadership style, demands, stressors, and ministry burnout* [Doctoral dissertation, Liberty University]. https://digitalcommons.liberty.edu/doctoral/3048

Chen, Y., & Feeley, T. H. (2015). Predicting binge drinking in college students' rational beliefs, stress, or loneliness? *Journal of Drug Education*, *45*(3-4), 133-155. https://doi.org/10.1177/0047237916639812

Cherry, A. L. (2013). Drug abuse. In M. E. Sharpe (Ed.), *Reference, social issues in America: An encyclopedia*. Routledge.

Chiesa, M., Wright, M., & Neeld, R. (2003). A description of an audit cycle of early dropouts from an inpatient psychotherapy unit. *Psychoanalytic Psychotherapy*, *17*, 138-149.

Choi, S., Adams, S. M., MacMaster, S. A., & Seiters, J. (2013). Predictors of residential treatment retention among individuals with co-occurring substance abuse and mental health disorders. *Journal of Psychoactive Drugs*, *45*(2), 122-131. https://doi.org/10.1080/02791072.2013.785817

Clarkin, J. F., & Levy, K. N. (2004). Influence of client variables on psychotherapy. In M.J. Lambert (Ed.), *Handbook of addressing treatment length expectations 199 psychotherapy and behavior change* (5th ed.; pp. 194-226). Wiley & Sons.

Cleveland, H., & Harris, K. (2010). Conversations about recovery at and away from a drop-in center among members of a collegiate recovery community. *Alcoholism Treatment Quarterly*, *28*(1), 78-94. https://doi.org/10.1080/07347320903436268

Conner, M., & Armitage, C. J. (1998). Extending the theory of planned behavior: A review and avenues for further research. *Journal of Applied Social Psychology*, *28*(15), 1429-1464. https://doi.org/10.1111/j.1559-1816.1998.tb01685.x

Cordaro, M., Tubman, J. G., Wagner, E. F., & Morris, S. L. (2012). Treatment process predictors of program completion or dropout among minority adolescents enrolled in a brief motivational substance abuse intervention. *Journal of Child & Adolescent Substance Abuse*, *21*(1), 51-68. https://doi.org/10.1080/1067828X.2012.636697

Courtois, C. A., & Steinberg, A. (L.). (2021). Sexual boundary violations in psychotherapy. In A. (L.) Steinberg, J. L. Alpert, & C. A. Courtois (Eds.), *Sexual boundary violations in psychotherapy: Facing therapist indiscretions, transgressions, and misconduct* (pp. 157-183). American Psychological Association. https://doi.org/10.1037/0000247-010

Creswell, J. W., & Creswell, J. D. (2023). *Research design: Qualitative, quantitative, and mixed methods approaches* (6th ed.). SAGE Publications.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry & research design: Choosing among five approaches* (4th ed.). SAGE Publications.

Cunningham, P. B., Foster, S. L., Kawahara, D. M., Robbins, M. S., & Bryan, S. W. (2021). Therapist strategies for managing midtreatment problems in evidence-based interventions in community settings. *Family Process*, *60*(3), 755-771. https://doi.org/10.1111/famp.12619

Davis, R. E., Bass, M. A., Ford, M. A., Bentley, J. P., Lee, K., & Doyle, N. A. (2019). Recreational prescription opioid misuse among college students in the USA: An application of the theory of planned behavior. *Journal of Health and Social Sciences*, *4*(3), 389-404. https://doi.org/10.19204/2019/rcrt10

Dickie, J. F. (2021). The power of performing biblical text today: For trauma-healing, evangelism, discipleship, and for supporting careful biblical study/translation. *Verbum et Ecclesia*, *42*(1), Article 2233. https://doi.org//10.4102/ve.v42i1.2233

Dodgen, C. E. (2004). Drug abuse. In C. D. Spielberger (Ed.), *Encyclopedia of applied psychology* (pp. 609-613). Elsevier. https://archive.org/details/enappsy/Enappsy-01/page/n609/mode/2up?q=Dodgen

Douglas, J. D., Tenney, M. C., & Silva, M. (2011). *Zondervan illustrated Bible dictionary* (Rev. ed.). Zondervan. https://archive.org/details/zondervanillustr0000unse_l4e2

Duckworth, A. (2016). *Grit: The power of passion and perseverance*. Scribner.

Erickson, M. J. (1985). *Christian theology* (3rd ed.). Baker.

Erickson, M. J. (2015). *Introducing Christian doctrine*. Baker.

Fishbein, M., & Ajzen, I. (2010). Predicting and changing behavior: The reasoned action approach. *Psychology Press*. https://doi.org/10.4324/9780203838020

Fisher, G. L. (2009). Treatment effectiveness. In G. L. Fisher & N. A. Roget (Eds.), *Encyclopedia of substance abuse prevention, treatment, and recovery* (pp. 942-943). SAGE Publications. https://doi.org/10.4135/9781412964500

Frelin, A. (2015). Relational underpinnings and professionality—A case study of a teacher's practices involving students with experiences of school failure. *School Psychology International*, *36*(6), 589-604. https://doi.org/10.1177/0143034315607412

French, D. P., & Cooke, R. (2012). Using the theory of planned behaviour to understand binge drinking: The importance of beliefs for developing interventions. *British Journal of Health Psychology*, *17*(1), 1-17. https://doi.org/10.1111/j.2044-8287.2010.02010.x

Fulgham, D. (2020). *Enrollment criteria and success rates in juvenile drug court: Ex post facto research study* (Publication No. 28316455) [Doctoral dissertation, University of Phoenix]. ProQuest Dissertations & Theses Global.

