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April, 2008

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Religious Institutions Grant Program
Grant No. 2005012
March 2008

Title: Charismatic Evangelicals' War on Drugs – The Case of the Assemblies of God

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Chapter I
Executive Summary

CASA's 2001 groundbreaking report, *So Help Me God: Substance Abuse, Religion and Spirituality*, concluded that the combination of religious and spiritual practice and science-based treatment have enormous potential for preventing substance abuse and addiction among teens and adults and for aiding in recovery. The most troubling findings of this study were the extent to which clergy see substance abuse as a problem among their congregants, yet lack the knowledge and training for dealing with it; and the failure among health care professionals to recognize the importance of religion and spirituality in prevention and recovery.[1]

The enthusiastic and continuing public and professional response to this report prompted CASA to continue its efforts to explore the connection between religion, spirituality and substance abuse. In 2004 and in 2005, CASA convened two conferences in New York City to explore the roles that religion and spirituality play in preventing substance abuse and aiding recovery. Through the conferences, CASA also sought to encourage the religious and medical communities to work together to prevent and treat substance abuse and addiction.

In 2004, CASA was awarded a small grant by the Louisville Institute to investigate a more specific aspect of the spirituality-substance abuse link: how the religious component of the Teen Challenge program--a network of faith-based recovery services affiliated with a Christian Evangelical movement, the Assemblies of God (AG)--influenced its substance abuse treatment philosophy and practice. Teen Challenge, founded by Rev. David Wilkerson in 1957, operates 185 programs in the United States and Puerto Rico. It began as a teen ministry, but has become a provider of substance abuse recovery programs serving both teenagers and adults. Most Teen Challenge centers offer a one-year residential program designed to help men and women lead addiction-free lives.

CASA's study explores the treatment philosophy, practices and other characteristics of Teen Challenge relative to professors affiliated with AG institutions of higher education and treatment providers who are not affiliated with the Assemblies of God.[*] Specifically, the study compared Teen Challenge to non-AG treatment providers on the following dimensions:

- Perspectives on issues such as the causes of substance abuse and addiction, basic elements of human nature and morality, the role of science, drug policy and key treatment goals and interventions;
- Structural capacity of the program and facilities;
- Characteristics of the treatment population;
- Range of services offered and used; and
- Characteristics of the provider staff, including job qualifications, caseloads, demographics and religious profiles.

Survey data from 68 college professors, 38 treatment administrators and 109 substance abuse counselors were collected and analyzed.

Key Findings

Perspectives on Substance Abuse and Treatment

The fundamental beliefs of AG Teen Challenge providers about human nature and morality, and their related perspectives on the causes of substance abuse and its treatment, differentiate them from their non-AG counterparts. Whereas the majority (82.4 percent) of AG treatment providers agrees or strongly agrees with the statement that "human nature essentially is perverse and corrupt," most (86.6 percent) non-AG providers agree or strongly agree with the statement that "human nature is basically good."

AG providers tend to have a strongly religious or spiritual interpretation of the causes of substance abuse and addiction and tend to reject biological explanations, whereas non-AG providers are more likely to adhere to biological theories of substance abuse and addiction and disagree with religious theories.

On drug policy, AG providers are likelier than non-AG providers to favor government funding of faith-based treatment programs and of incarceration of drug offenders and are less likely to support legalization of medical marijuana use or needle exchange programs.

AG providers tend to rank religious and/or spiritual needs as the most important component of treatment. Non-AG providers identify the development of positive self-concept and stress management skills as the most critical areas for intervention.

Structural Capacity and Treatment Population

AG facilities are smaller in size, process fewer cases and are staffed with fewer personnel than non-AG treatment facilities. With regard to the characteristics of the populations served by the programs, Teen Challenge clients are younger than clients in non-AG programs, likelier to be employed, more likely to be Hispanic, less likely to be black and less likely to be HIV-positive.

The main referral sources of Teen Challenge clients are family members (38.3 percent), criminal justice agencies (22.3 percent) and self referral (18.3 percent), whereas the majority of clients in non-AG programs are referred by criminal justice agencies (41.0 percent), by other treatment programs (20.6 percent) or self-referrals (21.0 percent).

[*] Treatment is viewed in this report as any set of recovery services guided by a specific etiological model. This understanding echoes the definition of treatment provided by the Substance Abuse and Mental Health Services Administration which describes treatment as "a path of recovery that can involve many interventions and attempts at abstinence" (Substance Abuse and Mental Health Services Administration, 2007a).

Clinical Practice

Bible classes, prayer meetings, training in work readiness and employability skills, vocational training, services to criminal offenders and services to mentally ill substance abusers are more likely to be available in AG programs than in non-AG programs. Medical services, HIV testing and counseling, TB testing, psychiatric assessment, legal counseling, individual and group psychotherapy and services for pregnant women are more likely to be available in non-AG programs.

Teen Challenge clients spend more hours per week than clients in non-AG programs in vocational training (11.1 vs. 6.6.), academic education (9.8 vs. 5.3), religious services (9.0 vs. 1.0) and Bible classes (11.1 vs. 0.7).

AG programs are less likely than non-AG programs to contract off-site services to supplement their on-site services.

Treatment Counselors' Characteristics

AG counselors are much less likely than non-AG counselors to be licensed or certified by state agencies (17.2 percent vs. 72.0 percent) and have slightly less experience working in the field of addiction counseling (average of 80.9 months vs. 95.9 months). AG counselors are likelier than non-AG counselors to be male (60.3 percent vs. 49.0 percent), younger (average of 40.6 years vs. 48.4 years) and less educated (38.0 percent vs. 7.9 percent have a high school diploma as their highest level of educational attainment) and much likelier to describe themselves as "very religious" (82.5 percent vs. 51.0 percent).

Variations in Beliefs Within the Assemblies of God Community

Because of their increasing interaction with the Teen Challenge ministry, CASA surveyed professors of human services and behavioral sciences who teach at liberal arts colleges affiliated with AG to explore variations in beliefs and attitudes within the AG community. These professors shared the same religious profile of administrators and counselors serving at AG programs, but their views on human nature, science and substance abuse and addiction were more similar to non-AG providers than to AG providers.

Recommendations

- To benefit from the large and growing body of knowledge about substance abuse and its treatment, Teen Challenge programs should engage in dialogue with secular models of addiction and recovery, including spiritual models not associated with institutionalized religions such as the 12-step recovery model, to expand their repertoire of interventions that can help clients without compromising the core religious values of AG.[*]

- To ensure clients receive medical and other essential services, Teen Challenge should collaborate with other treatment professionals and service providers to expand the range of services it can provide to clients.

- To strengthen faith-based treatment interventions, Teen Challenge should allow independent researchers to study their programs, identify best practices and make suggestions for improvement that would be consistent with its core religious values.

- To enhance professional qualifications, Teen Challenge should require its programs to comply with federal and state licensing and certification standards for treatment providers.

[*] In this report, we adopt a denominational approach to the definition of secularity and the term 'secular treatment programs' is used to refer to treatment models that are not directly linked to formal systems of religious doctrines, officially affiliated with religious groups and/or seeking behavioral changes through public religious conversion of treatment clients. Treatment modalities that do not meet these denominational criteria, including the 12-step recovery model, are labeled as secular.

- To meet the religious or spiritual needs of clients, secular treatment providers should discuss patients' spiritual needs and desires, and, where appropriate, refer clients to clergy or spiritually-based programs to support their recovery.

Many individuals and institutions made important contributions to this work. We wish to thank Reverend Mike Hodges, President of the Teen Challenge USA National Office, and Reverend Dave Batty, Executive Director of Teen Challenge Brooklyn, for their support of and assistance with this research project. Dr. Frank Guida, Director of Research at Odyssey House New York City, lent his expert help during the pilot testing of the survey instruments. We also wish to express our profound gratitude to the 215 treatment facility administrators, substance abuse counselors and college professors who graciously responded to the mail surveys and generously shared their experiences and opinions.

Hung-En Sung, PhD, was the principal investigator and Doris Chu, PhD, was the co-investigator for this project.

Chapter II
The Assemblies of God: Evangelical Involvement in Substance Abuse Ministry

Faith-based treatment of substance abuse in the United States emerged soon after the first settlers introduced the techniques of distillation from Europe. As alcohol increasingly became a disruptive force among Native Americans, some religious ceremonies led by tribal leaders began to focus on the restoration of the communal harmony and personal balance damaged by alcoholism.[2]

Organized faith-based efforts to help substance abusers did not start until the religious wing of the Temperance Movement initiated sobriety ministries among alcoholics in deteriorating urban neighborhoods in the last quarter of the 19th century.[3] Some of these treatment programs, such as the Salvation Army, are still in operation. The outbreak of illicit drug epidemics among inner-city youth in the 1950s and 1960s prompted major Christian denominations to branch out into the rehabilitation of other drug abusers.[4]

Charismatic Evangelical Christians[*] have had an active history of involvement in substance abuse recovery ministries since the 1950s, providing rehabilitation services to substance abusers as well as specialized training in addiction for pastors, missionaries and Christian counselors.

[*] The term Charismatic Evangelicalism is used in this report to refer to the particular branch of Protestant Christianity that emerged formally within the Pentecostal movement of the early 20th Century. On the one hand, this movement shares the Evangelical emphasis on the experience of conversion, the canon of the Bible as the only doctrinal authority, the missionary zeal and Christ's redeeming work on the cross as the only means of salvation. On the other hand, it embraces the Pentecostal exaltation of the baptism in the Holy Spirit as a distinct divine gift available to all believers. Charismatic Evangelicals also believe in and practice the charismatic gifts of prophesy and miraculous healings as described in the New Testament. Although the terms 'Charismatic' and 'Pentecostal' are employed interchangeably in

Their role in providing substance abuse treatment in the U.S. has grown in recent years, as a result of the federal government's Faith-Based and Community Initiative--Access to Recovery--which has provided hundreds of millions of dollars in grants to support the vouchers for faith-based substance abuse treatment in 14 states and a tribal territory.[*] [5]

Guided by conservative theological explanations of human nature and behavior, Charismatic Evangelicals tend to view substance abuse as a destructive behavior freely chosen by fallen humans.[6] Charismatic substance abuse counselors routinely challenge their clients to embrace the Christian faith to transform their lives and to find meaning and purpose, thus eliminating the need to abuse alcohol and other drugs.[7] As a transgression, addiction is above all considered a sin against God and symptomatic of a self-centered life.[8]

this report, some scholars make the distinction between traditional Pentecostals who have descended directly from the Azusa Street revival of the 1900s and formed denominations such as the Assemblies of God, Church of God in Christ, etc., and the Charismatic Christians who first emerged in the 1960s and have remained within the mainstream denominations (e.g., Charismatic Roman Catholics).

[*] ATR is a three-year competitive discretionary grant program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). One of the stated goals of the program is to "increase the array of faith-based and community-based providers for clinical treatment and recovery support services" (SAMHSA, 2007b). The 14 state grantees and one tribal organization include: California, Connecticut, Florida, Idaho, Illinois, Louisiana, Missouri, New Jersey, New Mexico, Tennessee, Texas, Washington, Wisconsin, Wyoming and the California Rural Indian Health Board. SAMHSA does not impose any set of eligibility criteria for providers to participate in ATR; each state grantee determines the eligibility criteria for providers, including those previously unable to compete for federal funds. Based on the eligibility criteria developed by the individual grantee, the provider may or may not be required to be licensed or certified.

This religious emphasis is at odds with the scientific conception of addiction as a brain disease with behavioral aspects.[9] The majority of current theories on addiction emphasize both physiological and social determinants.[10]

The Assemblies of God in the United States

The Assemblies of God is one of the largest and fastest growing Christian denominations in both the U.S. and the world. In 2005, AG reported more than 2.8 million adherents,[†] 1.6 million members and 1.8 million Sunday service attendees in the U.S. and over 54.7 million adherents worldwide.[‡] There were roughly 12,300 established AG churches in the U.S. and approximately 280,500 churches worldwide in more than 190 nations in 2005; more than 12,000 students were enrolled in the 19 AG-endorsed universities, bible colleges and universities in the U.S. and Puerto Rico. Many of the enrolled students were individuals training to become AG church pastors and ministerial leaders.

A Brief History

The AG movement emerged in the early years of the 20th century among Protestant Christians who felt that they needed more of God's power operating in their lives amidst the perceived rapid and decadent social and cultural changes around them. The Methodist minister, Charles Fox Parham--an early forefather of the movement--advocated a restoration of doctrinal purity and experiential Christian living as detailed in the New Testament. Key features of this tenet included the imminent and physical return of Christ, the concern for physical well-being and the supernatural healing of the sick, and the experience of a distinct spiritual empowerment beyond the conversion experience

[†] Adherents are defined in AG's church census as those churchgoers who consider an AG church their home church, whether or not they are enrolled as members.

[‡] Data on the number of worldwide AG members and attendees are not available.

evidenced by the outward sign of *glossolalia*[*] -- speaking in tongues. Many of the followers of Parham were people who experienced a deep sense of cultural loss due to the relentless modernization of the American culture and they found assurance and hope in an expression of faith based on the literal interpretation of the scriptures and their own private, albeit extraordinary, experiences.[11]

Parham's religious revival spread rapidly throughout the country.[12] A three-year revival meeting at Azusa Street Mission in Los Angeles attracted believers from across the nation and overseas and served as a springboard to send the movement's message beyond America. Although leaders of the movement desired unity with extant denominations and established churches, their emotional manifestations and practice of speaking in tongues rendered participants in the movement unwelcome in many congregations. Adherents were forced to seek refuge in houses of worship of their own.[13]

Over time, the movement spawned proselytizing outreach efforts resulting in the creation of hundreds of distinctly Pentecostal congregations. Southern leaders convened a general conference at Hot Springs, Arkansas in 1914.[14] Eudorus N. Bell, who was later recognized as the founder of AG, argued for the need to expand publishing, missionary and education efforts. A cooperative fellowship was established during the conference and incorporated under the name The General Council of the Assemblies of God.

[*] The phenomenon of speaking in tongues received some scrutiny from social sciences. In the scientific community, it is considered a derivative speech consisting of the reduction of one's native language to its most basic phonological components that anyone with unimpaired linguistic capabilities can produce (Samarin, 1979). It can be learned under experimental conditions (Spanos, Cross, Lepage, & Coristine, 1986) and speakers of these unintelligible languages experience transient epileptic-like electric changes in the temporal lobe similar to those recorded during transcendental meditations (Persinger, 1984). *Glossolalia* is most commonly practiced in Christian groups, but it also has been documented in a few other religious sects and traditions (Goodman, 1972; Kavan, 2004).

Participating delegates structured this new denomination to unite local Pentecostal assemblies while leaving each congregation self-governing and self-supporting. This decentralized structure survives to the present and is well known for its vehement defense of the sovereignty of local congregations. The administrative structure of AG expanded rapidly in the years leading up to the Second World War with a growing network of new agencies undertaking publishing, missionary, educational, pastoral and social responsibilities.[15]

Overcoming past rifts with other denominations, AG engaged in closer cooperation with evangelical Protestant churches in the postwar years. AG representatives attended the 1942 St. Louis meeting that formed the National Association of Evangelicals, with which the 1943 General Council of the Assemblies of God voted to affiliate. In order to consolidate its alignment with the nascent Evangelical coalition, AG engaged in greater cooperation with other Christian groups on issues of moral and social concern. Societal acceptance of AG has been evidenced by the emergence of its members onto the public stage. Some of the best known members of AG include Elvis Presley, James Watt (the Secretary of the Interior in the first Reagan administration), Shawntel Smith (the 1996 Miss America) and John Ashcroft (former U.S. Senator and Attorney General).

Core Doctrines

AG adopted its official statement of faith in 1918, four years after the Hot Springs conference. It remains a list of 16 simple beliefs, four of which are now considered by AG leadership as "defining truths":[16]

1. **Salvation through Christ**. All human beings have sinned and are alienated from their Creator. By sacrificing His son Jesus on the cross, God has extended his gracious forgiveness to all those who trust in him. And it is to this merciful God that humans are expected to respond in repentance and faith. By entering into a relationship with

God, a person lives in a new reality of hope and eternal life.

2. **Divine healing**. God's salvation entails not only the spiritual restoration of sinners but also the physical healing of the sick. Illness and suffering are signs and consequences of humans' fallen existence, and God is concerned for the well-being of his followers. Miraculous healing occurs because of God's merciful response to prayer.

3. **Baptism in the Holy Spirit**. Baptism is seen as a special work of the Holy Spirit beyond salvation and demonstrated by the initial physical sign of "speaking in tongues." With this vital experience of the Christian life, which often is accompanied by altered states of consciousness,[17] comes the empowerment for Christian witness and specific spiritual gifts for more effective ministry.

4. **The second coming of Christ**. Jesus will return to fulfill his redemptive work in two phases, separated by a time of severe judgment upon the sinful world. The first phase will be his covert coming to take the church out of the world. All Christians who have died will rise from their graves and those who are still alive will join them to be with Christ. A great tribulation will follow this first phase and this wrathful judgment from God will inflict unspeakable pains to the sinful and rebellious world. The second phase of Christ's return will be visible and imposing; he will begin a peaceful, prosperous and righteous reign for 1,000 years. This millennial kingdom will culminate in a final battle against Satan, who eventually will be defeated and subdued.[18]

These four pillars of AG's Christian faith give its members a distinctive identity amidst the diversity and fluidity of the American religious landscape. The insistence on the primacy of Jesus Christ in matters of salvation and hope puts AG squarely within the camp of Evangelical Christians, whereas the emphasis on divine healing and the baptism of the Holy Spirit casts them as postmodern mystics firmly anchored in ancient scriptural teachings.

Organizational Structure

AG is considered a cooperative fellowship in which each local congregation is a self-governing and self-supporting "assembly." Every General Council-affiliated congregation has the right to select its own pastor and elect its own officers as well as the power to discipline its members and sanction the pastor.[*] It also is responsible for its property holdings and financial transactions. The General Council is not involved in running the local congregations.

Beyond local congregations, the fellowship of AG is divided into 57 districts. Each district is headed by a District Council and has the power to ordain ministers, establish new churches and provide monetary aid or other resources for the congregations within its jurisdiction.

All ordained ministers within AG churches are members of the General Council and every church is represented by a delegate in the Council. According to AG, "The national headquarters operation exists primarily as a service organization - providing educational curriculum, organizing the missions programs, credentialing ministers, overseeing the church's colleges and seminary, producing communication channels for the churched and non-churched publics, and providing leadership for many national programs and ministries."[19]

Teen Challenge

AG's rise in addiction ministry began in 1957 with David Wilkerson, a then unknown AG minister from rural Pennsylvania.[20] One night, Wilkerson was sitting in his study reading *Life*

[*] There is another group of less autonomous member churches called district-affiliated churches. These usually are newly-established assemblies that have not reached the point where they qualify for full autonomy. Of the 12,298 local churches recorded in 2005, 6,868 (56 percent) were General Council-affiliated assemblies and 5,430 (44 percent) were district-affiliated assemblies (AG, 2006).

magazine and was struck by a pen drawing of seven New York City teenage boys on trial for a brutal murder of a young polio patient. Painfully torn between revulsion and compassion, the young Wilkerson left the mountain town of Philipsburg and traveled to New York City. He spent the next year listening and talking to hundreds of gang members in the streets of Manhattan, the Bronx and Brooklyn.

As a result of his encounters with these troubled youth, Wilkerson envisioned a safe haven for alcoholics, illicit drug addicts and gang members where their lives could be transformed through a ministry of mercy, conversion and discipleship. Teen Challenge was launched in 1958 from a small office in Staten Island, New York City. Wilkerson reached out to gang leaders and members through private visits and evangelistic rallies on "gang turf." In 1960, the Teen Challenge headquarters relocated to a large building in Brooklyn, where protection, beds and shelter were provided to homeless youth with problems of substance abuse, addiction and delinquency.

Teen Challenge was incorporated in 1961 as a not-for-profit religious entity, administered by an executive board formed by local AG ministers and advised by a board of professional consultants. During the ministry's first years of operation, it was supported financially by 65 Spanish-speaking AG congregations. But as the reputation and influence of the ministry grew, donations from a broader group of AG churches, other denominations, corporations and philanthropists increased.[21]

By the early 1970s, Teen Challenge emerged as a major player in the nascent substance abuse treatment system. It began to serve adults as well. By 2007, Teen Challenge was a network of 185 relatively autonomous AG-sponsored treatment centers coordinated by a national office in Springfield, Missouri, whose jurisdiction includes the United States and Puerto Rico.

The Executive Director of Teen Challenge represents and speaks for the constituency of local Teen Challenge ministries and provides leadership by way of accreditation standards,[*] curriculum distribution and referral of people who need Teen Challenge's services, training and management assistance.[22]

Teen Challenge engages local congregations, including not only Pentecostal churches but Evangelical churches in general, at the grass-roots level. Anyone who applies to start a new chapter of Teen Challenge must obtain the endorsement from the senior minister of his or her own church. Local churches become natural partners of Teen Challenge centers in their areas.[23] An intimate connection with local congregations highlights a fundamental asset that has maintained the operation of so many Teen Challenge centers across the country over the past five decades--volunteerism. Teen Challenge centers--as care communities patterned after local congregations--make use of volunteers to teach classes, befriend their clients and make donations. At the same time, Teen Challenge centers encourage clients to volunteer project services that benefit local churches. This approach has helped the ministry to thrive and grow with very limited resources from government or the mainstream treatment community.

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[*] Officially, Teen Challenge's internal accreditation standards "have been developed for the purpose of providing a means to maintain the integrity and unity of the Teen Challenge ministries and to enable Teen Challenge to fulfill its purpose. The goals of accreditation are: (1) To ensure that the standards are a tool for facilitating quality and consistency in all Teen Challenge centers; (2) To ensure the sovereignty and local control of each Teen Challenge center with minimum restrictions which are implemented for the legal, ethical and spiritual well being of all; and (3) To assist in providing a measure of public acceptance and approval, hopefully assisting in the center's public relations and fund-raising efforts, through the awarding of accreditation." (Teen Challenge USA, 2008) As such, these accreditation standards might overlap but are not entirely consistent with those of governmental authorities which tend to be concerned with programs' compliance with mental health laws, credentialing requirements, staff qualifications and safety regulations (e.g., New York State Office of Alcoholism and Substance Abuse Services, 2008).

Given the administrative autonomy and financial independence of local Teen Challenge centers, the total size of the network's client population and annual budget is difficult to ascertain. It has been estimated that Teen Challenge local chapters provide approximately 5,000 beds for recovering substance abusers.[24] Assuming that all these 5,000 beds are fully utilized, and based on the official statistics that the cost of serving a typical Teen Challenge client averages between $900 and $1,100 per month,[*] [25] the estimated annual budget of the ministry is $54 million to $66 million a year.

Program Results

Being one of the first large networks of residential treatment programs serving substance abusers in the United States,[†] Teen Challenge and its services were recognized by the mental health establishment and federal agencies during the early formation of the substance abuse treatment system. The faith-based service provider was a core member of that emerging community.

In a 1972 task force report jointly commissioned by the American Psychiatric Association and the National Association for Mental Health, Teen Challenge was selected and studied as one of nine major treatment programs and modalities then available to the substance-abusing population.[26] When the National Institute on Drug Abuse (NIDA) was created the following year, the evaluation of Teen Challenge was one of the first treatment studies it sponsored.[27] This NIDA-funded evaluation, which was led by Catherine B. Hess, MD, and focused on all Teen Challenge clients admitted in 1968, reported a treatment completion rate of 18 percent for the cohort. This completion rate was comparable to the rate of 19 percent found for therapeutic communities--a residential treatment modality with some programmatic features similar to Teen Challenge--in the first national treatment study, Drug Abuse Reporting Program (DARP), conducted during the same time period.[‡] [28] Treatment graduates reported seven-year post-treatment rates of heroin and marijuana use of five percent and 13 percent respectively, as compared to 19 percent and 49 percent among program dropouts.[§] NIDA researchers concluded that the basic feature distinguishing Teen Challenge graduates from dropouts was the participants' ability to find a meaningful anchor in their religious experience and support in the community of believers.[**] However, the lack of a control group or random assignment--key ingredients of the scientific method--limited the conclusions that could be drawn from the findings regarding efficacy.

There has not been any other federally-funded research on Teen Challenge practices and outcomes since the 1974 NIDA evaluation. Although not demonstrated by the NIDA evaluation, Teen Challenge has referenced that evaluation as a basis for its claim of the superiority of its faith-based solution over other treatment modalities. Teen Challenge publications repeatedly maintain that its

[*] According to a recently released service cost study, non-hospital residential care (in non-AG institutions) has a mean per client cost of $76.13 per day or $2,314.35 per month (Substance Abuse and Mental Health Administration Services, 2004).

[†] The movement of therapeutic communities did not catch on until the 1960s and dominated the field of residential treatment in the 1970s, which was catalyzed by the creation of the membership association Therapeutic Communities of America in 1975 (De Leon, 2000; Kurth, 2003).

[‡] Like Teen Challenge centers, therapeutic communities are substance-free residential settings that use the communal living approach, comprised of treatment staff and those in recovery as key agents of change (De Leon, 2000). Addiction is seen as a "whole person" disorder that requires a holistic approach to treatment (Kurth, 2003).

[§] A more recent national study with a five-year follow-up of treatment outcomes found that 25 percent of the tracked treatment participants, including completers and dropouts, reported cocaine use (Simpson, Joe, & Broome, 2002).

[**] Program dropouts listed excessive religion, lack of medication and lack of outside contacts as their main complaints about their treatment experiences. Whereas there appeared to be no baseline differences in religiosity between graduates and dropouts, the former showed extensive religious involvement after treatment. Many graduates were attending or had completed theological training to become ministers at the time of the study.

graduates demonstrate a "cure rate" of 70 percent in the NIDA study as compared to the rates of 15 percent or lower among graduates of other treatment programs.[29] However, the NIDA study never reported a "cure rate" and no specific sources ever have been cited to document a "cure rate" of 15 percent or lower which Teen Challenge claims for other interventions.

Two small studies of Teen Challenge graduates by external evaluators were completed in the 1990s. The first was a mail survey of fewer than 30 male Teen Challenge graduates.[30] Study participants reported a post-completion employment rate of 72 percent and an abstinence rate of 67 percent, and 76 percent were not under any kind of criminal justice supervision.[31] While these performance measures were comparable to those reported for completers of long-term residential treatment in national studies,[32] the absence of drug testing significantly reduced the reliability of drug relapse information and the small sample size, the use of different follow-up time intervals and the lack of a control group severely restricted the ability to generalize the findings of the study. The second evaluation study tracked down 59 people one or two years after they had completed Teen Challenge's year-long residential program and contrasted them with completers of hospital-based short-term residential treatment that lasted between one or two months.[33] While Teen Challenge graduates showed much better results in most assessment categories, the failure to include treatment dropouts and the incomparability between a long-term residential treatment program and a short-term residential program made findings from the study inconclusive.[*]

A 1998 evaluation report by the U.S. General Accounting Office that reviewed the 1977 NIDA evaluation of Teen Challenge and other research on Teen Challenge and other religious interventions found that "faith-based strategies have yet to be rigorously examined by the research community."[34]

Church and State

Teen Challenge's focus on serving the needs of substance abusers remained undisturbed until 1995, when the Texas Commission on Alcohol and Drug Abuse threatened to revoke Teen Challenge San Antonio's license and to impose fines of up to $25,000 a day and imprisonment if the Christian ministry refused to become staffed with certified counselors or therapists and provide detoxification services.[35] At the heart of the controversy was a conflict of views on the definition of substance abuse and addiction. Whereas state officials sided with the scientific interpretation of addiction as essentially a brain disease, Teen Challenge contended that addiction basically is a matter of morality. By meeting state standards and reporting requirements, Teen Challenge would be forced to adopt the biological model of treatment favored by the state and the larger scientific community.[36]

Conservative figures such as Newt Gingrich and libertarian think tanks, such as the Washington DC-based Institute of Justice and the National Center for Neighborhood Enterprise, rallied around Teen Challenge's cause. But the most influential factor was former Governor George W. Bush. Governor Bush set up a task force to study the potential for alternative certification for faith-based social services, including substance abuse treatment, offender rehabilitation and childcare programs. This task force issued the written report *Faith in Action: A New Vision for Church-State Cooperation in*

[*] Despite this lack of conclusive or even strong evidence, some scholars have uncritically accepted findings from the three evaluation studies reviewed here at their face value. For example, Princeton sociologist Robert Wuthnow asserts in his treatise *Saving America? Faith-Based Services and the Future of Civil Society* that the high investment as reflected by its low clients-to-staff ratio "makes it possible for Teen Challenge to achieve a high rate of recovery among clients, but the same level would not be possible… at the many faith-based or nonsectarian organization that provide short-term services to larger numbers of clients" (2004: p. 173). Others also argue for Teen Challenge's superiority over other programs (e.g., Glenn, 2000). In reality, there is no empirical support for these claims.

Texas[*] that led to the passage of the 1997 legislation establishing an alternative certification system exempting faith-based programs from regular licensing regulations.[† ‡] [37]

Teen Challenge programs in Texas and 13 other states gained access to federal aid money in 2004 when President George W. Bush's Faith-Based and Community Initiatives allocated 100 million dollars to faith-based and community-based treatment providers through the Access to Recovery (ATR) voucher program, which allowed religious organizations receiving government money through ATR to use religious curriculum in treatment.[38] Debates have raged around the constitutionality of ATR as many civil liberty groups claim it violates the separation of church and state, while others are disturbed by funding services that do not meet state licensing requirements or medically sanctioned standards.[39]

Teen Challenge's forced return to the public spotlight intensified its contacts with government leaders and policymakers. In October 1997, Dave Batty, the executive director of Teen Challenge in Brooklyn, was invited by the House of Representatives to testify about the impact of substance abuse on families receiving welfare.[40] In May 2001, John Castellani, the national executive director of Teen Challenge, testified before a House Government Reform subcommittee on the efficacy of religious social service providers.

In April 2003, the year before ATR went into operation, John P. Walters, director of the White House Office of National Drug Control Policy, appointed Dennis Griffith, the director of Teen Challenge for Southern California, to serve on the White House Advisory Commission on Drug-Free Communities.[41] In July, 50 Teen Challenge directors met with Claude Allen, the deputy secretary of the Department of Health and Human Services (DHHS), and Robert Polito, director of DHHS's Center for Faith-Based and Community Initiatives to discuss ways the Christian rehabilitation program could obtain government funds.[42] Teen Challenge directors were given confusing, if not conflicting, guidelines. On the one hand they were guaranteed that funding decisions would be made on performance and effectiveness considerations only and that the faith-based approach would not be an issue. On the other hand, federal officials reminded Teen Challenge administrators that publicly funded vouchers could not be used to proselytize.[43] Four months later, Walters spoke at a Teen Challenge graduation in Riverside, California and congratulated Teen Challenge staff on their success in restoring substance abusers' lives.[44]

Closing the Religious-Scientific Divide

Interest in expanding our understanding of human nature and behavioral change has led a growing group of medical and psychological scientists to seek insights in major religious and spiritual traditions.[§ 45] Serious scientific

[*] This report was criticized "because the task force was almost exclusively made up of ministers who ran such programs, the question before it was never whether such changes should be made, but how." (Ratcliffe, 2001, p. 1)

[†] Faith-based recovery programs continue to be registered with the Texas Commission on Alcohol and Drug Abuse (TCADA) but are exempted from licensure. As of October 2007, there are 207 faith-based programs certified through this alternative system, five of which are Teen Challenge programs (TCADA, 2007).

[‡] In an official white paper, Teen Challenge officials asserted that the organization "is committed to the ongoing improvement of their facilities and staff training programs. They recognize the need to consider the meaning, value and significance of outside accreditation. Teen Challenge would like to resolve these licensing and credentialing issues in a manner that safeguards the integrity of their mission and objectives." (Petersen, 2001, p. 21)

[§] The American Psychological Association (APA) has played a key role in this emerging relationship between behavioral science and religion. The movement started in 1994, with an article in the *American Psychologist* urging clinicians and researchers to take religious teachings and experiences seriously (Jones, 1994). APA responded positively to this call by sponsoring the publication of three edited volumes exploring the faith-health linkage in mental health, including *Religion and the*

research on religious institutions and spiritual experiences also is gaining appeal with a wider audience. Even more importantly, funding programs within the National Institutes of Health--including the National Institute on Aging, the National Institute on Alcohol Abuse and Alcoholism and the National Center for Complementary and Alternative Medicine--began in the 1990s to support controlled studies with formal hypothesis testing in the area of spirituality, religion and health.[46]

In 2001, CASA released a groundbreaking report titled *So Help Me God: Substance Abuse, Religion and Spirituality*.[47] This two-year study concluded that religion and spirituality had enormous potential for lowering the risk of substance abuse among teens and adults and, when combined with professional treatment, for promoting recovery. The two most troubling findings of this report were: (1) that while clergy typically see substance abuse as a problem in their congregations, they generally lack the knowledge and training for dealing effectively with the problem; and (2) health care professionals generally fail to take advantage of the important role of religion and spirituality in recovery.

CASA also sponsored two widely acclaimed conferences under the same name in September 2003 and September 2004. The conferences, through panel discussions and keynote addresses, covered the roles of religion and spirituality in substance abuse treatment and prevention, the training of clergy and treatment providers, substance abuse in the clergy and the underlying mechanisms (neurological, sociological and familial) of substance abuse, religion and spirituality. They also encouraged the religious and medical communities to work together to prevent and treat substance abuse and addiction.

Teen Challenge also has participated in this religion-science dialogue. For example, in October 2002, John Castellani, Teen Challenge's national executive director, was invited to speak at a conference on the scientific research on spiritual transformation sponsored by the Metanexus Institute.[48] Among his panelists and listeners were top medical and social scientists from the most prestigious universities of the country.

The research presented in this report, supported by a grant from the Louisville Institute, is a continuation of CASA's interests in the linkage between scientific inquiry and the religious dimensions of recovery and represents another attempt at meaningful dialogue between Teen Challenge and the research community. The hope is that such interactions can serve as platforms to foster fruitful exchanges between the faith-based treatment community and the mainstream treatment system remains.

Clinical Practice of Religion (Shafranske, 1996), *Integrating Spirituality into Treatment: Resources for Practitioners* (Miller, 1999), and *Judeo-Christian Perspectives on Psychology* (Miller & Delaney, 2005). Also, the American Society of Addiction Medicine always has included discussions about membership in inspirational groups, spirituality and prayer as alternative pathways to recovery in its authoritative treatise *Principles of Addiction Medicine* (Graham, Schultz, Mayo-Smith, Ries, & Wilford, 2003). Of course, referring to spiritual and/or faith-based approaches as 'alternatives' also suggests that these methods are not seen as part of the mainstream.

Chapter III
Teen Challenge vs. Secular Treatment Models: Findings from CASA's Surveys of Providers

To better understand the approach taken by Teen Challenge to addressing the substance abuse problems of its clients, and to compare its approach with that taken by non-AG treatment providers, CASA surveyed three groups of individuals over an eight-month period in 2006-2007: 35 professors of behavioral science from AG institutions of higher education; administrators of substance abuse treatment facilities (21 from AG programs and 17 from non-AG long-term residential treatment programs); and substance abuse counselors (58 from AG programs and 51 from non-AG long-term residential treatment programs).

The AG sample of professors of behavioral sciences and human services was randomly selected from the 19 institutions of higher education affiliated with the Assemblies of God; that of the non-AG professors was randomly selected from a pool of full-time professors listed in the directories of the Consortium of Liberal Arts Colleges and the Council of Public Liberal Arts Colleges.[*] The AG administrators and counselors were randomly selected from the 2006 Directory of Teen Challenge Facilities. Administrators of treatment facilities and substance abuse counselors from the non-AG comparison programs were randomly selected from the 2005 National Directory of Drug and Alcohol Abuse Treatment Programs, published by the Substance Abuse and Mental Health Services Administration.[†] To provide an additional source of comparison to the non-AG

[*] None of the 19 AG-affiliated institutions of higher education is listed in these two directories of liberal arts colleges.

[†] The SAMHSA directory does not indicate whether a program is faith-based. However, programs drawn from the directory that clearly were supported by religious organizations (e.g., Salvation Army, Catholic Charities) were excluded from the comparison sample. It remains possible, however, that some of the programs in the comparison sample are faith-based or have faith-based elements.

sample, we provide throughout this report comparable national statistics from two datasets: one of long-term residential treatment programs, some of which employ the therapeutic community model (the Drug Abuse Treatment Outcome Study) and one that includes only therapeutic community programs. (See Appendix A for details about the study's methodology and Appendices B, C and D for the consent forms and survey instruments used with each group of respondents.)

The goals of CASA's survey were to examine the perspectives of Teen Challenge providers, relative to non-AG providers, on substance abuse and how best to treat it and to understand the structural capacity of Teen Challenge programs, the characteristics of the population it serves, the range of services offered and used and the characteristics of its staff. CASA also compared the perspectives of Teen Challenge staff to that of other members of the AG community, specifically professors in the behavioral sciences--psychology, counseling, sociology, social work, practical theology--from AG-affiliated institutions of higher education.

Perspectives on Substance Abuse and Treatment

All treatment interventions are based on certain assumptions about the causes of substance abuse and addiction, human nature, free will and responsibility, and how various life factors can be altered to enhance the likelihood of recovery. Treatment philosophies of service providers not only determine what interventions are chosen and how the staff is recruited but also can influence how well the therapeutic approach matches the needs of clients.[49]

Our survey findings indicate that AG administrators and counselors have decidedly different views than non-AG treatment providers on human nature and morality, the causes of substance abuse, the role of science in addiction and its treatment and the larger issue of drug policy.