Garfield, S. L. (1994). Research on client variables in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.; pp. 190-228). Wiley & Sons.

Gilbert, W. C. (2022). Voices from the rooms and programs: Recovery capital speaks. *Journal of Social Work Practice in the Addictions*, *22*(1), 53-67. https://doi.org/10.1080/1533256X.2021.1946332

Grim, B. J., & Grim, M. E. (2019). Belief, behavior, and belonging: How faith is indispensable in preventing and recovering from substance abuse. *Journal of Religion & Health*, *58*(5), 1713-1750. https://doi.org/10.1007/s10943-019-00876-w

Hai, A. H., Wigmore, B., Franklin, C., Shorkey, C., von Sternberg, K., Cole, A. H., Jr., & DiNitto, D. M. (2021). Efficacy of two-way prayer meditation in improving the psychospiritual well-being of people with substance use disorders: A pilot randomized controlled trial. *Substance Abuse*, *42*(4), 832-841. https://doi.org/10.1080/08897077.2020.1865244

Hannan, C., Lambert, M., Harmon, C., Nielson, S., Smart, D., Shimokawa, K., & Sutton, S. W. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology*, *61*, 155-163. https://doi.org/10.1002/JCLP.20108

Hans, E., & Hiller, W. (2013). Effectiveness of and dropout from outpatient cognitive behavioral therapy for adult unipolar depression: A meta-analysis of nonrandomized effectiveness studies. *Journal of Consulting and Clinical Psychology*, *81*(1), 75-88. http://doi.org/10.1037/a0031080

Heitmann, J., van Hemel-Ruiter, M. E., Huisman, M., Ostafin, B. D., Wiers, R. W., MacLeod, C., DeFuentes-Merillas, L., Fledderus, M., Markus, W., & de Jong, P. J. (2021). Effectiveness of attentional bias modification training as add-on to regular treatment in alcohol and cannabis use disorder: A multicenter randomized control trial. *PLoS ONE*, *16*(6), Article 252494. https://doi.org/10.1371/journal.pone.0252494

Hoffman, K. R. (2016). *Developing a faith-based early intervention program for adults with alcohol and drug issues* (Publication No. 10100512) [Doctoral dissertation, Evangel University]. ProQuest Dissertations & Theses Global.

Huang, Y., & Smedema, S. (2023). Character strengths, coping, and addiction recovery: A mediation analysis. *International Journal of Mental Health Addiction*, 1-18. Advance online publication. 10.1007/s11469-023-01211-x

Hwang, Y. I. J., Albalawi, O., Adily, A., Hudson, M., Wand, H., Kariminia, A., O'Driscoll, C., Allnutt, S., Grant, L., Sara, G., Ogloff, J., Greenberg, D. M., & Butler, T. (2020). Disengagement from mental health treatment and re-offending in those with psychosis: A multi-state model of linked data. *Social Psychiatry and Psychiatric Epidemiology*, *55*(12), 1639-1648. https://doi.org/10.1007/s00127-020-01873-1

Hystad, J., & Wangensteen, T. (2022). Former inpatients' narratives of substance use four years after substance use disorder treatment: A qualitative follow-up study. *Nordic Studies on Alcohol & Drugs*, *39*(2), 190-202. https://doi.org/10.1177/14550725211050765

Jun, G. (2022). Missional discipleship in the public sphere: With special reference to lordship, followership, and Christlikeness in the concept of public discipleship. *Transformation*, *39(2)*, 111-121. https://doi.org/10.1177/02653788211062462

Kilmer, J. R., Fossos-Wong, N, Geisner, I. M., Yeh, J. C., Larimer, M. E., Cimini, M. D., Vincent, K. B., Allen, H. K., Barrall, A. L., & Arria, A. M. (2021). Nonmedical use of prescription stimulants as a "red flag" for other substance use. *Substance Use & Misuse*, *56*(7), 941-949. https://doi.org/10.1080/10826084.2021.1901926

Kilner, J. F. (2015). *Dignity and destiny*. William B. Eerdmans Publishing.

Knight, D. K., Joe, G. W., Morse, D. T., Smith, C., Knudsen, H., Johnson, I., Wasserman, G. A., Arrigona, N., McReynolds, L. S., Becan, J. E., Leukefeld, C., & Wiley, T. R. A. (2019). Organizational context and individual adaptability in promoting perceived importance and use of best practices for substance use. *Journal of Behavioral Health Services & Research*, *46*(2), 192-216. https://doi.org/10.1007/s11414-018-9618-7

Krause, N., & Rainville, G. (2022). Participation in combat, God-mediated control beliefs, and alcohol consumption. *Mental Health, Religion & Culture*, *25*(3), 320-331. https://doi.org/10.1080/13674676.2021.2005009

Kusmintarti, A., Thoyib, A., Ashar, K., & Maskie, G. (2014). The relationships among entrepreneurial characteristics, entrepreneurial attitude, and entrepreneurial intention. IOSR Journal of Business and Management. *16*, 25-32. https://doi.org/10.9790/487X-16622532

Landau, J., Stanton, M. D., Brinkman-Sull, D., Ikle, D., McCormick, D., Garrett, J., Baciewicz, G., Shea, R. R., Browning, A., & Wamboldt, F. (2004). Outcomes with the ARISE approach to engaging reluctant drug and alcohol-dependent individuals in treatment. *American Journal of Drug and Alcohol Abuse*, *30*(4), 711-748. https://doi.org/10.1081/ADA-200037533

Larson, O. G. (2019). *Changes in self-concept and substance-related cognitions during short-term residential substance use treatment* [Doctoral dissertation, Nova Southeastern University]. https://nsuworks.nova.edu/cps_stuetd/124/

Leedy, P. D., & Ormrod, J. E. (with Johnson, L. R.). (2019). *Practical research: Planning and design* (12th ed.). Pearson. https://www.pearsonhighered.com/assets/preface/0/1/3/4/0134775651.pdf

Liberty University. (2023, February 1). *Institutional review board*. https://www.liberty.edu/graduate/institutional-review-board

Lorberbaum, Y. (2015). *In God's image: Myth, theology, and law in classical Judaism.* Cambridge University Press. https://doi.org/10.1017/CBO9781107477940

Loveland, D., & Driscoll, H. (2014). Examining attrition rates at one specialty addiction treatment provider in the United States: A case study using a retrospective chart review. *Substance Abuse Treatment, Prevention, and Policy*, *9*, Article 41. https://doi.org/10.1186/1747-597X-9-41

Lowe, S. D., & Lowe, M. E. (2018). *Ecologies of faith in a digital age: Spiritual growth through online education*. InterVarsity Press.

Louie, E., Barrett, E. L., Baillie, A., Haber, P., & Morley, K. C. (2021). A systematic review of evidence-based practice implementation in drug and alcohol settings: Applying the consolidated framework for implementation research framework. *Implementation Science*, *16*(22), 1-29. https://doi.org/10.1186/s13012-021-01090-7

McDonald, I. B. (2023). *Addressing the issue of low attendance in Emmanuel church among young adults* [Doctoral dissertation, Liberty University]. https://digitalcommons.liberty.edu/doctoral/2845/

Mee-Lee, D., McLellan, A. T., & Miller, S. D. (2010). What works in substance abuse and dependence treatment. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 393-417). American Psychological Association. https://doi.org/10.1037/12075-013

Meyer, E. C., Walser, R., Hermann, B., La Bash, H., DeBeer, B. B., Morissette, S. B., Kimbrel, N. A., Kwok, O. M., Batten, S. V., & Schnurr, P. P. (2018). Acceptance and commitment therapy for co-occurring posttraumatic stress disorder and alcohol use disorders in veterans: Pilot treatment outcomes. *Journal of Traumatic Stress*, *31(*5), 781-789. https://doi.org/10.1002/jts.22322

Miles, M. B., Huberman, A. M., & Saldaña, Johnny. (2020). *Qualitative data analysis: A methods sourcebook* (4th ed.). SAGE Publications.

Miller, M. R. (2013). *Adolescent teen challenge program: An evaluation of efficacy* (Publication No. 3599509) [Doctoral dissertation, Chicago School of Professional Psychology]. ProQuest Dissertations & Theses Global.

Minnesota Adult and Teen Challenge. (2020). *Annual report.* https://www.mntc.org/wp-content/uploads/2021/11/21_AnnualReport7.pdf

Neale, J., Tompkins, C., Wheeler, C., Finch, E., Marsden, J., Mitcheson, L., Rose, D., Wykes, T., & Strang, J. (2015). "You're all going to hate the word 'recovery' by the end of this": Service users' views of measuring addiction recovery. *Drugs: Education, Prevention & Policy*, *22*(1), 26-34. https://doi.org/10.3109/09687637.2014.947564

National Institute on Drug Abuse. (2014). *Principles of drug addiction treatment: A research-based guide* (3rd ed.). https://nida.nih.gov/sites/default/files/podat-3rdEd-508.pdf

National Institute on Drug Abuse. (2016). Drug abuse treatment in the criminal justice system. In J. B. Shannon (Ed.), *Drug abuse sourcebook* (5th ed.; chapter 44). Omnigraphics.

National Institute on Drug Abuse. (2023, September 25). *Treatment and recovery*. https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery

New American Standard Bible. (1995). Thomas Nelson. (Original work published 1971)

Obert J. L., McCann M. J., Marinelli-Casey P., Weiner A., Minsky S., Brethen P., Rawson R. (2000). The matrix model of outpatient stimulant abuse treatment: history and description. *Journal of Psychoactive Drugs*, *32*(2), 157-164. https://doi.org/10.1080/02791072.2000.10400224

O'Keefe, T. (2020). Clinical hypnotherapy for stopping drug and alcohol addiction: Building resilience in clients to reduce relapses and remain clean and sober. *Australian Journal of Clinical Hypnotherapy & Hypnosis*, *41*(1), 16–26.