Perspectives on Human Nature and Morality

Whereas AG treatment providers conceive of human nature essentially as perverse and corrupt (82.4 percent vs. 16.4 percent of non-AG providers), most non-AG respondents perceive human nature to basically be good (86.6 percent vs. 22.1 percent of AG providers). Virtually no administrator and counselor respondents from either of the two groups accept the fatalistic belief that there is little that people can do to change the course of their lives (2.9 percent of AG respondents and 1.5 percent of non-AG respondents). These beliefs are consistent with the Pentecostal theology traditionally expounded by AG that God has given humans free will, and that humans are able to freely choose or reject salvation.[*] [50]

Although both groups unanimously disagree with the statement "life does not serve any purpose" (98.3 percent of AG respondents and 100 percent of non-AG respondents), AG and non-AG administrators and counselors differ considerably in their interpretations of life's purpose and meaning. AG respondents are less likely than non-AG respondents to agree or strongly agree that life only is meaningful if one provides the meaning oneself (10.1 percent vs. 39.7 percent). AG respondents are almost twice as likely as non-AG respondents to believe that life is meaningful only because God exists (92.9 percent vs. 47.1 percent). This finding is not particularly surprising given that the most popular approach to recovery in the U.S. has been the 12-step model[51] in which recovery is thought to result in part from relying on the will of a Higher Power. More importantly, a growing body of research attests to the fact that the process of recovery is experienced by many as a deeply spiritual journey.[52]

[*] Although this teaching, known as Arminianism, is not generally preached from the pulpit, it is evident by AG's philosophy of missions. Charismatic Evangelicals see mission work or religious proselytism as crucial because all human beings can make the decision to receive or reject God's salvation in Christ.

Only one-quarter (26.1 percent) of the Teen Challenge respondents (vs. 75.0 percent of the non-AG respondents) agree or strongly agree with the statement that "right and wrong are not a simple matter of black and white, there are many shades of gray." AG respondents are twice as likely as non-AG respondents to agree or strongly agree that "right and wrong should be based on God's laws" (100 percent vs. 52.2 percent). And, more non-AG respondents than AG respondents believe that "morality is a personal matter and society should not force everyone to follow one standard" (76.5 percent vs. 42.4 percent).

More AG than non-AG respondents agree or strongly agree that they feel a deep sense of responsibility for reducing pain and suffering in the world (86.2 percent vs. 66.7 percent). Sympathy for the plight of others and the willingness to improve the fortune of the downtrodden were common sentiments among substance abuse counselors from both groups who, for the most part, were former substance abusers. (See Figure 1)

Perspectives on the Causes of Substance Abuse and Addiction

When asked to rank 12 factors thought to lead to substance abuse and addiction that are addressed in various treatment approaches,[*] [53] the top two ranked factors among AG administrators and counselors are that substance abuse "is a consequence of separation from God" and "caused by a lack of meaning and purpose in life." The two lowest ranked factors among AG respondents are that substance abuse "is a brain disease" and "people are genetically predisposed to drug use." In contrast, the non-AG group ranks the neurological and genetic explanations as the top two factors leading to substance abuse and addiction.[†] (See Figure 2)

Perspectives on Science

AG administrators and counselors have a stronger inclination to search for insights and guidance outside science and are relatively more suspicious of or less confident in science than non-AG treatment providers. Nevertheless, there is a broad consensus among most AG and non-AG respondents that, in matters of substance abuse treatment, religion and science address different needs and that cooperation between adherents to each perspective is most fruitful.

Nearly half of the non-AG (49.2 percent) and AG (44.1 percent) counselors and administrators believe that science and religion are complementary tools in substance abuse treatment. Yet significantly more AG respondents than non-AG respondents believe that conflict best characterizes the relationship between science and religion in substance abuse treatment (25.0 percent vs. 10.8 percent); nearly one in four (23.5 percent) AG respondents considers himself to be on the side of religion in this clash. Nevertheless, the overwhelming majority of non-AG respondents (89.2 percent) and AG respondents (75.0 percent) disavow this imagery of battle or struggle.

Eighty-one percent of AG respondents and 58.2 percent of non-AG respondents think that society too often adheres to science and not enough to feelings and faith. AG respondents are likelier than non-AG respondents to agree or to strongly agree with the statements "modern science does more harm than good" (20.6 percent vs. 7.5 percent) and "sciences breaks down people's ideas of right and wrong" (44.1 percent vs. 16.2 percent). No AG respondents agreed with the evolutionary interpretation of human origin; 40.3 percent of non-AG respondents agree that "human beings evolved from other species of animals."

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[*] Respondents were asked to rank the items from 1 (the most important) to 12 the (least important), such that the lower the score, the greater the perceived importance of the factor in leading to substance abuse.

[†] The explanation that substance abuse is a learned behavior also was highly ranked among non-AG respondents, but the ranking for this factor was similar to that of the AG respondents (average ranking of 4.8 vs. 5.2).

While only a small group of respondents from both groups agree or strongly agree that science is capable of solving social problems like crime and substance abuse, more non-AG respondents than AG respondents agree with this position (16.4 percent vs. 2.9 percent). (See Figure 3)

Views on Drug Policy

More non-AG administrators and counselors than AG administrators and counselors support increased governmental spending on substance abuse treatment generally (88.1 percent vs. 60.6 percent). More AG respondents than non-AG respondents support the allocation of public money to faith-based treatment programs (89.6 percent vs. 63.6 percent). Openness to and proactive search for public funding are very recent developments for Teen Challenge; its own pre-2000 publications emphasized the importance of its financial independence from governmental assistance.[54]

Whereas 69.2 percent of non-AG respondents favor less government spending in incarceration of drug offenders, most AG respondents (72.1 percent) want the government to spend the same amount or more money to incarcerate drug offenders.

AG respondents are likelier than non-AG respondents to oppose the legalization of medical use of marijuana (92.2 percent vs. 46.3 percent). Virtually all AG respondents (98.5 percent) and 89.7 percent of the non-AG respondents believe that marijuana should not be legalized under any circumstance.

Significantly more non-AG respondents than AG respondents favor publicly funded needle or syringe exchange programs to prevent the spread of HIV infections among drug injectors (75.8 percent vs. 28.1 percent). (See Figure 4)

Views on Treatment Approaches

When ranking therapeutic goals, AG respondents rank clients' spiritual or religious needs and their self-control and discipline skills as the two most important areas for treatment intervention. At the same time, they perceive pharmacological strategies and advocacy/ empowerment as the least important of the 10 suggested interventions. These findings are consistent with Teen Challenge's faith-based approach promoted by the ministry.[55]

Non-AG respondents identify the development of a positive self-concept and the enhancement of stress management skills as the top treatment priorities, and consider the use of pharmacological interventions and addressing antisocial personality issues to be less important tools.[*] Non-AG respondents ranked addressing clients' spiritual or religious needs as moderately important.

Both groups emphasize the necessity of building a healthy self-concept, the need for vocational and educational training and the value of a positive rapport between counselors and clients. Each of these coincides with the goals of regular residential treatment.[56] (See Figure 5)

Structural Capacity[†]

AG treatment facilities tend to have fewer beds, process fewer cases and to be staffed with fewer personnel than non-AG treatment facilities. AG facilities have a lower average maximum residential capacity than non-AG facilities (44.9 beds vs. 57.5 beds) and a lower average past-year intake of new admissions (74.9 vs. 239.0). AG facilities, on average, also have fewer full-time or part-time therapists/counselors (2.6 vs.

[*] This finding suggests that while the role of biological and genetic factors in the determination of substance addiction has been widely accepted by secular treatment providers, it has had only limited implications for the way in which treatment services are delivered within residential treatment programs, where the treatment approach has remained largely psychosocially oriented.

[†] Treatment administrators were asked to provide information on structural capacity, the treatment population and clinical practice (see findings presented on pages 18-20). However, due to the limited sample size of administrators and missing data, significance tests were omitted from these analyses. Therefore, findings presented in this section are suggestive but should be interpreted with caution.

7.3), fewer full-time or part-time employees (15.6 vs. 25.2) and, as such, a larger residential client-to-full-time or part-time therapist/ counselor ratio (13.5 clients per therapist/ counselor vs. 8.5 clients per therapist/ counselor).[*] The average length of time between being placed on the waiting list and treatment admission in AG programs is about a quarter of the time of non-AG programs (5.9 days vs. 22.6 days).[†]

On average, Teen Challenge clients are expected to complete nearly 12 months of treatment and a typical client completes about nine months (76.3 percent of the required length). In contrast, clients from non-AG programs are expected to stay in treatment for an average of 7.5 months and a typical client remains in treatment for about 5.4 months (71.3 percent of the required length).[‡] (See Figure 6)

Treatment Population

AG and non-AG programs serve different substance-abusing populations. Whereas client characteristics reported for non-AG programs closely resemble those found among clients of long-term residential treatment programs in major national studies, Teen Challenge clients are younger than non-AG clients, much likelier to be employed (22.9 percent vs. 4.3 percent) and less likely to be HIV-positive (2.2 percent vs. 9.9 percent).

AG and non-AG programs are equally likely to serve male (67.1 percent vs. 67.6 percent) and female (32.8 percent vs. 32.5 percent) clients and to have single sex facilities. AG programs, relative to non-AG programs, have a higher proportion of white (78.6 percent vs. 68.5 percent) and Hispanic (7.1 percent vs. 4.2 percent) clients. AG programs have a smaller proportion of black clients than non-AG programs (10.9 percent vs. 25.3 percent).[§]

AG programs are far likelier than non-AG programs to receive clients referred by family members (38.3 percent vs. 0.6 percent), friends (11.7 percent vs. 0.6 percent) and school or employers (4.9 percent vs. 0.4 percent). They are less likely than non-AG programs to receive referrals from criminal justice agencies (22.3 percent vs. 41.0 percent), physicians or hospitals (4.3 percent vs. 15.8 percent) and other substance abuse treatment programs (0.1 percent vs. 20.6 percent). The top three sources of referral for AG programs are family members (38.3 percent), criminal justice agencies (22.3 percent) and self-referral (18.3 percent) as compared to criminal justice agencies[**] (41.0 percent), self-referral (21.0 percent) and other treatment programs (20.6 percent) for non-AG programs. (See Figure 7)

Clinical Practice

To understand the range of services offered and used, CASA surveyed treatment administrators for information on service availability and surveyed counselors for information on a typical client's weekly participation in the various services offered at a facility.

[*] The observed averages of 7.3 counselors and 25.2 total employees per facility for non-AG treatment programs in this study are similar to the national averages of 11 counselors and 30.4 total employees per facility reported for therapeutic communities in a recent NIDA survey (Institute for Behavioral Research, 2005).

[†] The national average waiting period for clients of long-term residential treatment programs is 20.6 days (Substance Abuse and Mental Health Services Administration, 2006).

[‡] The National Treatment Center Study reported an average retention rate of 60.5 percent for clients admitted to therapeutic communities (Institute for Behavioral Research, 2005).

[§] The rate of black clients of 25.3 percent recorded for non-AG programs is similar to the 27.9 percent reported for long-term residential treatment programs in the 2005 Treatment Episodes Data Set study (Substance Abuse and Mental Health Services Administration, 2006).

[**] The criminal justice system constitutes the largest source of referral (40. 7 percent) for therapeutic communities in the country, followed by social service agencies (21.6 percent) (Institute for Behavioral Research, 2005).

Services Offered

CASA identified 18 treatment-related services offered at substance abuse treatment programs nationally.[*] The range of services typically provided at AG treatment programs is considerably narrower than that provided at non-AG programs.

Of those programs offered onsite, several services or interventions are likelier to be available at AG programs than at non-AG programs: Bible classes (100.0 percent vs. 35.3 percent), prayer meetings (100.0 percent vs. 29.4 percent) and vocational training (57.1 percent vs. 35.3 percent). Also, AG programs are likelier to offer services[†] to criminal offenders (81.0 percent vs. 64.7 percent).

Services less likely to be available at AG programs than at non-AG programs include: individual psychotherapy (0.0 percent vs. 41.2 percent), group psychotherapy (0.0 percent vs. 35.3 percent), psychiatric assessment (0.0 percent vs. 23.5 percent), primary medical care (0.0 percent vs. 23.5), legal counseling (0.0 percent vs. 5.9 percent), medical examination (4.8 percent vs. 37.5 percent), 12-step recovery programs (5.3 percent vs. 82.4 percent), tuberculosis testing (9.5 percent vs. 35.3 percent), services for pregnant women (10.0 percent vs. 18.8 percent), HIV counseling (19.0 percent vs. 35.3 percent) and HIV testing (19.0 percent vs. 29.4 percent).[‡] (See Figure 8A)

Because not all services are offered onsite, CASA explored the extent to which programs contracted with other providers for additional services. AG programs are less likely than non-AG programs to offer off-site services for the majority of the 18 service categories. This may be because the interaction between Teen Challenge and its environment largely is restricted to local Christian churches and some community institutions such as schools.[57] (See Figure 8B)

Services Used

On average, Teen Challenge clients spend many more hours per week than non-AG clients in vocational training (11.1 vs. 6.6.), academic education (9.8 vs. 5.3), religious services (9.0 vs. 1.0) and Bible classes (11.1 vs. 0.7). Clients treated in non-AG programs, in contrast, spend more hours per week than Teen Challenge clients in group counseling sessions[§] (5.5 vs. 2.8). Clients from both types of programs spend the same amount of time in individual counseling sessions (1.6 hours per week). (See Figure 9)

Treatment Providers

Job Qualifications and Caseloads

AG counselors are less likely to be licensed or certified by state agencies than non-AG counselors (17.2 percent vs. 72.0 percent),[**] and

[*] Administrators were shown a list of 45 treatment interventions and asked to identify which services were offered at their facility. They also were asked to indicate whether available services were offered on-site or off-site. Findings concerning the 18 services that were most widely provided are reported. It is important to note that this analysis focused solely on service availability and not on the intensity or efficacy of delivered services.

[†] The specific types of serviced offered are not specified.

[‡] There is a strong belief among conservative Evangelicals that secular psychotherapy should be completely abandoned and that efforts should be devoted to the development of a Christian counseling guided by the standards of the Bible alone (e.g., Powlison, 2003). Therefore, although no Teen Challenge site offered individual and/or group psychotherapy, Teen Challenge counselors reported that individual and group counseling sessions, of a religious rather than secular psychotherapeutic nature, are routine activities in their programs.

[§] Counseling for non-AG programs mostly is of a psychotherapeutic nature whereas counseling for Teen Challenge programs mostly consists of religious-based counseling.

[**] On average, nearly half (46.9 percent) of the counselors working in therapeutic communities in the U.S. are certified or licensed counselors (Institute for Behavioral Research, 2005). However, there is enormous variation across facilities. In 20 percent of therapeutic communities, all employed counselors are licensed, while 16.9 percent of therapeutic communities employ no licensed counselors.

have spent somewhat less time working in the field of addiction counseling (average of 80.9 months vs. 95.9 months). AG counselors and non-AG counselors are equally likely to have been in recovery from substance abuse (75.4 percent vs. 76.5 percent) and report serving in their present positions or counseling at the same facility for similar amounts of time (55.5 months vs. 51.5 months). Findings regarding the average caseload per counselor as reported by AG treatment administrators versus counselors were inconsistent. The average caseload for AG programs, as reported by treatment administrators, is half the rate reported for non-AG programs (6.3 vs. 12.0 clients per counselor). Yet, the average caseload reported by AG counselors is slightly higher than that of non-AG programs (15.1 vs. 12.0 clients per counselor).[*] (See Figure 10A)

CASA asked counselors to identify the most important contributors to the development of their skills as counselors. Nearly half of AG and non-AG counselors rank their experience as a recovering substance abuser as the most important asset to their professional development (45.6 percent vs. 40.8 percent), followed by their previous or present job experience as a counselor (43.9 percent vs. 38.8 percent). Relatively few counselors choose formal schooling (7.0 percent vs. 10.2 percent) or substance abuse counseling training (3.5 percent vs. 10.2 percent) as the important elements in developing their counseling skills. (See Figure 10B)

The vast majority of both AG counselors and non-AG counselors believe that they have the skills and confidence needed to conduct effective counseling (96.5 percent vs. 98.0 percent) and that they are satisfied or very satisfied with the work they do (94.8 percent vs. 98.0 percent).

Demographic Characteristics

AG substance abuse counselors are likelier than non-AG counselors to be male (60.3 percent vs. 49.0 percent), younger (40.6 years vs. 48.4 years) and to have a highest educational attainment of a high school diploma or less (37.9 percent vs. 7.8 percent). Only 32.8 percent of AG counselors report having a bachelor's degree or higher compared to 52.9 percent of non-AG counselors.[†] AG counselors also are less likely than non-AG counselors to be white (65.5 percent vs. 74.5 percent). (See Figure 11)

Religious Profile

More AG counselors than non-AG counselors describe themselves as very religious (82.5 percent vs. 51.0 percent). However, 95.4 percent of all the counselor respondents describe themselves as moderately or very religious (100 percent of Teen Challenge and 90 percent of non-AG respondents). Whereas 91.4 percent of AG counselors report attending church services at least once a week, only 25.5 percent of non-AG counselors attend church that frequently. Nearly all AG counselors (98.2 percent) engage in Bible reading at least once a week as compared to 35.3 percent of non-AG counselors. And virtually all (98.3 percent) AG counselors have practiced religious proselytism at some point in their lives compared to slightly more than half (53.3 percent) of the non-AG counselors. AG counselors also are likelier than non-AG counselors to report having looked to God for help frequently or very frequently (100 percent vs. 86.3 percent) and to have had the

[*] The average self-reported caseload by Teen Challenge counselors of 15.1 clients per counselor is statistically indistinguishable from the caseload reported by counselors from non-AG programs. But the discrepancy between reports of AG administrators vs. counselors could have resulted from differential sampling as the 12 Teen Challenge administrators and the 58 Teen Challenge counselors were drawn from different samples.

[†] Although the educational categories used in our survey are different from those used in the National Treatment Center Study, it still is valid to conclude that counselors from non-AG programs have an educational attainment level closer to the national average. About 29.0 percent of counselors employed at therapeutic communities hold a master's degree or higher and 71.0 percent have a bachelor's degree or lower (Institute for Behavioral Research, 2005).

experience of being "born again" (98.3 percent vs. 66.7 percent).[*] (See Figure 12)

Variations in Beliefs Within the Assemblies of God Community

Despite their visibility and influence, AG administrators and counselors are not the only substance abuse experts within the AG community. Numerous social and behavioral scientists with doctoral degrees from major state universities now teach at the 19 colleges, universities and seminaries affiliated with the Assemblies of God. Most of the higher education institutions are small liberal arts institutions accredited by regional associations of colleges and universities. The student enrollment in these schools surpassed 15,000 in 2004 and continues to grow.[58]

AG institutions of higher education prepare students to become licensed psychologists, certified social workers and credentialed school counselors. Specialized degree programs in addiction studies also have been established to train future substance abuse counselors. One such curriculum, the Addiction Studies program at Bethany University, is designed to meet the licensing requirements of the California Association of Alcohol and Drug Abuse Counselors and program majors are required to complete California's Certification Program in Addiction Counseling.