Ormbostad, H. A. K., Otterholt, E., & Stallvik, M. (2021). Investigating patients' perceptions of residential substance use treatment. Is drop out a deliberate or impulsive act? *Journal of Social Work Practice in the Addictions*, *21*(3), 255-272. https://doi.org/10.1080/1533256X.2021.1933850

Osilla, K. C., & Stern, S. A. (2009). Treatment of alcohol and drug use disorders. In G. L. Fisher & N. A. Roget (Eds.), *Encyclopedia of substance abuse prevention, treatment, and recovery* (pp. 951-955). SAGE Publications.

Owen, P., Gerrard, M. D., & Owen, G. (2007, April). *Following-up with graduates of Minnesota Teen Challenge: Results of telephone surveys with persons completing treatment in 2001 through 2005*. Global Teen Challenge. https://www.iteenchallenge.org/wp-content/uploads/itc-resources/MNTeenChallengeFollow-up_4-071.pdf

Padwa, H., & Cunningham, J. A. (2014). National institute on drug abuse (NIDA). In N. E. Marion & W. M. Oliver (Eds.), *Drugs in American society: An encyclopedia of history, politics, culture, and the law*. ABC-Clio.

Papamalis, F. E. (2020). Examining the relationship of personality functioning and treatment completion in substance misuse treatment. *Substance Abuse: Research and Treatment*, *14*, 1-19. https://doi.org/10.1177/1178221820951777

Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). SAGE Publications. https://study.sagepub.com/patton4e

Peterson, C., & Seligman, M. E. P. (2004). *Character strengths and virtues: A handbook and classification*. Oxford University Press. https://psycnet.apa.org/record/2004-13277-000

Pfund, R. A., Peter, S. C., McAfee, N. W., Ginley, M. K., Whelan, J. P., & Meyers, A. W. (2021). Dropout from face-to-face, multi-session psychological treatments for problem and disordered gambling: A systematic review and meta-analysis. *Psychology of Addictive Behaviors*, *35*(8), 901–913. https://doi.org/10.1037/adb0000710

Pinedo, M., Zemore, S., Beltrán-Girón, J., Gilbert, P., & Castro, Y. (2020). Women's barriers to specialty substance abuse treatment: A qualitative exploration of racial/ethnic differences. *Journal of Immigrant and Minority Health*, *22*(4), 653-660. https://doi.org/10.1007/s10903-019-00933-2

Quinn, C. A., Walter, Z. C., de Andrade, D., Dingle, G., Haslam, C., & Hides, L. (2022). A controlled trial examining the strength-based Grit well-being and self-regulation program for young people in residential settings for substance use. *International Journal of Environmental Research and Public Health*, *19*(21), Article 13835. https://doi.org/10.3390/ijerph192113835

Reis, B. F., & Brown, L. G. (2006). Preventing therapy dropout in the real world: The clinical utility of videotape preparation and client estimate of treatment duration. *Professional Psychology: Research and Practice*, *37*(3), 311-316. https://doi.org/10.1037/0735-7028.37.3.311

Ross, A., & Jackson. (2013). Investigating the theory of planned behaviour's application to binge drinking among university students. *Journal of Substance Use*, *18*(3), 184-195. https://doi.org/10.3109/14659891.2012.661024

Saldana, J. (2021). *Coding manual for qualitative researchers.* SAGE Publications. https://us.sagepub.com/en-us/nam/the-coding-manual-for-qualitative-researchers/book273583

Schwandt, T. A. (2007). *The SAGE dictionary of qualitative inquiry* (3rd ed.). SAGE Publications. https://doi.org/10.4135/9781412986281

Sealock, M. D. (2011). Evaluative evidence of rehab/treatment programs. In M. Kleiman & J. Hawdon (Eds.), *Encyclopedia of drug policy: "The war on drugs" past, present, and future*. SAGE Publications.

Seidman, I. (2019). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (5th ed.). Teachers' College Press.

Si, H., Shi, J., Tang, D., Wu, G., & Lan, J. (2020). Understanding intention and behavior toward sustainable usage of bike sharing by extending the theory of planned behavior. *Resources, Conservation and Recycling*, *152*, Article 104513. https://doi.org/10.1016/j.resconrec.2019.104513

Şimşek, M., Dinç, M., & Ögel, K. (2019). Determinants of the addiction treatment drop-out rates in an addiction counseling center: A cross-sectional study. *Psychiatry and Clinical Psychopharmacology*, *29*(4), 446-454. https://doi.org/10.1080/24750573.2018.1505283

Springer, K. L., & Bedi, R. P. (2021). Why do men drop out of counseling/psychotherapy? An enhanced critical incident technique analysis of male clients' experiences. *Psychology of Men & Masculinity*, *22*(4), 776-786. https://doi.org/10.1037/men0000350

Stanton, M. D. (2004). Getting reluctant substance abusers to engage in treatment/self-help: A review of outcomes and clinical options. *Journal of Marital and Family Therapy*, *30*(2), 165-182. https://doi.org/10.1111/j.1752-0606.2004.tb01232.x