Faculty members from AG institutions of higher education frequently present seminars on counseling skills, case management and other intervention techniques to AG staff at its regional conferences.[59]

As part of this study, CASA compared the religious profiles and worldviews of AG professors of sociology, psychology, social work and practical theology--because of their increasing interaction with the Teen Challenge ministry[60]--with those of Teen Challenge staff.

Religious Profile

The religious profile of professors from AG colleges is virtually indistinguishable from that of AG counselors, despite the obvious differences in their academic training. AG counselors are about as likely as AG professors to see themselves as very religious (82.5 percent vs. 94.1 percent), to attend religious services at least once a week (91.4 percent for both groups), to have tried to convert others to Christianity (98.2 percent vs. 94.3 percent), to frequently look to God for help (100.0 percent vs. 97.1 percent) and to have had the experience of being "born again" (98.3 percent vs. 97.1 percent).[†] The only statistically significant difference was that 98.3 percent of AG counselors report reading the Bible at least once a week compared to 88.3 percent of AG professors. (See Figure 13)

Perspectives on Human Nature and Morality

AG professors and AG treatment administrators and substance abuse counselors tended to have similar beliefs about human nature and morality. However, although virtually all AG respondents accept that morality should be based on God's laws, AG administrators (4.8 percent) and counselors (29.8 percent) are less likely than AG professors (81.3 percent) to believe that "right and wrong are not a simple matter of black and white; there are many shades of gray." (See Figure 14)

Perspectives on the Causes of Substance Abuse and Addiction

When asked to rank 12 causal explanations of substance abuse and addiction on a scale of 1 (most relevant) to 12 (least relevant), AG professors are significantly less likely than AG administrators and counselors to attribute substance abuse to separation from God

[*] A 2006 Gallup poll found that 43 percent of American adults call themselves 'born again'; the rate is considerably lower than the 66.7 reported by counselors from non-AG programs in this study (Gallup Poll, 2006).

[†] These differences are not statistically significant.

(average ranking of 5.4 vs. 2.1 and 3.2) and more likely to attribute substance abuse to a genetic disposition (average ranking of 6.9 vs. 9.2 and 8.3). (See Figure 15)

Perspectives on Science

Despite a few important commonalities, science is the issue that most clearly separates AG college professors from AG treatment program staff. Being members of both the scientific and faith communities, AG college professors seemed to have developed a more accepting attitude toward science than their Teen Challenge peers.

AG professors unanimously disagree with the idea that "modern science does more harm than good," whereas 19.0 percent of AG administrators and 21.4 percent of AG counselors accept this statement. AG professors are less likely than AG administrators and counselors to agree or strongly agree with the statement "science breaks down people's ideas of right and wrong" (17.1 percent vs. 42.9 percent vs. 44.6 percent). AG college professors also are less likely than AG administrators and counselors to perceive science and religion to be in conflict (11.4 percent vs. 40.0 percent vs. 22.9 percent), and are more likely to see science and religion as complementary (74.3 percent vs. 40.0 percent vs. 45.6 percent). (See Figure 16) While the concept of biological evolution appears to be anathema to all AG administrators and counselors (100 percent rejection rate), 11.4 percent of AG professors agree or strongly agree with the assertion that human beings evolved from other species of animals.

Views on Drug Policy

AG professors and AG administrators and counselors are similarly supportive of the government funding faith-based treatment programs (90.9 percent vs. 94.7 percent vs. 89.5 percent). Yet, although the majority of all AG respondents are against legalizing marijuana for any purpose--including medical use, AG professors are likelier than AG administrators and counselors to support the legalization of the medical use of marijuana (41.4 percent vs. 5.9 percent vs. 9.8 percent, respectively) and to support legalizing all uses of marijuana (13.8 percent vs. 0.0 percent vs. 1.9 percent). (See Figure 17)

Views on Treatment Approaches

Spiritual needs and self-control/discipline are identified by AG professors as well as AG administrators and counselors as the top priority areas that treatment should address. Yet AG professors are likelier than AG administrators or counselors to rank stress reduction (average ranking of 4.1 vs. 6.4 and 5.1) and the therapeutic role of medication (average ranking of 6.4 vs. 9.1 and 8.1) as important treatment approaches. (See Figure 18)

Teen Challenge and its Institutional Contexts

Delivering faith-based treatment services requires a balance between providing the right interventions to the right people on the one hand and preserving and enriching the faith's religious identity on the other hand. It involves proposing a coherent theoretical framework and developing a set of clinical practices that is consistent with the therapeutic theory and religious faith. Obviously, the key to success depends both on the internal integrity of the organization and the external networking of services, resources and information. Findings from CASA's surveys as well as interviews with key AG leaders show that, over the years, Teen Challenge has had to attune its interactions with three major institutional contexts: the state environment, the treatment environment and the faith environment. The type and strength of the ties established with each of these institutional environments either have facilitated or undermined the flow of legal, political, financial, informational and client resources to Teen Challenge, which in turn has influenced its ability to carry out its stated mission of helping substance abusers. (See Figure 19)

The State Environment

The state environment is composed of federal, state and local agencies bearing the responsibility of regulating and supporting substance abuse treatment. Teen Challenge had kept itself off of state regulatory and funding agencies' radar screens in its first three decades of operations. Local chapters of Teen Challenge adopted a congregational approach characterized by administrative autonomy and financial independence; they sought neither government recognition nor public funding.

The catalyst of change was the 1995 certification controversy in Texas in which the Texas Commission on Alcohol and Drug Abuse required that the Christian ministry become staffed with certified counselors or therapists and provide detoxification services if needed. This event profoundly transformed the relationship of the recovery ministry to the government, first at the state level and then at the federal level after the election of former Texas Governor George W. Bush as President of the United States. Bush intervened on behalf of Teen Challenge to exempt faith-based programs from regular licensing regulations, and to secure the continuation of its operations in Texas, and furthered the cause of Teen Challenge by promoting his Faith-Based and Community Initiatives with Teen Challenge showcased as the prototype of religious social services deserving government support.[61]

A different branch of the state has been a silent but fundamental ally of Teen Challenge. According to surveyed administrators, clients referred by criminal justice agencies represent one-fifth (22.3 percent) of Teen Challenge's treatment population. The criminal justice system has become the only state institution of significance that maintains substantive exchanges with many local chapters of the ministry.

The Treatment Environment

The treatment environment refers to service providers who make clinical interventions available and treatment researchers who study and evaluate these interventions. The Christian ministry was very much at the center of the budding treatment-evaluation network in the 1970s. Teen Challenge was well known within the small circle of substance abuse providers that existed at that time and became one of the first treatment programs to be evaluated scientifically by the newly created National Institute on Drug Abuse. But gradually, as Teen Challenge became convinced that it was producing much better results than other treatment models, the ministry parted ways with the treatment-evaluation community. The level of involvement with other service programs, treatment researchers and regulatory authorities varies enormously from center to center.

CASA's survey findings suggest that isolation from the treatment-evaluation environment has put Teen Challenge at a disadvantage in several ways. First, very few Teen Challenge centers contract outside services or mobilize community resources to strengthen their capacities. This shortage of connections and exchanges is particularly severe in it relationship to the medical community. The lack of medical testing and health care services seriously has restricted the ability of Teen Challenge centers to admit and service drug addicts with special needs such as HIV-infected individuals. Although limited financial resources partly could explain the narrower range of services offered at Teen Challenge centers, the ideological underpinnings of its therapeutic model may play a role.[*]

Isolation from the mainstream treatment-evaluation community also may have reduced the referral of new cases from hospitals, physicians and other substance abuse treatment

[*] A 1992 position paper commissioned by Teen Challenge put forth that "the methodologies and goals of TC [Teen Challenge] are most analogous to church ministry, especially as it is realized in pastoral counseling" (Wever, 1992: p. 4). Rather than pursuing treatment completion and abstinence through services and behavioral interventions, it is argued, Teen Challenge promotes changes in its clients through "the much larger, central, and *a priori* issue of Christian discipleship" (p. 4).

programs to Teen Challenge centers. Not taking part in the referral system of the treatment community may mean missing an opportunity to better match the needs of substance abusers seeking treatment to available services and resources.

The lack of rigorous evaluation by independent researchers may have undermined Teen Challenge's ability to assess accurately its own performance and to design research-informed reforms.

The segregation from the treatment-evaluation community could have resulted in the underdevelopment of Teen Challenge potentials, especially those of their counselors. Eschewing readily available resources for professional development--such as research-based guidelines and manuals on referral, counseling, case management and aftercare services--may be an unnecessary sacrifice in order to maintain religious identity. Recent partnerships between departments of behavioral sciences and human services from colleges affiliated with the Assemblies of God and Teen Challenge in the training of administrators and counselors are encouraging steps toward greater integration with the treatment environment.[62]

The Faith Environment

Teen Challenge enjoys a good reputation and ample support not only within the Assemblies of God but also from the larger Evangelical community. In October 2006, the bestseller narrating the origins of the ministry, *The Switchblade and the Cross*,[63] was chosen as the top 32nd book that has shaped Evangelicals.[64] With more than 50 million copies in print in more than 40 languages, it is described as one of the landmark titles that changed the way Evangelicals think, talk, witness and worship.[*]

Teen Challenge engages local congregations, both Pentecostal churches and Evangelical churches more generally, at the grass-root level. For example, anyone who applies to start a new chapter of Teen Challenge must obtain the endorsement from the senior minister of his or her own church. Local churches become natural partners of Teen Challenge centers in their areas. To Teen Challenge clients, "the church provides a safe place where they can find security, acceptance, wholeness, recognition and even the rights and privileges of membership."[65] This intimate connectedness with local congregations highlights a fundamental asset--volunteering--that has maintained the operation of so many Teen Challenge centers across the country over the past five decades. Volunteering always has been a way of bridging the gap that may exist between American congregations and the needs of the wider society.[66] Teen Challenge centers, as care communities patterned after local congregations, make use of volunteers to teach classes, befriend clients and make donations. At the same time, Teen Challenge centers encourage clients to volunteer project services that benefit local churches.

The two largest sources of client referrals for Teen Challenge programs identified in this study, family and self-referrals, are most likely to have been facilitated by the extensive informal networks that exist within and across local congregations. Teen Challenge programs advertise for clients and volunteers at local churches. Local churches are more likely to volunteer services and to refer clients to Teen Challenge or other religious social service organizations than to invest heavily on organizing formal social service programs of their own. Few organizations devote more than a small proportion of their annual budget to supporting service ministries,[67] but the massive number of churches that have been enlisted in offering financial support renders their small contributions critical to the success of Teen Challenge recovery programs.

[*] According to a recent national survey, 26.3 percent of Americans, or more than 70 million people, are Evangelicals (Green, 2007).

Chapter IV
Recommendations and Next Steps

Since the beginning of the Teen Challenge program, there have been significant advances in understanding the science of addiction and in the development of evidence-based approaches to treatment. Teen Challenge's decision to remain separate from evidence-based treatment may have resulted in missed opportunities for its administrators and counselors. At the same time, the growing understanding within the treatment community of the importance of spirituality to many people in recovery calls for an expansion of religious or spiritual offerings by traditionally secular treatment providers.

Recent partnerships between departments of behavioral sciences and human services from colleges affiliated with AG and Teen Challenge in the training of administrators and counselors hold potential for bridging the gap between scientific and religious approaches to recovery within faith-based programs. Likewise, effective collaboration between secular treatment programs and clergy or spiritually-based programs might provide the option of spiritual-oriented services to all members of the recovery community.

To benefit from the large and growing body of knowledge about substance abuse and its treatment, Teen Challenge programs should engage in dialogue with secular models of addiction and recovery, including spiritual models not associated with institutionalized religions such as the 12-step recovery model, to expand their repertoire of interventions that can help clients without compromising the core religious values of AG. Spiritual practice and evidence based treatment protocols need not be mutually exclusive. Teen Challenge administrators should better understand and fairly assess recovery theories and practices accepted by non-AG treatment providers. As our findings have shown, despite important differences in treatment philosophy, there are many commonalities between AG and non-AG treatment providers. These commonalities can

serve as shared language for a meaningful dialogue that does not eradicate real differences but leads to mutual understanding and learning.

To ensure clients receive medical and other essential services, Teen Challenge should collaborate with other treatment professionals and service providers to expand the range of services it can provide to clients. Since effective treatment attends to multiple needs of the individual, not just his or her substance abuse, AG providers should tap into other community-based resources and address the medical, psychological, social, vocational and legal problems associated with clients' substance abuse and addiction. Such service networking can be calibrated to ensure that the religious core and identity of Teen Challenge is preserved.

To strengthen faith-based treatment interventions, Teen Challenge should allow independent researchers to study their programs, identify best practices and make suggestions for improvement that would not conflict with its core religious values. Although external research evaluations are rare among treatment providers, AG program administrators should strive for excellence by looking to evaluation research for useful feedback regarding performance measurement, quality control and improvement. Methodologically sound research can determine whether services have been delivered as planned and whether they have yielded expected outcomes. It also can provide AG with suggestions for promising interventions congruent with its religious values.

To enhance professional qualifications, Teen Challenge should require its programs to comply with federal and state licensing and certification standards for treatment providers. Credentials and certification are good ways to expose providers to evidence-based practices. Clinical knowledge and skills evaluated in these licensing examinations do not have to replace the religious core of AG programs, but can serve as useful supplements to their faith-based interventions. Also, credentialing and certification have the potential to boost the professional identity and public image of AG administrators and counselors.

To meet the religious or spiritual needs of clients, secular treatment providers should discuss patients' spiritual needs and desires, and, where appropriate, refer clients to clergy or spiritually-based programs to support their recovery. Whereas the 12-step model has been adopted widely as an important spiritual component of traditional residential treatment, the recovery of clients with an interest in religious or spiritual involvement might be facilitated by resources from local faith-based institutions.

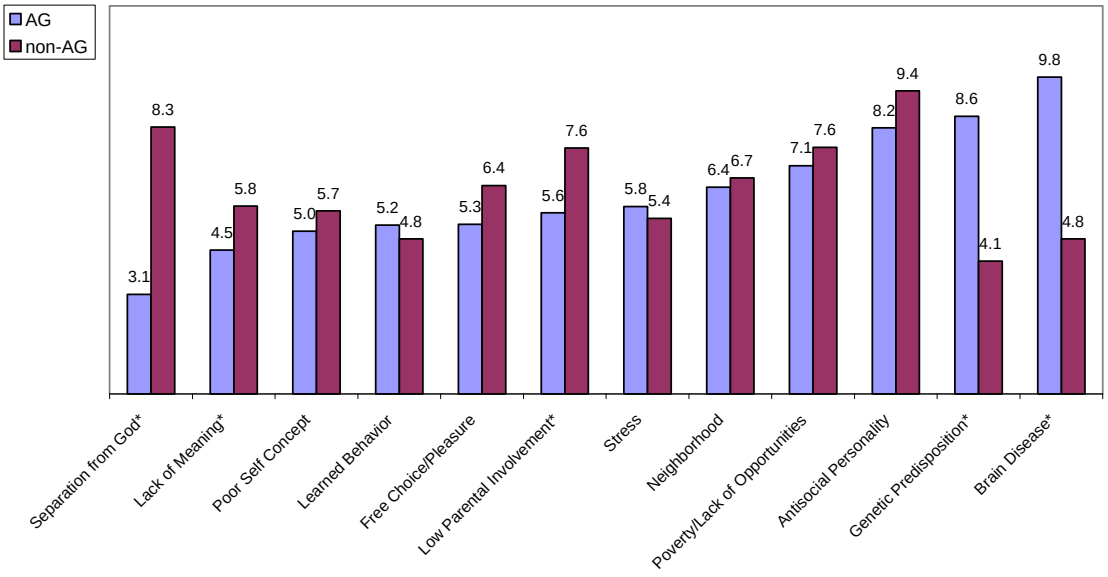
Figures

Figure 1
Comparison of Clinical Staff's Views on Human Nature and Morality by Percent Who Agree or Strongly Agree

	AG (N=70)	non-AG (N=68)
Right and wrong should be based on God's laws.*	100.0	52.2
Life is meaningful only because God exists.*	92.9	47.1
I feel a deep sense of responsibility for reducing pain and suffering in the world.	86.2	66.7
Human nature is fundamentally perverse and corrupt.*	82.4	16.4
Morality is a personal matter and society should not force everyone to follow one standard.*	42.4	76.5
Right and wrong are not a simple matter of black and white; there are many shades of gray.*	26.1	75.0
Human nature is basically good.*	22.1	86.6
Life is only meaningful if you provide the meaning yourself.*	10.1	39.7
There is little that people can do to change the course of their lives.	2.9	1.5
Life does not serve any purpose.	1.7	0.0

* Starred response options are those that showed statistically significant differences ($p<.05$) between AG and non-AG respondents.

Figure 2
Comparison of Clinical Staff's Views on Potential Explanations for Substance Abuse by Mean Rankings



* Response options that showed statistically significant differences ($p<.05$) in rankings between AG and non-AG respondents.
Note: Respondents were asked to rank each of these explanations of drug abuse/addiction on a scale of 1 to 12, "1" being the best explanation and "12" being the worst explanation. Thus, lower scores indicate a stronger belief in the factor as a cause of substance abuse.

Figure 3
Comparison of Clinical Staff's Views on Science
by Percent Who Agree or Strongly Agree

	AG (N=70)	non-AG (N=68)
We believe too often in science, and not enough in feelings and faith.*	81.0	58.2
Science breaks down people's ideas of right and wrong.*	44.1	16.2
The relationship between science and religion in drug abuse treatment is one of:*		
Collaboration: Each can be used to validate the other.	44.1	49.2
Independence: They address different aspects of recovery.	30.9	40.0
Conflict: I consider myself to be on the side of religion.	23.5	6.2
Conflict: I consider myself to be on the side of science.	1.5	4.6
Any change humans cause in nature- no matter how scientifically-based- is likely to make things worse.	36.4	26.5
Overall, modern science does more harm than good.*	20.6	7.5
Science is capable of solving our social problems like crime and drug abuse.*	2.9	16.4
Human beings evolved from other species of animals.*	0.0	40.3

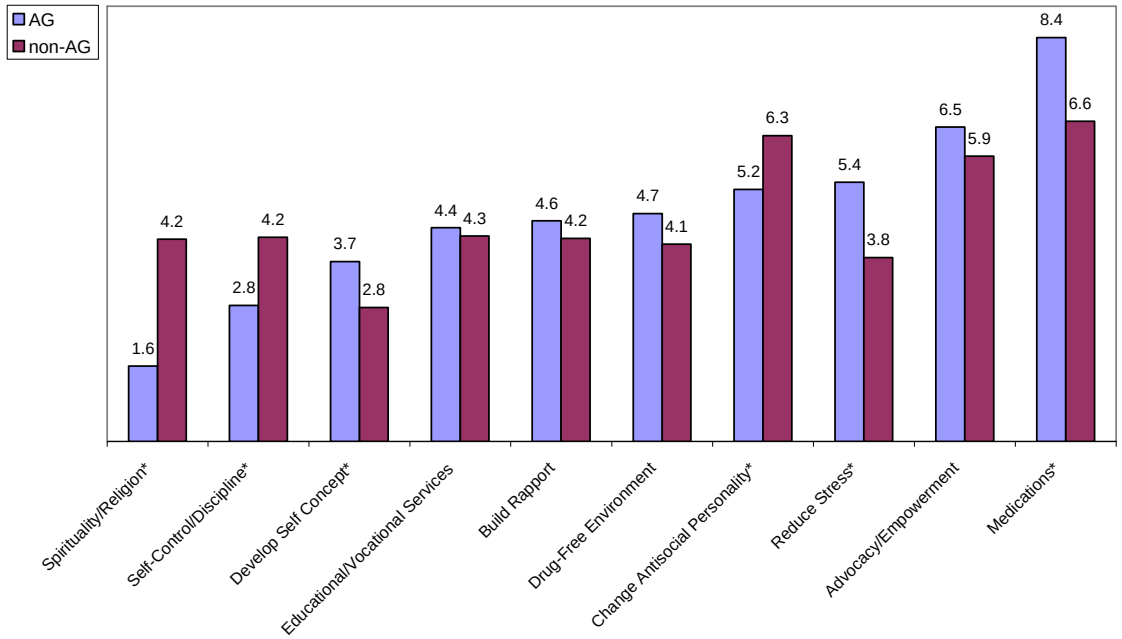
* Starred response options are those that showed statistically significant differences ($p<.05$) between AG and non-AG respondents.

Figure 4
Comparison of Clinical Staff's Drug Policy Preferences by Percent

	AG (N=70)	non-AG (N=68)
Would you like to see more or less government spending in drug abuse treatment?*		
Less/much less	12.1	3.0
Same as now	27.3	9.0
More/much more	60.6	88.1
Should the government fund faith-based drug treatment programs?*		
No	10.4	36.4
Yes	89.6	63.6
Would you like to see more or less government spending on incarceration of drug offenders?*		
Less/much less	27.9	69.2
Same as now	41.2	20.0
More/much more	30.9	10.8
Would you support government spending in needle or syringe exchange programs to prevent HIV infections among drug injectors?*		
No	71.9	24.2
Yes	28.1	75.8
Do you think the *medical* use of marijuana should be made legal?*		
Should	7.8	53.7
Should not	92.2	46.3
Do you think *all* uses of marijuana should be made legal?*		
Should	1.5	10.3
Should not	98.5	89.7

* Starred response options are those that showed statistically significant differences ($p<05$) between AG and non-AG respondents.

Figure 5
Comparison of Clinical Staff's Views on Treatment Approaches by Mean Rankings



* Response options that showed statistically significant differences ($p<.05$) in rankings between AG and non-AG respondents.
Note: Respondents ranked these explanations on a scale of 1 to 10, "1" being the best approach and "10" being the worst approach.

Figure 6
Comparison of Program Staffing and Capacity as Reported by Administrators

	AG (N=21)	non-AG (N=17)
Number of full-time/part-time therapists or counselors	2.6	7.3
Total number of full-time/part-time personnel on payroll	15.6	25.2
Maximum residential capacity (beds)	44.9	57.5
Number of clients admitted in past year	74.9	239.0
Ratio of clients to therapists or counselors	13.5:1	8.5:1
Average caseload per counselor (cases)	6.3	12.0
Average length on the waiting list (days)	5.9	22.6
Required length of treatment (days)	350.8	228.7
Average length of treatment completed (days)	267.6	163.1
Percent of the required treatment stay completed by a typical client	76.3	71.3

Note: Due to the limited sample size of administrators and missing data, significance tests were omitted from these analyses. Therefore, these findings are suggestive but should be interpreted with caution.

Figure 7
Comparison of Client Characteristics as Reported by Administrators by Percent

	AG (N=21)	non-AG (N=17)
Gender		
Male	67.12	67.6
Female	32.8	32.5
Race/ethnicity		
White	78.6	68.5
Black	10.9	25.3
Hispanic	7.1	4.2
Other	3.4	2.0
Age		
17 or younger	11.9	11.3
18-24 years old	30.8	23.9
25-34 years old	30.4	24.3
35-44 years old	20.2	23.7
45 or older	6.7	16.8
Education		
Have high school diploma or GED	56.4	54.3
Employment		
Working part-time or full-time	22.9	4.3
Health		
HIV positive	2.2	9.9
Primary drug of use		
Cocaine/crack	27.3	33.6
Heroin	16.9	12.2
Amphetamine/methamphetamine	16.8	15.1
Prescription pain killers	15.7	7.8
Alcohol	11.4	13.1
Marijuana/Hashish	9.8	17.3
Other	2.1	0.9
Source of referrals		
Family members	38.3	0.6
Criminal justice	22.3	41.0
Self	18.3	21.0
Friends	11.7	0.6
School/work	4.9	0.4
Physicians/hospitals	4.3	15.8
Other treatment programs	0.1	20.6

Note: Due to the limited sample size of administrators and missing data, significance tests were omitted from these analyses. Therefore, these findings are suggestive but should be interpreted with caution.

Figure 8A
Comparison of Service Availability
as Reported by Administrators (offered on-site) by Percent

	AG (N=21)	non-AG (N=17)
Bible classes	100.0	35.3
Prayer meetings	100.0	29.4
Services to criminal offenders	81.0	64.7
Work readiness/employability skills	66.7	64.7
Vocational training	57.1	35.3
Remedial education/high school/GED	52.4	41.2
HIV testing	19.0	29.4
HIV counseling	19.0	35.3
Services to pregnant women	10.0	18.8
TB testing	9.5	35.3
12-step recovery programs	5.3	82.4
Services to mentally ill individuals	5.0	35.3
Medical examination	4.8	37.5
Individual psychotherapy	0.0	41.2
Group psychotherapy	0.0	35.3
Primary medical care	0.0	23.5
Psychiatric assessment	0.0	23.5
Legal counseling	0.0	5.9

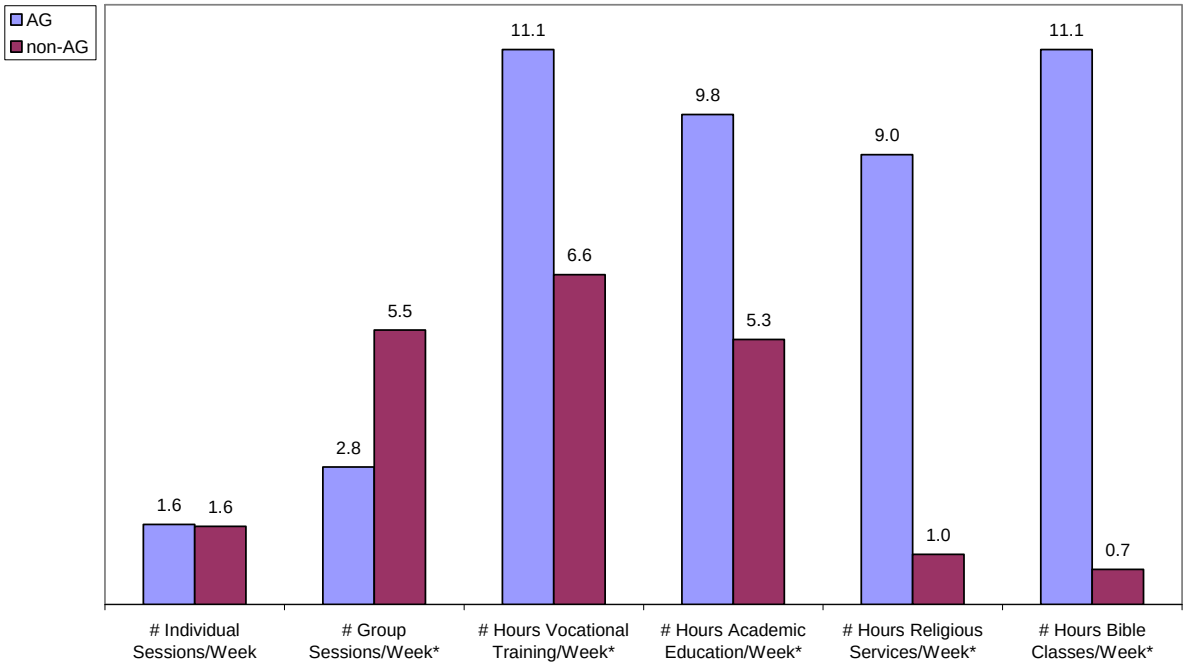
Note: Due to the limited sample size of administrators and missing data, significance tests were omitted from these analyses. Therefore, these findings are suggestive but should be interpreted with caution.

Figure 8B
Comparison of Service Availability
as Reported by Administrators (offered off-site) by Percent

	AG (N=21)	non-AG (N=17)
Medical examination	57.1	50.0
TB testing	52.4	58.8
Primary medical care	47.6	64.7
HIV testing	47.6	64.7
HIV counseling	33.3	52.9
Legal counseling	23.8	58.8
Psychiatric assessment	23.8	47.1
Remedial education/high school/GED	14.3	35.3
12-step recovery programs	5.3	0.0
Services to mentally ill individuals	5.0	29.4
Services to pregnant women	5.0	6.3
Vocational training	4.8	41.2
Individual psychotherapy	4.8	35.3
Group psychotherapy	4.8	29.4
Services to criminal offenders	4.8	11.8
Bible classes	0.0	29.4
Work readiness/employability skills	0.0	23.5
Prayer meetings	0.0	23.5

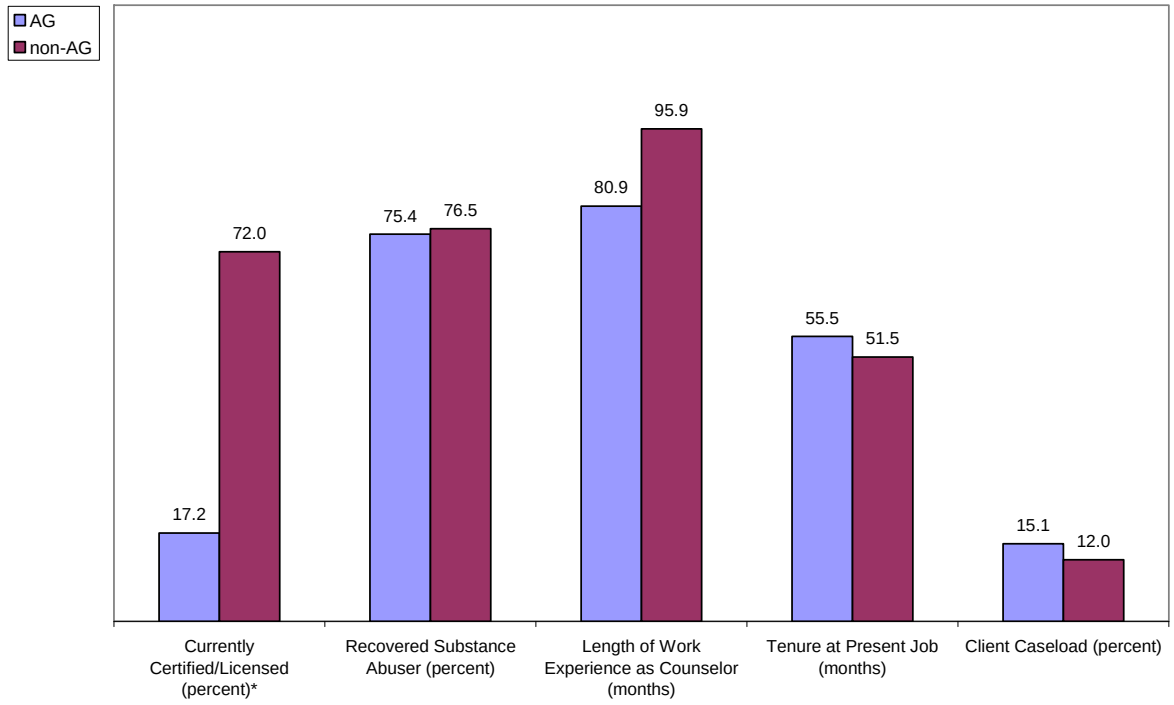
Note: Due to the limited sample size of administrators and missing data, significance tests were omitted from these analyses. Therefore, these findings are suggestive but should be interpreted with caution.

Figure 9
Comparison of Program Activities for a Typical Client as Reported by Counselors by Mean Response



* Response options that showed statistically significant differences (p<.05) between AG and non-AG respondents.

Figure 10A
Comparison of Counselors' Job Experiences



* Response options that showed statistically significant differences (p<.05) between AG and non-AG respondents.

Figure 10B
Comparison of Counselors' Views on Key Elements in the Development of Their Counseling Skills by Percent

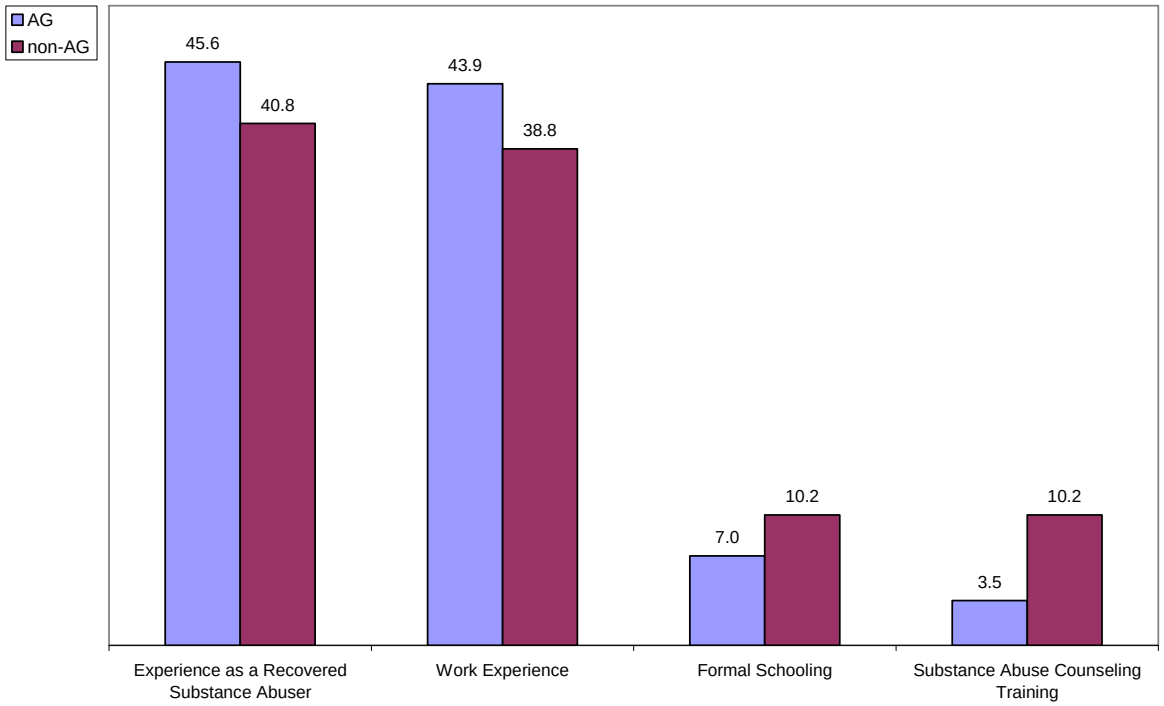
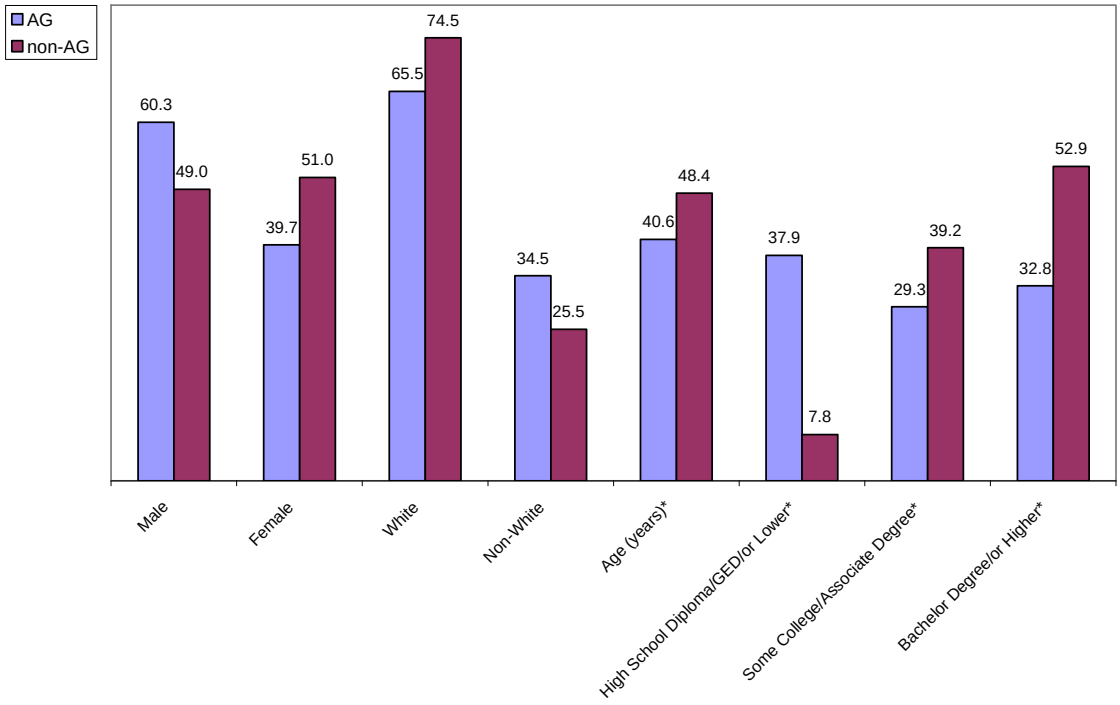
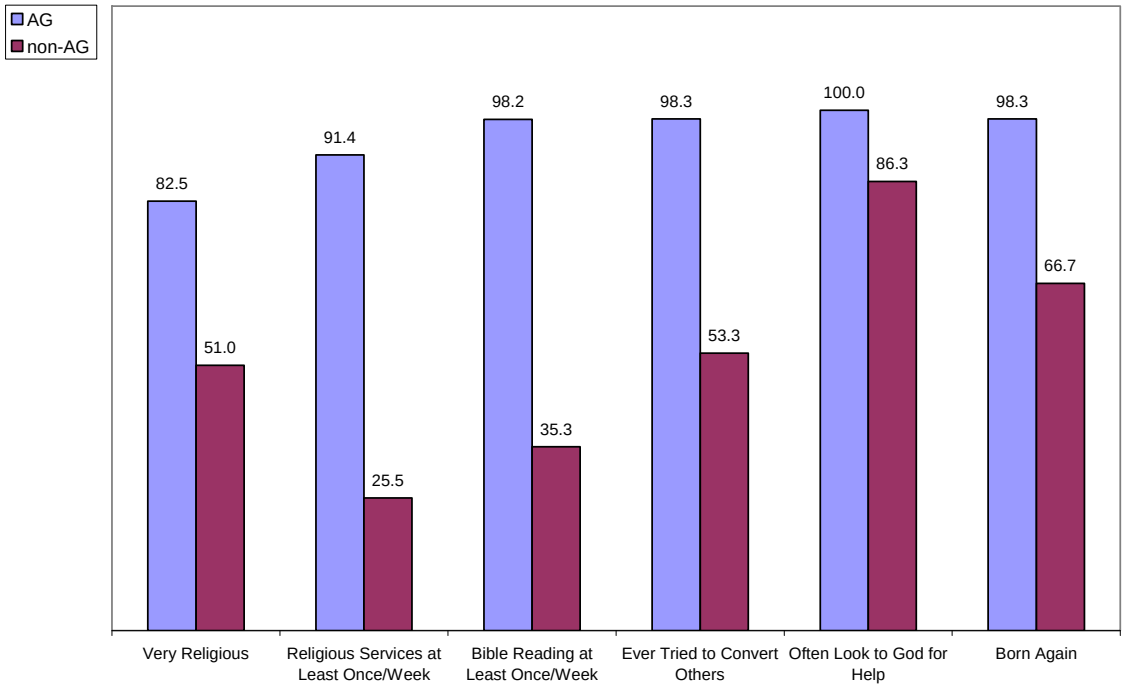