Steibel, S. R. G., & Bergen, M. S. (2019). The body: Discipleship of our physicality. *Christian Education Journal*, *16*(1), 95-111. https://doi.org/10.1177/0739891318820332

Stitzer, M. (2009). National institute on drug abuse clinical trials network. In G. L. Fisher & N. A. Roget (Eds.), *Encyclopedia of substance abuse prevention, treatment, and recovery* (pp. 611-612). SAGE Publications. https://doi.org/10.4135/9781412964500

Substance Abuse and Mental Health Services Administration. (2021). *Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health*. https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHT MLFiles2020/2020NSDUHFFR1PDFW102121.pdf

Sussman, R., & Gifford, R. (2019). Causality in the theory of planned behavior. *Personality and Social Psychology Bulletin*, *45*(6), 920-933. https://doi.org/10.1177/0146167218801363

Swift, J. K., & Callahan, J. L. (2011). Decreasing treatment dropout by addressing expectations for treatment length. *Psychotherapy Research*, *21*(2), 193-200. https://doi.org/10.1080/10503307.2010.541294

Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *80*(4), 547-559. https://doi.org/10.1037/a0028226

Teplin, L. A., Potthoff, L. M., Aaby, D. A., Welty, L. J., Dulcan, M. K., & Abram, K. M. (2021). Prevalence, comorbidity, and continuity of psychiatric disorders in a 15-year longitudinal study of youths involved in the juvenile justice system. *JAMA Pediatrics*, *175*(7), Article 205807. https://doi.org/10.1001/jamapediatrics.2020.5807

Teter, C. J., DiRaimo, C. G., West, B. T., Schepis, T. S., & McCabe, S. E. (2020). Nonmedical use of prescription stimulants among US high school students to help study: Results from

a national survey. *Journal of Pharmacy Practice*, *33*(1), 38-47. https://doi.org/10.1177/0897190018783887

Thomas, G. (2019). *The image of God in the theology of Gregory of Nazianzus.* Cambridge University Press. https://doi.org/10.1017/9781108593410

Visnovsky, E., Turcek, M., Hajduk, M., & Pecnak, J. (2022). Retention in the outpatient treatment of alcohol dependence based on Lesch's typology and the involvement of a close person. *Bratislava Medical Journal*, *123*(11), 785-790. https://doi.org/10.4149/BLL_2022_126

Waters, R. (2019). After prison, healthy lives built on access to care and community. *Health Affairs*, *38*(10), 1616-1621. https://doi.org/10.1377/hlthaff.2019.01163

Whitmore, T. (2019). Narrow is the way: Christian discipleship and the R1 university. *Practical Matters*, *12*, 67-84. https://www.academia.edu/44948867/Narrow_is_the_Way_Christian_Discipleship_and_the_R1_University

Winters, K. C. (2018). Substance abuse treatment. In R. J. R. Levesque (Ed.), *Encyclopedia of adolescence* (2nd ed.; pp. 3856-3863). Springer. https://doi.org/10.1007/978-3-319-33228-4_309

Wisdom, J. P. (2009). Adolescents, substance abuse and treatment. In G. L. Fisher & N. A. Roget (Eds.), *Encyclopedia of substance abuse prevention, treatment, and recovery* (pp. 20-24). SAGE Publications. https://edge.sagepub.com/sites/default/files/12.9_Substance_Abuse_and_Treatment.pdf

Wright, C. J. H. (2017). *Cultivating the fruit of the spirit.* InterVarsity Press. https://us.langham.org/fruit/

Yin, R. K. (2018). *Case study research and applications: Design and methods* (6th ed.). SAGE Publications. https://us.sagepub.com/en-us/nam/case-study-research-and-applications/book250150

Zemore, S. E., Ware, O. D., Gilbert, P. A., & Pinedo, M. (2021). Barriers to retention in substance use treatment: Validation of a new, theory-based scale. *Journal of Substance Abuse Treatment, 131*, Article 108422. https://doi.org/10.1016/j.jsat.2021.108422

APPENDIX A

IRB Approval

[External] IRB-FY23-24-1751- Initial: Initial - Exempt
do-not-reply@cayuse.com <do-not-reply@cayuse.com>
Fri 5/3/2024 10:56
To: Lenss. John <jlenss@iberly.edu>;Sironen.Rich (School of Divinity Instruction)
<[redacted]>

[EXTERNAL EMAIL: Do not dick any links or open attachments unless you know the sender and trust the content]

LIBERTY UNIVERSITY
INSTITUTIONAL REVIEW BOARD

May 3, 2024
John Lenss
Rich Sironen
Re: IRB Exemption - IRB-FY23-24-1751 SUCCESSES TREATING SUBSTANCE USE DISORDER: A CASE STUDY OF MINNESOTA ADULT AND TEEN CHALLENGE

Dear John Lenss, Rich Sironen,

The Liberty University Institutional Review Board ORB) has reviewed your application per the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data-safeguarding methods described in your IRB application, and no further IRB oversight ls required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):
Category 2.(iii). Research that only includes interactions involving educational tests(cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria Is met:

The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).
For a PDF of your **exemption letter.** click on your study number in the My Studies card on your Cayuse dashboard. Next, click the Submissions bar beside the Study Details bar on the Study Details page. Finally, click Initial under Submission Type and choose the Letters tab toward the bottom of the Submission Details page. Your information sheet and final versions of your study documents, **which you must use to conduct your study,** can also be found on the same page under the Attachments tab.

This exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.
If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,
G. Michele Baker, PhD, CIP
Administrative Chair
Research Ethics Office

APPENDIX B

Permission Email - Riverview Church

Dear Riverview Church,

As a doctoral candidate in the John W. Rawlings School of Divinity at Liberty University, I am conducting research into the reasons that some people can complete their substance use disorder treatment when 50% of those who start to drop out are part of the requirements for a Ph.D. degree. The title of my research project is Successes Treating Substance Use Disorder: A Case Study of Minnesota Adult and Teen Challenge, and the purpose of my research purpose of this case study is to understand the successful completion of the long-term program for graduates of the Minneapolis, Minnesota Adult, and Teen Challenge. This study will specifically explore demographic differences and similarities between graduates and the graduates' perceptions of why they feel they were able to complete the program while others failed. At this stage in the research, successful completion will be generally defined as graduating from the program and not having a relapse for one year. The theory guiding this study is the Theory of Planned Behavior, as it proposes that an individual's decision whether to engage in any specific behavior, such as drug or alcohol use, is predicated by their intention to engage in that behavior. TPB will explain a person’s intention to stop their substance use as a conscious behavior that this study seeks to understand.

I want your permission to obtain and utilize your facility to contact and recruit participants for my research.

Participants will be asked to contact me to schedule an interview. Participants will be presented with consent information before participating. Participating in this study is entirely voluntary, and participants are welcome to discontinue participation at any time.

Thank you for considering my request. If you choose to grant permission, please provide a signed statement on official letterhead indicating your approval or respond by email.

APPENDIX C

Riverview Church Approval

Ben Fischer

Senior Pastor

Tue 4/9/2024 18:45

[EXTERNAL EMAIL: Do not click any links or open attachments unless you know the sender and trust the content.]

I absolutely give you my approval.

APPENDIX D

Permission Email - Minnesota Adult and Teen Challenge

Dear Minnesota Adult and Teen Challenge,

As a doctoral candidate in the John W. Rawlings School of Divinity at Liberty University, I am conducting research into the reasons that some people can complete their substance use disorder treatment when 50% of those who start to drop out are part of the requirements for a Ph.D. degree. The title of my research project is Successes Treating Substance Use Disorder: A Case Study of Minnesota Adult and Teen Challenge, and the purpose of my research purpose of this case study is to understand the successful completion of the long-term program for graduates of the Minneapolis, Minnesota Adult, and Teen Challenge. This study will specifically explore demographic differences and similarities between graduates and the graduates' perceptions of why they feel they were able to complete the program while others failed. At this stage in the research, successful completion will be generally defined as graduating from the program and not having a relapse for one year. The theory guiding this study is the Theory of Planned Behavior, as it proposes that an individual's decision whether to engage in any specific behavior, such as drug or alcohol use, is predicated by their intention to engage in that behavior. TPB will explain a person’s intention to stop their substance use as a conscious behavior that this study seeks to understand.

I want your permission to obtain and utilize your facility to contact and recruit participants for my research.

Participants will be asked to contact me to schedule an interview. Participants will be presented with consent information before participating. Participating in this study is entirely voluntary, and participants are welcome to discontinue participation at any time.

Thank you for considering my request. If you choose to grant permission, please provide a signed statement on official letterhead indicating your approval or respond by email.

APPENDIX E

Minnesota Adult and Teen Challenge Approval

Tue 4/9/2024 10:48

Hi John,

This is approved. Will this email response suffice?

Thanks,

[redacted]

Director, Alumni Services

Mn Adult & Teen Challenge

www.mntc.org

APPENDIX F

Recruitment Email

Dear Potential Participant,

As a doctoral candidate in the John W. Rawlings School of Divinity at Liberty University, I am conducting research into the reasons that some people can complete their substance use disorder treatment when 50% of those who start to drop out are part of the requirements for a Ph.D. degree. The title of my research project is Successes Treating Substance Use Disorder: A Case Study of Minnesota Adult and Teen Challenge, and the purpose of my research purpose of this case study is to understand the successful completion of the long-term program for graduates of the Minneapolis, Minnesota Adult, and Teen Challenge. This study will specifically explore demographic differences and similarities between graduates and the graduates' perceptions of why they feel they were able to complete the program while others failed. At this stage in the research, successful completion will be generally defined as graduating from the program and not having a relapse for one year. The theory guiding this study is the Theory of Planned Behavior, as it proposes that an individual's decision whether to engage in any specific behavior, such as drug or alcohol use, is predicated by their intention to engage in that behavior. TPB will explain a person’s intention to stop their substance use as a conscious behavior that this study seeks to understand.