Figure 11
Comparison of Counselors' Demographic Characteristics



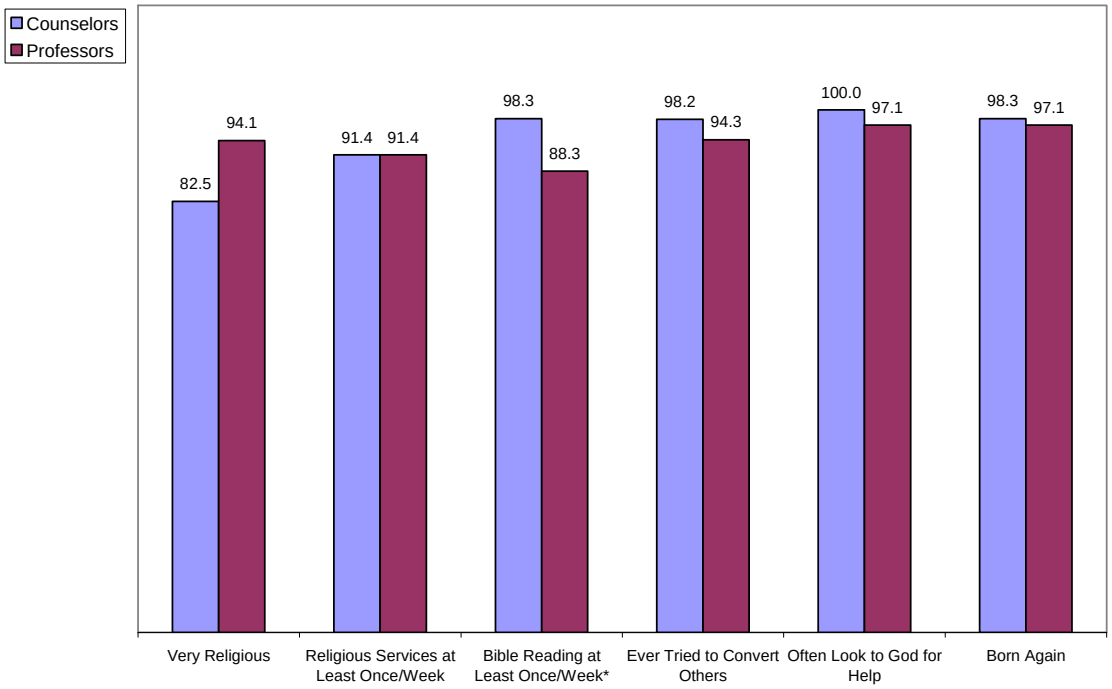
* Response options that showed statistically significant differences (p<.05) between AG and non-AG respondents.

Figure 12
Comparison of the Religious Profile of Counselors



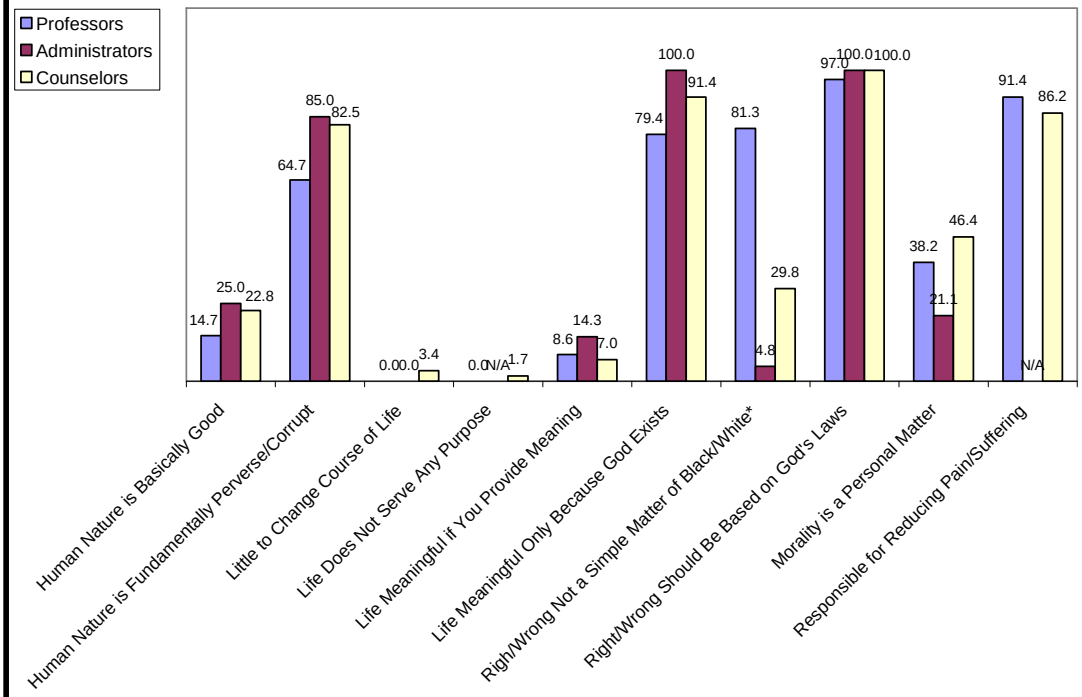
* All response options showed statistically significant differences ($p<.05$) between AG and non-AG respondents.

Figure 13
Comparison of the Religious Profile Between AG Counselors and AG Professors



* Response options that showed statistically significant differences (p<.05) between Professor and Counselor

Figure 14
Comparison of Views on Human Nature and Morality Within the Assemblies of God



* Response options that showed statistically significant differences (p<.05) between Professor, Administrator and Counselor respondents.

Figure 15
Comparison of Views on Causes of Drug Abuse and Addiction Within the Assemblies of God by Mean Rankings

	Professors (N=35)	Administrators (N=21)	Counselors (N=58)
Learned behavior	4.3	5.5	5.2
Stress	5.4	6.4	5.6
Free choice/pleasure	5.4	5.1	5.3
Separation from God*	5.4	2.1	3.2
Lack of meaning	5.5	4.4	4.3
Low parental involvement	6.1	6.2	5.2
Neighborhood	6.4	6.2	6.5
Poor self concept	6.8	5.6	4.7
Genetic predisposition*	6.9	9.2	8.3
Poverty/lack of opportunities	7.3	6.7	7.3
Brain disease	9.2	10.3	9.7
Antisocial personality	9.9	8.7	8.0

* Starred response options are those that showed statistically significant differences ($p<.05$) between Professor, Administrator and Counselor respondents.

Figure 16
Comparison of Views on Science Within the Assemblies of God
by Percent Who Agree or Strongly Agree

	Professors (N=35)	Administrators (N=21)	Counselors (N=58)
We believe too often in science, and not enough in feelings and faith.	61.8	89.5	79.2
Science breaks down people's ideas of right and wrong.*	17.1	42.9	44.6
Science is capable of solving our social problems like crime and drug abuse.	14.3	4.8	3.4
Human beings evolved from other species of animals.*	11.4	0.0	0.0
Any change humans cause in nature- no matter how scientifically-based- is likely to make things worse.*	5.9	N/A	36.4
The relationship between science and religion in drug abuse treatment is on of: *			
Conflict: I consider myself to be on the side of science.	0.0	0.0	1.8
Conflict: I consider myself to be on the side of religion.	11.4	40.0	21.1
Independence: They address different aspects of recovery.	14.3	20.0	31.6
Collaboration: Each can be used to validate the other.	74.3	40.0	45.6
Overall, modern science does more harm than good.*	0.0	19.0	21.4

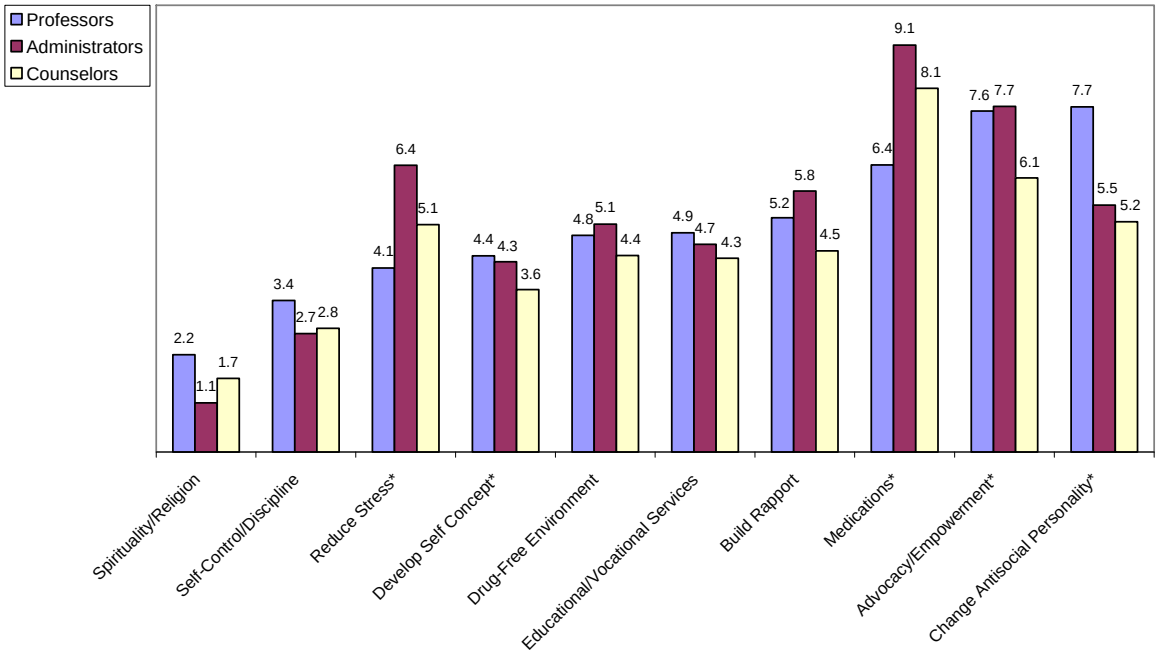
* Starred response options are those that showed statistically significant differences ($p<.05$) between Professor, Administrator and Counselor respondents.

Figure 17
Comparison of Views on Drug Policy Preferences Within the Assemblies of God by Percent

	Professors (N=35)	Administrators (N=21)	Counselors (N=58)
Would you like to see more or less government spending in drug abuse treatment?			
Less/much less	20.0	30.0	9.1
Same as now	31.4	20.0	27.3
More/much more	48.6	50.0	63.6
Should the government fund faith-based drug treatment programs?			
No	9.1	5.3	10.5
Yes	90.9	94.7	89.5
Would you like to see more or less government spending in incarceration of drug offenders?			
Less/much less	22.9	23.8	28.6
Same as now	40.0	33.3	44.6
More/much more	37.1	42.9	26.8
Would you support government spending in needle or syringe exchange programs to prevent HIV infections among drug injectors?			
No	61.8	89.5	67.4
Yes	38.2	10.5	32.6
Do you think the *medical* use of marijuana should be made legal?*			
Should	41.4	5.9	9.8
Should not	58.6	94.1	90.2
Do you think *all* uses of marijuana should be made legal?*			
Should	13.8	0.0	1.9
Should not	86.2	100.0	98.1

* Starred response options are those that showed statistically significant differences ($p<.05$) between Professor, Administrator and Counselor respondents.

Figure 18
Comparison of Views on Treatment Approaches Within the Assemblies of God by Mean Rankings



* Response options that showed statistically significant differences (p<.05) between Professor, Administrator and Counselor respondents.

Figure 19
Utilization of Contextual Resources by AG

Institutional Contexts	Service Domains	Level of Utilization		
		Low	Medium	High
The state environment: Pertinent state and federal governments	Certification and licensing	√		
	Financial support	√		
	Referral of clients		√	
The treatment environment: Treatment and medical communities	Care and services	√		
	Research and training	√		
	Referral of clients	√		
The faith environment: Religious community – Christian churches	Volunteer services			√
	Financial support			√
	Referral of clients			√

Appendix A: Methodology

Three sets of mail surveys were conducted for this study: surveys of professors of behavioral science; administrators of substance abuse treatment facilities; and substance abuse counselors. For each set of surveys, the sample included respondents from the Assemblies of God (AG) and a comparison group of non-AG respondents.

Data Collection

Each survey package mailed to respondents included a copy of the questionnaire, a consent form and a cash incentive. The cash incentive was five dollars for the college professors and the treatment facility administrators and three dollars for substance abuse counselors.

Informed Consent

This survey project complied with the protection of human subjects in research protocols of the U.S. Department of Health and Human Services. The survey instrument and methodology were reviewed by CASA's Institutional Review Board (IRB) which required informed and signed consent of all individuals who would respond to the survey. All 202 respondents returned signed consent forms and the original copies of the forms will be kept at CASA for three years.

Survey of College Professors

Questions and themes were pre-tested through a small pilot survey among faculty members of Arkansas State University. The final survey was conducted by mail (see Appendix B), using a random selection procedure, in which the pool of full-time professors of behavioral sciences and human services was assembled from the directories of the Consortium of Liberal Arts Colleges, the Council of Public Liberal Arts Colleges and the 19 institutions of higher education from the Assemblies of God. A total of 111 survey packages were mailed out and 67 (60 percent) returned with valid responses. Thirty-five completed questionnaires (51 percent

of the final sample of professors) were from AG schools and 33 (49 percent) were from non-AG schools.[*]

Survey of Treatment Programs Administrators

Questions and themes were pre-tested through a small pilot survey among 10 facility administrators of the Odyssey House, a major secular substance abuse treatment provider. The final survey was conducted by mail (see Appendix C). Potential respondents were directors of long-term residential treatment programs randomly selected from the National Directory of Drug and Alcohol Abuse Treatment Programs 2005, published by the Substance Abuse and Mental Health Services Administration[68] and the 2007 Directory of Teen Challenge Facilities.[69] A total of 112 survey packages were mailed out and 38 (34 percent) returned with valid responses. The AG group was formed by 21 facility directors and represented 55 percent of the final sample of administrators, whereas the comparison group was composed by 17 facility directors from non-AG treatment programs who represented 45 percent of the final sample of administrators.

Survey of Substance Abuse Counselors

Questions and themes were pre-tested through a small pilot survey among 12 substance abuse counselors from Odyssey House. The final survey was conducted by mail (see Appendix D). Potential respondents were counselors from residential treatment programs randomly selected from the National Directory of Drug and Alcohol Abuse Treatment Programs 2005[70] and the 2007 Directory of Teen Challenge Facilities.[71] A total of 217 survey packages were mailed out and 109 (50 percent) returned with valid responses. The AG group was formed by 58 counselors who represented 53 percent of the final sample of substance abuse counselors, whereas the comparison group was composed of 51 counselors from non-AG residential treatment programs.

Response Rate

Researchers originally projected an overall response rate of 75 percent. But a pilot survey revealed that a lower response rate was likely to be obtained. Therefore, a small monetary incentive[72] was offered to respondents.[†] The final overall response rate was 49 percent, with significant response rate differentials across the three sets of surveys. Differences in response rates, however, between AG and non-AG respondents were not statistically significant in any of the three surveys. (See Figure A1) A response rate of 49 percent compares favorably with average response rates of 30 to 40 percent reported by standard mail surveys dealing with health and substance abuse issues.[73]

Rejection/Refusal Rate

While the rejection rate of 51 percent (225 refusals) seems significant, it is consistent with mail surveys dealing with health and substance abuse issues.[74] The response rate of 34 percent among treatment facility administrators (38 percent for the AG group and 30 percent for the non-AG group) was the lowest observed rate among the three samples. This could have yielded two undesired effects in the analysis of administrators' data. First, the underpowered sample may risk not detecting real differences even when they are there.[75] Second, there could have been fundamental differences (e.g., confidence about one's program or openness to external investigation) between the minority

[*] Data collected from professors affiliated with non-AG colleges are not presented in this report as they do not directly address research questions posted by this study. They will be examined in a future analysis of the ideological outlooks of intellectuals working in secular and religious institutions.

[†] The number of contacted survey candidates was raised by 10 percent from 400 to 440, as described in the grant proposal.

who responded to the survey and the majority who did not, which put the representativeness and the generalizability of related findings in question. The fact that the low response rate occurred in both AG and the non-AG comparison groups suggests, however, that any bias may have been equally distributed between groups. In any event, findings from the analysis of administrators' data are tentative and must be interpreted with caution.

Figure A1
Mail Survey Response Rates

	Professor Survey		Administrator Survey		Counselor Survey	
	Non-AG Colleges	AG Colleges	Non-AG Programs	AG Programs	Non-AG Programs	AG Programs
Number of questionnaires	51	60	57	55	105	112
Number of questionnaires completed and returned	33	35	17	21	51	58
Response rate by subgroups	65%	58%	30%	38%	49%	52%
Response rate by groups	61%		34%		50%	
Overall response rate	49%					

Appendix B: Facility Administrator Survey

CONSENT FORM

The National Center on Addiction and Substance Abuse (CASA) at Columbia University is conducting this survey of drug treatment facility administrators to elicit their perspectives related to drug abuse, recovery, and treatment interventions. Please read the following information carefully so that you can make an informed decision about whether or not you are interested in participating in this study.

What is our purpose? A primary aim of this research study is to compare the treatment philosophy of administrators of faith-based drug rehabilitation centers with that of administrators of secular treatment centers. The information we obtain from this survey will be used to explore how the religious core of faith-based treatment shapes its conceptualization of drug abuse and clinical practices

What are the procedures? If you choose to participate, you will read, sign and date this consent form, respond to the questions on the enclosed survey, and then return them both in the enclosed stamped addressed enveloped within two weeks of receipt. We estimate that it will take approximately 15 minutes to complete the survey.

Who is being asked to participate? We have randomly selected 55 drug abuse treatment administrators from the directory provided by the Teen Challenge USA and another 55 administrators from non-religious providers of substance abuse treatment.

Are there any risks or discomforts? There is the possibility that you may experience minor discomfort with the topics of some of the questions. You are always free to decline to answer particular questions.

What are the benefits? You will not directly benefit from participation in this research study. However, your participation presents us with a unique opportunity to understand what similarities and differences exist between facility administrators employed by faith-based treatment providers and those by secular treatment providers.

What about confidentiality? In order to protect your confidentiality, your name will not be asked anywhere in the questionnaire itself and as soon as we receive your survey package, the signed consent form will be separated from the questionnaire and kept in a locked cabinet. Survey data will be stored in computers protected with password and firewall. Only senior researchers will have access to these survey data and consent information.

What if I have questions? If you have any questions regarding the research or your participation either now or at any time in the future, you may contact the Principal Investigator of this study, Dr. Hung-En Sung collect at (212) 841-5203. For questions about your rights as a research participant or to report harm as a result of participation, please contact Mr. Rush L. Russell, CASA's IRB Authorizing Director collect at (212) 841-5200.

If you wish to participate, please sign below. Your written consent is required for your participation.

I, _____, understand the nature of this research and I consent to my participation in this survey. I understand that this information will be used only for research purpose and that my confidentiality will be protected.

_____ _____

Signature Date

Treatment Provider: _____ Teen Challenge USA

_____ Non-religious drug abuse treatment program

General Staffing and Personnel Questions

Indicate the number of full time, part time (less than 35 hours per week) and contracted staff funded specifically for this facility?

	Full Time	**Part Time**	**Contractual**
Manager / Supervisors:			
Clinical Therapists or Counselors:			
Medical Staff:			
Security Staff:			
Clerical Staff:			
Other:			
Total:			

Indicate the number of clinical staff employed by your facility who has each of the following as their highest educational degree or qualification. Contractual staff should be included with part time.

	Full Time	**Part Time**
Doctor or master's degree:		
Bachelor's degree:		
H.S. diploma or GED:		
Less than high school:		

Indicate the number of clinical staff who are recovering alcoholics or drug abusers:

	Full Time	**Part Time**
Recovering Substance Abusers:		

Client Characteristics

(Answer the next four questions based on information available from the most recent fiscal year)

Indicate the number of admissions completed within the last fiscal year:

Admissions in prior fiscal year:		FY_____

(Answer the next three questions using ACTUAL percentages if admission statistics are available. Report ESTIMATED percentages otherwise.)

Please indicate the percentage of all your admissions within the last fiscal year which satisfy the following client characteristics:

Yearly Period (M/Y-M/Y): _____

Characteristic	Actual	Estimated
Gender:		
Male		
Female		
Ethnic Background:		
Caucasian (Not of Hispanic Origin)		
African American (Not of Hispanic Origin)		
Asian		
Hispanic		
Native American		
Other		
Age Groups:		
17 and younger		
18 – 24		
25 – 34		
35 – 44		
45 and older		

Characteristic	Actual	Estimated
Medical Status:		
Pregnant		
HIV Positive or Active AIDS		
Employment / Education Status:		
Full-Time or Part-Time Employed		
High School Diploma / GED		

For this same fiscal year, indicate the percentage of clients whose primary drug problem is:

Substance	Actual	Estimated
Heroin:		
Cocaine / Crack:		
Amphetamines / Methamphetamines:		
Prescription Pain Relievers / Opioids		
Barbiturates / Tranquilizers:		
Marijuana / Hashish:		
Hallucinogens (LSD, PCP, Ecstasy):		
Alcohol:		
Other (specify): _____		

Indicate the percentage of clients admitted within the same fiscal year from the following referral sources:

Referral Source	Actual	Estimated
Self:		
Family members:		
Criminal justice authorities:		
Physicians / Hospitals:		
Other programs including AA or NA:		
Friends:		
Schools / Work:		

Assessment and Counseling Characteristics

What diagnostic instrument(s) do you use for initial client intake (Check all that apply):

Instrument	
ASI:	
SASSI:	
MAST:	
Your own bio/psychosocial:	
Other (Specify):	

Please estimate the approximate number of hours each week an average substance abuse counselor spends performing the following activities:

Type of activity	Hours
Admissions & assessments:	
Group therapy sessions:	
Individual counseling:	
Lectures:	
Case management duties:	
Updating case files:	
Administrative duties:	
Other:	

What is the average number of clients assigned to each staff level?

	Counselor	Supervisor
Average case load		

Do you have case management services? If yes, what is the average number of cases assigned to each case manager:

Case Management (Circle One)	YES / NO
Average number of cases	

5) Under what conditions are clients unsuccessfully discharged from your programs? Please list all of the reasons.

Reasons for Discharge	**(Circle One)**
First positive urine test	YES / NO
Second positive urine test	YES / NO
A consistent pattern of urine test	YES / NO
Drink alcohol one time	YES / NO
Drink alcohol twice	YES / NO
A consistent pattern of using alcohol	YES / NO
No show for treatment group-1 time	YES / NO
No show for treatment groups	YES / NO
A sporadic pattern of attendance at treatment	YES / NO
Disruptive in group sessions	YES / NO
Not following the rules of the program	YES / NO
The client gets arrested	YES / NO
The client does not see his/her probation/parole officer	YES / NO
The client leaves the facility	YES / NO
Other, specify:_____	
Other, specify:_____	
Other, specify:_____	
Other, specify:_____	
Other, specify:_____	

Program Characteristics

If there is currently a waiting list for your program; please list the average duration in days between being placed on the waiting list and treatment admission. If there is no wait, put zero (0):

Average # of days on wait list	_____ days

Indicate the expected length of the program. If treatment length is based on client needs, behavior, and treatment progress, include the average number of days a client spends in the program.

	Length in days	**Average # of days**
Treatment length:		

Describe your use of drug testing in the treatment program.

A. Use drug testing

_____ Yes

_____ No

B. If yes, how often?

_____ Times a week

_____ Times a Month

_____ Other

(List)_____

4) If your program has several phases, please indicate the following:

PHASES	**TYPE OF SERVICE**	**AVERAGE LENGTH**
Phase I:		_____ days
Phase II		_____ days
Phase III		_____ days
Phase IV		_____ days

Very Important

5) For this service delivery unit, what is the (put zero if not provided):

Residential Capacity: _____

Outpatient Capacity: _____

6) Are there any bilingual staff in the program? If "YES" which non-English languages are spoken?

___ No

___ Yes Language: _____

7) Does this facility offer clients assistance in obtaining a Medicaid Card or a Social Security Card?

___ No

___ Yes

8) Are any forms of identification needed for admission? What forms of ID are accepted?

___ No

___ Yes ID: _____

9) What are the program fees for an average resident?

Deposit: _____

Monthly fee: _____

10) What kinds of payment are accepted?

☐ Medicaid ☐ Medicare

☐ Client Payments ☐ Government Grant

11) Are any exams or evaluations (e.g., psychiatric evaluation, medical exam) needed prior to admission? If "YES" describe what is needed.

___ No

___ Yes Evaluations: _____

12) Indicate the substance abuse services provided at this site by your treatment program, along with the length of sessions in minutes, and the number of sessions per month.

Place an "X" in each cell if the answer is "YES":

SUBSTANCE ABUSE COUNSELING

	Not Offered	Offered	Length of Average Session in Minutes	Number of Sessions per Month
Initial Intake/Assessment	☐	☐		
Individual Counseling	☐	☐		
Group Counseling	☐	☐		
Encounter Group	☐	☐		
Rap Group/Session	☐	☐		
Self-Help Groups	☐	☐		
Individual Family Counseling	☐	☐		
Family Group Counseling	☐	☐		
Stress Management Counseling	☐	☐		
Relapse Prevention Counseling	☐	☐		
Aftercare Counseling	☐	☐		
Peer Counseling	☐	☐		
Gender Specific Counseling	☐	☐		
Religious services	☐	☐		
Bible classes	☐	☐		
Other - Specify_____				

13) Indicate the services provided on-site by your treatment program and those provided off-site through a negotiated working agreement between agencies (check only one box for each).

Place an "X" in the appropriate box if the answer is "YES":

VOCATIONAL/EDUCATIONAL SERVICES	Offered On-Site	Offered Off-site	Not Offered
Vocational/Educational Rehabilitation	☐	☐	☐
Work Readiness and Employability Skills	☐	☐	☐
Life Skills Training	☐	☐	☐
Remedial Education (GED/High School Education)	☐	☐	☐
Adult Education or College Preparation.	☐	☐	☐
Employment Referral Placement	☐	☐	☐

MEDICAL SERVICES	Offered On-Site	Offered Off-site	Not Offered
Medical Exams	☐	☐	☐
Primary Medical Care	☐	☐	☐
Pre/Post Natal Care	☐	☐	☐
HIV Testing	☐	☐	☐
AIDS Treatment	☐	☐	☐
HIV Counseling	☐	☐	☐
TB Testing	☐	☐	☐
STD Testing	☐	☐	☐
Other: _____	☐	☐	☐

LEGAL SERVICES	Offered On-site	Offered Off-Site	Not Offered
Legal Counseling	☐	☐	☐
Legal Representation	☐	☐	☐
Reports to Court	☐	☐	☐
Family Law	☐	☐	☐
Social Drinker/Deferment Program	☐	☐	☐
Other _____	☐	☐	☐

MENTAL HEALTH SERVICES	Offered On-site	Offered Off-site	Not Offered
Individual Psychotherapy	☐	☐	☐
Group Psychotherapy	☐	☐	☐
Psychiatric or Psychological Assessment	☐	☐	☐
Psychiatric Medication Management	☐	☐	☐

Place an "X" in the appropriate box if the answer is "YES":

DETOXIFICATION SERVICES	Offered On-site	Offered Off-site	Not Offered
Opiates	☐	☐	☐
Cocaine	☐	☐	☐
Crack	☐	☐	☐
Alcohol	☐	☐	☐
Other Barbiturates/Amphetamines	☐	☐	☐
Social Model Detoxification	☐	☐	☐
Hospital Based Detoxification	☐	☐	☐

SERVICES TO SPECIAL POPULATIONS	Offered On-site	Offered Off-site	Not Offered
Assistance for illiterate clients	☐	☐	☐
Services to mentally or developmentally disabled	☐	☐	☐
Services to mentally ill individuals	☐	☐	☐
Services to youths	☐	☐	☐
Services to families	☐	☐	☐
Services to criminal offenders	☐	☐	☐
Services to pregnant women	☐	☐	☐

SPIRITUAL / RELIGIOUS SERVICES	Offered On-site	Offered Off-site	Not Offered
12-Step Recovery Program	☐	☐	☐
Prayer Meetings	☐	☐	☐
Bible Classes	☐	☐	☐
Worship Services	☐	☐	☐
Evangelism Activities	☐	☐	☐
Other _____	☐	☐	☐

V. Views on Human Nature

Do you agree or disagree with the following…

1. Human nature is basically good.
   - __ Strongly agree
   - __ Agree
   - __ Disagree
   - __ Strongly disagree

2. Human nature is fundamentally perverse and corrupt.
   __ Strongly agree
   __ Agree
   __ Disagree
   __ Strongly disagree

3. There is little that people can do to change the course of their lives.
   __ Strongly agree
   __ Agree
   __ Disagree
   __ Strongly disagree

4. Life is only meaningful if you provide the meaning yourself.
   __ Strongly agree
   __ Agree
   __ Disagree
   __ Strongly disagree

5. Life is meaningful only because God exists.
   __ Strongly agree
   __ Agree
   __ Disagree
   __ Strongly disagree

6. Right and wrong are not a simple matter of black and white; there are many shades of gray.
   __ Strongly agree
   __ Agree
   __ Disagree
   __ Strongly disagree

7. Right and wrong should be based on God's laws.
   __ Strongly agree
   __ Agree
   __ Disagree
   __ Strongly disagree

8. Morality is a personal matter and society should not force everyone to follow one standard.
   __ Strongly agree
   __ Agree
   __ Disagree
   __ Strongly disagree

VI. Views on Science

Do you agree or disagree with the following…

1. As a society, we believe too often in science, and not enough in feelings and faith.
   - __ Strongly agree
   - __ Agree
   - __ Disagree
   - __ Strongly disagree

2. Overall, modern science does more harm than good.
   - __ Strongly agree
   - __ Agree
   - __ Disagree
   - __ Strongly disagree

3. One of the bad effects of science is that it weakens people's ideas of right and wrong.
   - __ Strongly agree
   - __ Agree
   - __ Disagree
   - __ Strongly disagree

4. Human beings evolved from other species of animals.
   - __ Strongly agree
   - __ Agree
   - __ Disagree
   - __ Strongly disagree

5. Science is capable of solving our social problems like crime and drug abuse.
   - __ Strongly agree
   - __ Agree
   - __ Disagree
   - __ Strongly disagree

VII. Understanding of Drug Abuse

Each of the following statements reflects a particular view about the causes of drug abuse. Please rank the statements from 1 to 12. Assign a 1 to the statement that you think is the best explanation for drug abuse, a 2 to the next "best" explanation, and so forth. A 12 should reflect the least plausible explanation.

If you don't think that the statements capture the real causes of drug abuse, please mark "none of the above."

a. _____ Drug abuse is a learned behavior.
b. _____ Drug abuse is a brain disease.
c. _____ Drug abuse is one of the many consequences of living in an impoverished and disorganized neighborhood where drugs and crime are rampant.
d. _____ Drug abuse is a form of stress mismanagement.
e. _____ Drug abuse is determined by antisocial personality.
f. _____ Drug abuse is a maladaptive reaction to poverty and lack of opportunities.
g. _____ Drug abuse is a consequence of separation from God.
h. _____ Drug abuse is caused by a poor self-concept.
i. _____ Drug abuse is caused by a lack of meaning and purpose in life
j. _____ Drug abuse is caused by deficits in parental monitoring and family bonding.
k. _____ People are genetically predisposed to drug abuse.
l. _____ People freely choose to abuse drugs because the pleasures associated with drug use outweigh its costs or pains.
_____ None of the above (In the space below, please take some time to identify what you think are good explanations for drug abuse).

VIII. Drug Policy Preferences

1. Would you like to see more or less government spending in drug abuse treatment? Remember that more government spending might require a tax increase.

__ Spend much more
__ Spend more
__ Spend the same as now
__ Spend less
__ Spend much less

2. Would you like to see more or less government spending in incarceration of drug offenders? Remember that government spending might require a tax increase.

__ Spend much more
__ Spend more
__ Spend the same as now
__ Spend less
__ Spend much less

3. Do you think the *medical* use of marijuana should be made legal or not?

__ Should
__ Should not
__ Don't know

4. Do you think *all* uses of marijuana should be made legal or not?

__ Should
__ Should not
__ Don't know

5. Would you support government spending in needle or syringe exchange programs to prevent HIV infections among drug injectors?

__ No
__ Yes
__ Don't know

6. Should the government fund faith-based drug treatment programs?

__ No
__ Yes
__ Don't know

IX. Drug Abuse Treatment

Each of the following statements reflects a particular drug treatment goal. Please rank the statements from 1 to 10. Assign a 1 to the treatment goal you think is most important, a 2 to the next most important goal, and so forth. A 10 should reflect the goal you think is the least important.

If you don't think that any of the strategies or goals is important or should be stressed, please mark "none of the above."

a. _____ Treatment must focus on helping clients to develop a more positive self-concept.
b. _____ Treatment must focus on helping clients to develop ways of reducing stress.
c. _____ Treatment must emphasize the need for clients to live in a drug-free environment.
d. _____ Advocacy or empowerment services must be offered to counter discrimination against addicts or recovering addicts in clients' communities.
e. _____ Treatment must include educational programs or vocational training services.
f. _____ Treatment must address the spiritual or religious needs of clients.
g. _____ Treatment must include medications either as maintenance or during detoxification.
h. _____ Treatment must focus on helping the client develop self-control and discipline.
i. _____ Treatment must focus on changing the antisocial personality that underlies drug addiction.
j. _____ Treatment must focus on establishing a rapport between counselors and clients.
_____ None of the above (In the space below, please take some time and identify the therapies/strategies/goals you think should be stressed).

1. The relationship between science and religion in drug abuse treatment is one of: (Check one)

__ Conflict: I consider myself to be on the side of science.
__ Conflict: I consider myself to be on the side of religion.
__ Independence: They address different aspects of recovery.
__ Collaboration: Each can be used to validate the other.

Thanks for taking time to complete this questionnaire. Please return the signed and dated consent form as well as this completed questionnaire in the postage paid envelope to:

Doris Chu, Ph.D.
Department of Criminology, Sociology, and Geography
Arkansas State University
P.O. Box 2003
State University, AR 72467

Appendix C: Drug Abuse Counselor Survey

CONSENT FORM

The National Center on Addiction and Substance Abuse (CASA) at Columbia University is conducting this survey of drug abuse counselors to elicit their perspectives related to drug abuse, recovery, and treatment interventions. Please read the following information carefully so that you can make an informed decision about whether or not you are interested in participating in this study.

What is our purpose? A primary aim of this research study is to compare the treatment philosophy of counselors working at faith-based drug rehabilitation programs with that of counselors at secular treatment programs. The information we obtain from this survey will be used to explore how the religious core of faith-based treatment shapes its conceptualization of drug abuse and clinical practices

What are the procedures? If you choose to participate, you will read, sign and date this consent form, respond to the questions on the enclosed survey, and then return them both in the enclosed stamped envelope within two weeks of receipt. We estimate that it will take approximately 15 minutes to complete the survey.

Who is being asked to participate? We have randomly selected 130 drug abuse counselors from the counselor directory provided by the Teen Challenge USA and another 130 from the Odyssey House.

Are there any risks or discomforts? There is the possibility that you may experience minor discomfort with the topics of a few of the questions. You are always free to decline to answer particular questions.