Participants must be 18-year-old or older graduates of the Minnesota Adult and Teen Challenge Long Term Recovery program and at least one year sober. They will be asked to participate in a one-on-one, audio-recorded, in-person interview. The interview should take approximately 60-90 minutes to complete. Names and other identifying information will be collected as a part of this study, but participant identities will not be disclosed.

To participate, please contact me to discuss an interview. If you meet my participant criteria, I will work with you to schedule an interview.

A consent document is attached to this email. The consent document contains additional information about my research. To participate, you will need to sign the consent document and return it to me at the time of the interview.

Sincerely,

John Lenss

APPENDIX G

Recruitment Verbal - In-Person

Hello Potential Participant,

As a doctoral candidate in the John W. Rawlings School of Divinity at Liberty University, I am conducting research into the reasons that some people can complete their substance use disorder treatment when 50% of those who start to drop out are part of the requirements for a Ph.D. degree. The title of my research project is Successes Treating Substance Use Disorder: A Case Study of Minnesota Adult and Teen Challenge, and the purpose of my research purpose of this case study is to understand the successful completion of the long-term program for graduates of the Minneapolis, Minnesota Adult, and Teen Challenge. This study will specifically explore demographic differences and similarities between graduates and the graduates' perceptions of why they feel they were able to complete the program while others failed. At this stage in the research, successful completion will be generally defined as graduating from the program and not having a relapse for one year. The theory guiding this study is the Theory of Planned Behavior, as it proposes that an individual's decision whether to engage in any specific behavior, such as drug or alcohol use, is predicated by their intention to engage in that behavior. TPB will explain a person's intention to stop their substance use as a conscious behavior that this study seeks to understand.

Participants must be 18-year-old or older graduates of the Minnesota Adult and Teen Challenge Long Term Recovery program and at least one year sober. They will be asked to participate in a one-on-one, audio-recorded, in-person interview. The interview should take approximately 60-90 minutes to complete. Names and other identifying information will be collected as a part of this study, but participant identities will not be disclosed.

Would you like to participate?

["Yes" response:] That is Great. Could you send me your email address so I can send you the consent form? Then, we can set up a time for an interview.

["No" response:] I understand. Thank you for your time.

A consent document will be emailed to you prior to the interview and provided at the time of the interview. The consent document contains additional information about my research. To participate, you will need to sign the consent document and return it to me at the time of the interview.

Thank you for your time. Do you have any questions?

APPENDIX H

Recruitment Verbal - Phone Script

Hello Potential Participant,

As a doctoral candidate in the John W. Rawlings School of Divinity at Liberty University, I am conducting research into the reasons that some people can complete their substance use disorder treatment when 50% of those who start to drop out are part of the requirements for a Ph.D. degree. The title of my research project is Successes Treating Substance Use Disorder: A Case Study of Minnesota Adult and Teen Challenge, and the purpose of my research purpose of this case study is to understand the successful completion of the long-term program for graduates of the Minneapolis, Minnesota Adult, and Teen Challenge. This study will specifically explore demographic differences and similarities between graduates and the graduates' perceptions of why they feel they were able to complete the program while others failed. At this stage in the research, successful completion will be generally defined as graduating from the program and not having a relapse for one year. The theory guiding this study is the Theory of Planned Behavior, as it proposes that an individual's decision whether to engage in any specific behavior, such as drug or alcohol use, is predicated by their intention to engage in that behavior. TPB will explain a person's intention to stop their substance use as a conscious behavior that this study seeks to understand.

Participants must be 18 or older, Minnesota Adult and Teen Challenge Long Term Recovery program graduates, and at least one year sober. They will be asked to participate in a one-on-one, audio-recorded, in-person interview. The interview should take approximately 60-90 minutes to complete. Names and other identifying information will be collected as a part of this study, but participant identities will not be disclosed.

Would you like to participate?

["Yes" response:] That is Great. Could you send me your email address so I can send you the consent form? Then, we can set up a time for an interview.

["No" response:] I understand. Thank you for your time.

A consent document will be emailed to you prior to the interview and provided to you at the time of the interview. The consent document contains additional information about my research. To participate, you will need to sign the consent document and return it to me at the time of the interview.

Thank you for your time. Do you have any questions?

APPENDIX I

Consent

Title of the Project: Success Treating Substance Use Disorder: A Case Study of Minnesota Adult and Teen Challenge

Principal Investigator: John Lenss, Doctoral Candidate, John W. Rawlings School of Divinity, Liberty University

Invitation to Be Part of a Research Study

You are invited to participate in a research study. To participate, you must be 18 or older, been sober for the past year, and a Minnesota Adult and Teen Challenge graduate in Minneapolis, Minnesota. Taking part in this research project is voluntary.

Please read this entire form and ask questions before deciding whether to participate in this research.

What is the study about, and why is it being done?

The purpose of the study is to utilize data from a single addiction recovery program, Minnesota Adult and Teen Challenge, to understand why some clients are successful with their treatment program and others are not. The current situation must be better documented and understood to assist others suffering from substance use disorder.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following:

> Participate in an in-person, audio-recorded interview that will take no more than 90 minutes.

How could you or others benefit from this study?

Participants should not expect a direct benefit from participating in this study.