What are the benefits? You will not directly benefit from participation in this research study. However, your participation presents us with a unique opportunity to understand what similarities and differences exist between drug abuse counselors employed by faith-based treatment providers and those by secular treatment providers.

What about confidentiality? In order to protect your confidentiality, your name will not be asked anywhere in the questionnaire itself and as soon as we receive your survey package, the signed consent form will be separated from the questionnaire and kept in a locked cabinet. Survey data will be stored in computers protected with password and firewall. Only senior researchers will have access to these survey data and consent information.

What if I have questions? If you have any questions regarding the research or your participation either now or at any time in the future, you may contact the Principal Investigator of this study, Dr. Hung-En Sung collect at (212) 841-5203. For questions about your rights as a research participant or to report harm as a result of participation, please contact Mr. Rush L. Russell, CASA's IRB Authorizing Director collect at (212) 841-5200.

If you wish to participate, please sign below. Your written consent is required for your participation.

I, _____, understand the nature of this research and I consent to my participation in this survey. I understand that this information will be used only for research purpose and that my confidentiality will be protected.

_____ _____

Signature Date

Background Information

1. Which treatment program are you affiliated with?
   - __ Teen Challenge USA
   - __ Non-Teen Challenge USA

2. Are you male or female?
   - __ Male
   - __ Female

3. Year of birth: 19__

4. With which racial or ethnic group do you identify?
   - __ African American
   - __ White
   - __ Hispanic
   - __ Asian American
   - __ Native American
   - __ Other

5. What is the highest grade of school you have completed?
   - __ Less than high school graduation
   - __ High school graduation or GED
   - __ Some college or associate degree
   - __ Four-year college graduation
   - __ Graduate degree

6. Are you certified or licensed in addictions counseling?
   - __ Not certified or licensed
   - __ Currently certified or licensed
   - __ Previously but not currently certified or licensed

7. Are you yourself a recovered or recovering substance abuser?
   - __ No
   - __ Yes

8. How many years of experience do you have in drug abuse counseling
   - __ Years
   - __ Months

9. How long have you been in your present job?
   - __ Years
   - __ Months

10. On average, how many clients are on your treatment caseload at anytime?
   - __ Clients

Religion and Spirituality

11. To what extent do you consider yourself a religious or spiritual person?
    - __ Very religious or spiritual
    - __ Moderately religious or spiritual
    - __ Slightly religious or spiritual
    - __ Not religious or spiritual at all

12. What is your current religious preference?
    - __ Protestantism
    - __ Judaism
    - __ Hinduism
    - __ Scientology
    - __ Atheism
    - __ Catholicism
    - __ Islam
    - __ Buddhism
    - __ Agnosticism
    - __ Other (please specify: _____)

13. Have you ever had another religious preference besides the religion mentioned in Q. 12.
    - __ No
    - __ Yes

14. How often do you attend religious services?
    - __ Never
    - __ Several times a year
    - __ 2-3 times a month
    - __ Once a week
    - __ Once or twice a year
    - __ Once a month
    - __ Nearly once a week
    - __ Several times a week

15. How often do you read the Bible?
    - __ Not read
    - __ Several times a year
    - __ 2-3 times a month
    - __ Once a week
    - __ Once or twice a year
    - __ Once a month
    - __ Nearly once a week
    - __ Several times a week

16. Have you ever tried to encourage someone to believe in God or to accept God as his or her savior?

__ No
__ Yes
__ Not applicable

17. I look to God for strength, support, and guidance.

__ A great deal
__ Quite a bit
__ Somewhat
__ Not at all

18. Would you say you have been "born again" or have had a "born again" experience – that is, a turning point in your life when you committed yourself to God?

__ No
__ Yes

Human Nature

Do you agree or disagree with the following…

19. Human nature is basically good.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

20. Human nature is fundamentally perverse and corrupt.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

21. Life does not serve any purpose.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

22. There is little that people can do to change the course of their lives.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

23. Life is only meaningful if you provide the meaning yourself.
- __ Strongly agree
- __ Agree
- __ Disagree
- __ Strongly disagree

24. Life is meaningful only because God exists.
- __ Strongly agree
- __ Agree
- __ Disagree
- __ Strongly disagree

25. Right and wrong are not a simple matter of black and white; there are many shades of gray.
- __ Strongly agree
- __ Agree
- __ Disagree
- __ Strongly disagree

26. Right and wrong should be based on God's laws.
- __ Strongly agree
- __ Agree
- __ Disagree
- __ Strongly disagree

27. Morality is a personal matter and society should not force everyone to follow one standard.
- __ Strongly agree
- __ Agree
- __ Disagree
- __ Strongly disagree

28. I feel a deep sense of responsibility for reducing pain and suffering in the world.
- __ Strongly agree
- __ Agree
- __ Disagree
- __ Strongly disagree

Science

Do you agree or disagree with the following…

29. As a society, we believe too often in science, and not enough in feelings and faith.
- __ Strongly agree
- __ Agree
- __ Disagree
- __ Strongly disagree

30. Overall, modern science does more harm than good.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

31. One of the bad effects of science is that it breaks down people's ideas of right and wrong.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

32. Human beings evolved from other species of animals.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

33. Science is capable of solving our social problems like crime and drug abuse.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

34. Any change humans cause in nature - no matter how scientifically-based - is likely to make things worse.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

Drug Abuse

35. Each of the following statements reflects a particular view about the causes of drug abuse. Please rank the statements from 1 to 12. Assign a 1 to the statement that you think is the best explanation for drug abuse, a 2 to the next "best" explanation, and so forth. A 12 should reflect the least plausible explanation.

If you don't think that the statements capture the real causes of drug abuse, please mark "none of the above."

a. _____ Drug abuse is a learned behavior.
b. _____ Drug abuse is a brain disease.
c. _____ Drug abuse is one of the many consequences of living in an impoverished and disorganized neighborhood where drugs and crime are rampant.
d. _____ Drug abuse is a form of stress mismanagement.
e. _____ Drug abuse is determined by antisocial personality.
f. _____ Drug abuse is a maladaptive reaction to poverty and lack of opportunities.
g. _____ Drug abuse is a consequence of separation from God.
h. _____ Drug abuse is caused by a poor self-concept.
i. _____ Drug abuse is caused by a lack of meaning and purpose in life.
j. _____ Drug abuse is caused by deficits in parental monitoring and family bonding.
k. _____ People are genetically predisposed to drug abuse.
l. _____ People freely choose to abuse drugs because the pleasures associated with drug use outweigh its costs or pains.
_____ None of the above (In the space below, please take some time to identify what you think are good explanations for drug abuse).

Drug Policy Preferences

36. Would you like to see more or less government spending in drug abuse treatment? Remember that more government spending might require a tax increase.

__ Spend much more
__ Spend more
__ Spend the same as now
__ Spend less
__ Spend much less

37. Would you like to see more or less government spending in incarceration of drug offenders? Remember that government spending might require a tax increase.

__ Spend much more
__ Spend more
__ Spend the same as now
__ Spend less
__ Spend much less

38. Do you think the *medical* use of marijuana should be made legal ?

__ Should
__ Should not
__ Don't know

39. Do you think *all* uses of marijuana should be made legal?

__ Should
__ Should not
__ Don't know

40. Would you support government spending in needle or syringe exchange programs to prevent HIV infections among drug injectors?

__ No
__ Yes
__ Don't know

41. Should the government fund faith-based drug treatment programs?

__ No
__ Yes
__ Don't know

Drug Abuse Treatment

42. Each of the following statements reflects a particular drug treatment strategy or goal. Please rank the statements from 1 to 10. Assign a 1 to the strategy or goal of drug treatment you think is most important, a 2 to the next most important strategy or goal, and so forth. A 10 should reflect the strategy or goal you think is the least important.

If you don't think that any of the strategies or goals is important or should be stressed, please mark "none of the above."

a. _____ Treatment must focus on helping clients to develop a more positive self-concept.
b. _____ Treatment must focus on helping clients to develop ways of reducing stress.
c. _____ Treatment must emphasize the need for clients to live in a drug-free environment.
d. _____ Treatment must offer advocacy or empowerment services to counter problems in their communities.
e. _____ Treatment must include educational and vocational services.
f. _____ Treatment must address the spiritual or religious needs of clients.
g. _____ Treatment must include medications either as maintenance or during detoxification.
h. _____ Treatment must focus on helping the client develop self-control and discipline.
i. _____ Treatment must focus on changing the antisocial personality that underlies drug addiction.
j. _____ Treatment must focus on establishing a rapport between counselors and clients.
_____ None of the above (In the space below, please take some time and identify the therapies/strategies/goals you think should be stressed).

43. The relationship between science and religion in drug abuse treatment is one of: (Check one)

__ Conflict: I consider myself to be on the side of science.
__ Conflict: I consider myself to be on the side of religion.
__ Independence: They address different aspects of recovery.
__ Collaboration: Each can be used to validate the other.

Practice of Counseling

Please indicate the number or frequency of services delivered to an average client in your program. If no such service is provided in your program, please mark "Not Applicable."

44. How many individual counseling sessions does a typical client in your program attend?
    - __ Sessions a week
    - __ Not applicable

45. How many group counseling sessions does a typical client in your program attend?
    - __ Sessions a week
    - __ Not applicable

46. How many urine specimens from a typical client are collected each month?
    - __ Specimens a month
    - __ Not applicable

47. How many hours of vocational training does a typical client receive in a week?
    - __ Hours a week
    - __ Not applicable

48. How many hours of academic education does a typical client with needs receive in a week?
    - __ Hours a week
    - __ Not applicable

49. How many hours of religious services does a typical client attend in a week?
    - __ Hours a week
    - __ Not applicable

50. How many hours of Bible classes does a typical client receive in a week?
    - __ Hours a week
    - __ Not applicable

51. How many individual counseling sessions do you lead in a typical week?
    - __ Sessions a week
    - __ Not applicable

52. How many group counseling sessions do you lead or help to lead in a typical week?
    - __ Sessions a week
    - __ Not applicable

53. Do you offer vocational training to treatment clients?
    - __ No
    - __ Yes

54. Do you offer educational classes to treatment clients?

__ No
__ Yes

55. How many hours of religious services do you lead or help to lead in a typical week?

__ Hours a week
__ Not applicable

56. How many hours of Bible classes do you teach in a typical week?

__ Hours a week
__ Not applicable

57. Do you agree that you have the skills and confidence needed to conduct effective counseling?

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

58. Now think about the counseling skills that you actually use in your job. Which of the following was most important in developing these skills? (Check one)

__ Formal schooling
__ Past experience as a recovering substance abuser
__ Drug abuse counseling training
__ Experience gained in my present or a previous job

59. On the whole, how satisfied are you with the work you do?

__ Very satisfied
__ Moderately satisfied
__ A little dissatisfied
__ Very dissatisfied

Thanks for taking time to complete this questionnaire. Please return the signed and dated consent form as well as this completed survey in the postage paid envelope to:

Doris Chu, Ph.D.
Department of Criminology, Sociology, and Geography
Arkansas State University
P.O. Box 2003
State University, AR 72467

Appendix D: College Professor Survey

CONSENT FORM

The National Center on Addiction and Substance Abuse (CASA) at Columbia University is conducting this survey of college professors to elicit their perspectives related to drug abuse, recovery, and treatment interventions. Please read the following information carefully so that you can make an informed decision about whether or not you are interested in participating in this study.

What is our purpose? A primary aim of this research is to compare the perceptions of substance addiction and recovery among professors from Christian colleges with that of professors at secular colleges. The information we obtain from this survey will be used to explore how the religious core of Christian higher education institutions shapes the beliefs and views of their faculty members with regard to substance abuse.

What are the procedures? If you choose to participate, you will read, sign and date this consent form, respond to the questions on the enclosed survey, and then return them both in the enclosed stamped addressed enveloped within two weeks of receipt. We estimate that it will take approximately 15 minutes to complete the survey.

Who is being asked to participate? We have randomly selected 55 professors of counseling, human services, and/or practical theology teaching at the 19 colleges and/or seminaries affiliated with the Assemblies of God. In addition, 55 professors of behavioral sciences and human services from secular colleges will also be randomly selected from member institutions of the Consortium of Liberal Arts Colleges and the Council of Public Liberal Arts Colleges.

Are there any risks or discomforts? There is the possibility that you may experience minor discomfort with the topics of some of the questions. You are always free to decline to answer particular questions.

What are the benefits? You will not directly benefit from participation in this research study. However, your participation presents us with a unique opportunity to understand what similarities and differences exist between Christian college professors and those at secular liberal arts colleges regarding their views on substance abuse.

What about confidentiality? In order to protect your confidentiality, your name will not be asked anywhere in the questionnaire itself and as soon as we receive your survey package, the signed consent form will be separated from the questionnaire and kept in a locked cabinet. Survey data will be stored in computers protected with password and firewall. Only senior researchers will have access to these survey data and consent information.

What if I have questions? If you have any questions regarding the research or your participation either now or at any time in the future, you may contact the Principal Investigator of this study, Dr. Hung-En Sung collect at (212) 841-5203. For questions about your rights as a

research participant or to report harm as a result of participation, please contact Mr. Rush Russell, CASA's IRB Authorizing Director collect at (212) 841-5200.

If you wish to participate, please sign below. Your written consent is required for your participation.

I, _____, understand the nature of this research and I consent to my participation in this survey. I understand that this information will be used only for research purpose and that my confidentiality will be protected.

_____ _____

Signature Date

Background Information

1. Which academic department are you affiliated with? _____

2. Are you male or female?
   - __ Male
   - __ Female

3. Year of birth: 19__

4. With which racial or ethnic group do you identify?
   - __ African American
   - __ White
   - __ Hispanic
   - __ Asian American
   - __ Native American
   - __ Other

5. What is the highest grade of school you have completed?
   - __ Some college or associate degree
   - __ Four-year college graduation
   - __ Master's degree
   - __ Doctoral degree

6. Are you certified or licensed in addictions counseling?
   - __ Not certified or licensed
   - __ Currently certified or licensed
   - __ Previously but not currently certified or licensed

7. Are you yourself a recovered or recovering substance abuser?
   - __ No
   - __ Yes

8. Have you ever taught any substance abuse related courses?
   - __ No
   - __ Yes

9. How many years of experience do you have in teaching substance related courses?
   - __ Years
   - __ None

10. How long have you been in your present job?
   - __ Years
   - __ Months

Religion and Spirituality

11. To what extent do you consider yourself a religious or spiritual person?
    - __ Very religious or spiritual
    - __ Moderately religious or spiritual
    - __ Slightly religious or spiritual
    - __ Not religious or spiritual at all

12. What is your current religious preference?
    - __ Protestantism
    - __ Judaism
    - __ Hinduism
    - __ Scientology
    - __ Atheism
    - __ Catholicism
    - __ Islam
    - __ Buddhism
    - __ Agnosticism
    - __ Other (please specify_____)

13. Have you ever had another religious preference besides being (religion mentioned in Q. 12).
    - __ No
    - __ Yes

14. How often do you attend religious services?
    - __ Never
    - __ Several times a year
    - __ 2-3 times a month
    - __ Once a week
    - __ Once or twice a year
    - __ Once a month
    - __ Nearly once a week
    - __ Several times a week

15. How often do you read the Bible?
    - __ Never
    - __ Several times a year
    - __ 2-3 times a month
    - __ Once a week
    - __ Once or twice a year
    - __ Once a month
    - __ Nearly once a week
    - __ Several times a week

16. Have you ever tried to encourage someone to believe in God or to accept God as his or her savior?

__ No
__ Yes

17. To what extent do you look to God for strength, support, and guidance?

__ A great deal
__ Quite a bit
__ Somewhat
__ Not at all

18. Would you say you have been "born again" or have had a "born again" experience – that is, a turning point in your life when you committed yourself to God?

__ No
__ Yes

Human Nature

Do you agree or disagree with the following…

19. Human nature is basically good.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

20. Human nature is fundamentally perverse and corrupt.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

21. Life does not serve any purpose.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

22. There is little that people can do to change the course of their lives.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

23. Life is only meaningful if you provide the meaning yourself.
- __ Strongly agree
- __ Agree
- __ Disagree
- __ Strongly disagree

24. Life is meaningful only because God exists.
- __ Strongly agree
- __ Agree
- __ Disagree
- __ Strongly disagree

25. Right and wrong are not a simple matter of black and white; there are many shades of gray.
- __ Strongly agree
- __ Agree
- __ Disagree
- __ Strongly disagree

26. Right and wrong should be based on God's laws.
- __ Strongly agree
- __ Agree
- __ Disagree
- __ Strongly disagree

27. Morality is a personal matter and society should not force everyone to follow one standard.
- __ Strongly agree
- __ Agree
- __ Disagree
- __ Strongly disagree

28. You feel a deep sense of responsibility for reducing pain and suffering in the world.
- __ Strongly agree
- __ Agree
- __ Disagree
- __ Strongly disagree

Science

Do you agree or disagree with the following…

29. We, as a society, believe too often in science, and not enough in feelings and faith.
- __ Strongly agree
- __ Agree
- __ Disagree
- __ Strongly disagree

30. Overall, modern science does more harm than good.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

31. One of the bad effects of science is that it weakens people's ideas of right and wrong.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

32. Human beings evolved from other species of animals.

__ Strongly agree
__ Agree
__ Disagree
__ Strongly disagree

33. Science is capable of solving our social problems like crime and drug abuse.

__ Strongly agree
__ Agree
__ Disagree
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34. Any change humans cause in nature - no matter how scientifically-based - is likely to make things worse.

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Drug Abuse

35. Each of the following statements reflects a particular view about the causes of drug abuse. Please rank the statements from 1 to 12. Assign a 1 to the statement that you think is the best explanation for drug abuse, a 2 to the next "best" explanation, and so forth. A 12 should reflect the least plausible explanation.

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l. _____ People freely choose to abuse drugs because the pleasures associated with drug use outweigh its costs or pains.
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Drug Policy Preferences

36. Would you like to see more or less government spending in drug abuse treatment? Remember that more government spending might require a tax increase.

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__ Spend more
__ Spend the same as now
__ Spend less
__ Spend much less

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__ Should not
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40. Would you support government spending in needle or syringe exchange programs to prevent HIV infections among drug injectors?

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__ Yes
__ Don't know

41. Should the government fund faith-based drug treatment programs?

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Drug Abuse Treatment

42. Each of the following statements reflects a particular drug treatment strategy or goal. Please rank the statements from 1 to 10. Assign a 1 to the strategy or goal of drug treatment you think is most important, a 2 to the next most important strategy or goal, and so forth. A 10 should reflect the strategy or goal you think is the least important.

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__ Independence: They address different aspects of recovery.
__ Collaboration: Each can be used to validate the other.

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Department of Criminology, Sociology, and Geography
Arkansas State University
P.O. Box 2003
State University, AR 72467

Notes

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