Potential benefits to Minnesota Adult and Teen Challenge and similar programs could be indications of improvements to their current treatment programs that may increase the number of people who are able to complete the long-term program; benefits and those coming into the program may be a decrease in those dropping out early; thus more people being helped with substance use disorder.

What risks might you experience from being in this study?

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential by replacing names with codes.
- Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password and biometrically locked computer in a secure facility and in a notebook in a locked cabinet in the PI's office. After three years, all electronic records will be deleted, and all hardcopy records will be shredded.
- Recordings will be stored on a password-locked computer in a secure facility for three years and then deleted. The researcher will have access to these recordings.

How will you be compensated for being part of the study?

Participants will not be compensated for participating in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your participation will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please get in touch with the researcher using the email address/phone number in the next paragraph. If you do so, the data collected from you will be destroyed immediately and not included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is John Lenss. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at [redacted]. You may also contact the researcher's faculty sponsor, Dr. Rich Sironen, at [redacted].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and want to talk to someone other than the researcher, **you are encouraged** to contact the IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) ensures that human subjects research will be conducted ethically as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

The researcher has my permission to audio-record me as part of my participation in this study.

_____

Printed Subject Name

_____

Signature & Date

APPENDIX J

Interview Questions

Before Treatment Background Information

1. What area were you living in before you got help?
2. How long have you been a substance abuser?
3. What was your substance(s) of choice?
4. How old were you when you got to MNTC?

Opinions about Treatment

5. Did you backslide during treatment, or could you make it through the first time?
    a. Do you have an opinion as to why you backslid?
6. Name three reasons you believe allowed you to complete the program.
7. Would you say that you were more emotionally mature when you graduated compared to when you went into MNTC?
8. If you believe your faith had some influence, describe how it affected your ability to complete your treatment program.
9. How old were you when you graduated from MNTC?
10. Did you have a mentor during treatment?

Since Graduation

11. Do you still talk with your mentor?
12. Where is home now?
13. Is there anything else that you would like to add?

APPENDIX K

Grit Scale

	Not at all like me	Not much like me	Somewhat like me	Mostly like me	Very much like me
1. New ideas and projects sometimes distract me from previous ones.	5	4	3	2	1
2. Setbacks encourage me. I do not give up easily.	1	2	3	4	5
3. I often set a goal but later pursue a different one.	5	4	3	2	1
4. I am a hard worker.	1	2	3	4	5
5. I need help focusing on projects that take over a few months to complete.	5	4	3	2	1
6. I finish whatever I begin.	1	2	3	4	5
7. My interests change from year to year.	5	4	3	2	1
8. I am diligent. I never give up.	1	2	3	4	5
9. I have been obsessed with a particular idea or project for a short time but later lost interest.	5	4	3	2	1
10. I have overcome setbacks to conquer a significant challenge.	1	2	3	4	5

Add all the scores and then divide by ten.

The maximum score is 5

APPENDIX L

Grit Scale Approval

info@angeladuckworth.com

Mon 4/8/2024 14:34

Dear Dr. Duckworth,

As a doctoral candidate in the John W. Rawlings School of Divinity at Liberty University, I am conducting research into the reasons that some people can complete their substance use disorder treatment when 50% of those who start to drop out are part of the requirements for a Ph.D. degree. The title of my research project is Successes Treating Substance Use Disorder: A Case Study of Minnesota Adult and Teen Challenge, and the purpose of my research purpose of this case study is to understand the successful completion of the long-term program for graduates of the Minneapolis, Minnesota Adult, and Teen Challenge. This study will specifically explore demographic differences and similarities between graduates and the graduates' perceptions of why they feel they were able to complete the program while others failed. At this stage in the research, successful completion will be generally defined as graduating from the program and not having a relapse for one year. The theory guiding this study is the Theory of Planned Behavior, as it proposes that an individual's decision whether to engage in any specific behavior, such as drug or alcohol use, is predicated by their intention to engage in that behavior. TPB will explain a person's intention to stop their substance use as a conscious behavior that this study seeks to understand.

After reading your 2016 book, Grit, I would like to use your Grit Scale in my Substance Use Disorder treatment study.

My idea with the Grit Scale is to ask the questions in the scale of the graduates to determine whether the amount of grit someone has indicates whether they will complete their treatment program.

Do I have your permission to use the grit scale, as detailed in Chapter 4 of your book?

Thank you for considering my request. If you choose to grant permission, please provide a signed statement on official letterhead indicating your approval or respond by email.

info@angeladuckworth.com

Mon 4/8/2024 21:09

Thank you for taking the time to write!

Unfortunately, my research and teaching priorities mean that I don't have time to respond to each and every email in my inbox—as much as I wish I could.

In hopes that one of my colleagues or an online resource can help you, see below for contacts and links.

I'm a parent or teacher. Can you direct me to the most useful online information?
Sign up for my weekly tip of the week and, for parents and educators in particular, find free resources at characterlab.org

How do I get permission to use the Grit Scale?
There are no restrictions for non-commercial uses for research, translation, or education. However, copyright protections prohibit reproduction in books, magazines, or other outlets, and/or commercial use.