2011

Court mandated treatments: Participation in Alcoholics Anonymous

Ruth Sophia Guerrero

COURT MANDATED TREATMENTS: PARTICIPATION IN ALCOHOLICS ANONYMOUS

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

---

by

Ruth Sophia Guerrero

September 2011

COURT MANDATED TREATMENTS: PARTICIPATION IN ALCOHOLICS ANONYMOUS

A Project

Presented to the

Faculty of

California State University,

San Bernardino

by

Ruth Sophia Guerrero

September 2011

Approved by:

[redacted]

Dr. Tom Davis, Faculty Supervisor
Social Work

6/14/11
Date

[redacted]

Dr. Rosemary McCaslin,
M.S.W. Research Coordinator

ABSTRACT

The purpose of this study was to conduct a descriptive analysis of the effect of Alcoholics Anonymous (A.A.) on court mandated substance abuse treatment programs. As social workers we need an understanding of substance abuse court mandated treatment programs which have gained in popularity due to the continued abuse of alcohol in our society. This study utilized a snowball sample of individuals participating in A.A. A qualitative and quantitative research method was used to examine the affects of A.A. on the mandated treatment program(s) and the roles A.A. and the treatment program play in recovery.

Research findings revealed those who participated in these programs and A.A. felt A.A. provided a support system which consists of other individuals in the recovery process. The mandated participants valued their participation in A.A., the foundation and structure of A.A. and the programs which lead them to A.A. Recommendations for further research include a larger sample size to ensure these findings were the norm and not outliers and a control group is needed consisting of court mandated participants without A.A. participation involvement for a comparison study. In conclusion by

understanding of the importance of A.A. in relation to court mandated substance abuse treatment programs we can better empower clients to utilize A.A. in their recovery.

ACKNOWLEDGMENTS

Thank you to my family and friends who have helped me through this process. A special thank you to my husband, mother, mopsy and popsy who's continually support urged me on.

Thank you to Dr. Tom Davis my thesis advisor who has offered me support and guidance in the completion of this project.

DEDICATION

To my husband, Matty, who supported me throughout my schooling; I could not have done it without your love and understanding.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE

INTRODUCTION

Introduction

Chapter one presents an overview of the problem, definitions of substance use and abuse, historical background information and how this issue impacts social work practice. There are many substances that are abused in our society. This study is focused on alcohol and its particular effects on our society on macro, mezzo and micro levels and why it is important to pay attention to alcohol use and abuse.

Problem Statement

Substance abuse has become a plague on our society. It hurts both the individuals who abuse substances and those around them. The National Institute of Drug Abuse (NIDA, 2007) states in *The Science of Addiction* that:

> Abuse and addiction to alcohol . . . and illegal substances cost Americans upwards of half a trillion dollars a year, considering their combined medical, economic, criminal, and social impact. Every year, abuse of illicit drugs and alcohol contributes to the

> death of more than 100,000 Americans, while tobacco is linked to an estimated 440,000 deaths per year. (p. 3)

Substance abuse, particularly alcohol misuse and abuse, affect every aspect of our society.

A national survey published by Substance Abuse and Mental Health Services Administration, SAMHSA, (2008), report that "slightly more than half of Americans aged 12 or older reported being current drinkers of alcohol…This translates to an estimated 126.8 million people" (p. 10). As a society we have tried to combat substance abuse with laws, fines, incarceration and mandated treatment programs. The first anti-drug law was passed in 1875, outlawing opium dens in San Francisco, CA (Common Sense for Drug Policy, 2007). Other laws have been passed since, such as prohibition against alcohol in 1919. Presidents like Nixon have even declared "war" on drugs (Common Sense for Drug Policy, 2007). In 2000, California voters passed Proposition 36, allowing people convicted of first or second time nonviolent drug possession to receive drug treatment instead of prison (Common Sense for Drug Policy, 2007). This shows understanding that drug abuse needs to be treated, not punished.

The US Department of Justice, reports that:

> More than 36% of the 5.3 million convicted adult offenders under the jurisdiction of probation authorities, jails, prisons, or parole agencies in 1996 had been drinking at the time of the offenses for which they had been convicted. This translates into just under 2 million convicted offenders nationwide on an average day. (Greenfield, 1998, p. 20)

It was also found:

> About 6 in 10 convicted jail inmates said that they had been drinking on a regular basis during the year before the offense for which they were serving time. Nearly 2 out of 3 of these inmates, regardless of whether they drank daily or less often, reported having previously been in a treatment program for an alcohol dependency problem. (Greenfield, 1998, p. 27)

In order to understand how one is impaired when drinking alcohol we turn to NIDA, (2007) where *The Science of Addiction* describes what occurs:

> Alcohol consumption can damage the brain and most body organs. Areas of the brain that are especially

vulnerable to alcohol-related damage are the cerebral cortex (largely responsible for our higher brain functions, including problem solving and decision making), the hippocampus (important for memory and learning), and the cerebellum (important for movement coordination). (p. 23)

According to the Bureau of Justice, in 2004 37% of felony cases filed was drug offenses, followed by property offenses at 31%. In 2006 approximately 17,600 people died in 13,470 alcohol related car accidents and 1.46 million were arrested for driving while intoxicated (DWI) or a driving under the influence (DUI) (DUI Foundation, 2008). Drunk driving is one of the major causes of death among people 25 and younger (DUI Foundation, 2008).

There are many organizations concerned with alcohol abuse and drug abuse such as Students Against Destructive Decisions (SADD), Alcoholics Anonymous (A.A.), Mothers Against Drunk Driving (MADD) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). SADD is geared towards middle school, high school and college age groups. SADD's mission is "To provide students with the best prevention tools possible to deal with the issues of

underage drinking, other drug use, impaired driving and other destructive decisions" (SADD, 2009, p. 1).

A.A. is a non-profit twelve step recovery programs run by those who are in recovery themselves, fighting against their alcoholism. "Since its inception in the United States in 1935, Alcoholics Anonymous has grown to become the largest and most well-known self-help organization for alcohol problems not only in the United States but worldwide" (Laudet, 2008, p. 71). A.A.'s "only requirement is the desire to stop drinking" (Alcoholics Anonymous World Services, Inc., 2010, p.1).

A.A. consists of both men and women who come together to "share their experience, strength and hope" with other members to solve their problems of alcoholism and help each other on the road to recovery (Alcoholics Anonymous World Services, Inc., 2010, p.1). A.A. groups are supported by member donations, not association fees. A.A. has no affiliation with any group so there is no appearance of bias (Alcoholics Anonymous World Services, Inc., 2010). Their "primary purpose is to stay sober and help other alcoholics to achieve sobriety" (Alcoholics Anonymous World Services, Inc., 2010, p.1). Alcoholics

Anonymous and the role it plays in substance abuse recovery will be explained further in Chapter 2.

MADD is a non-profit organization with the mission of stopping drunk driving, preventing underage drinking and supporting stricter policies regarding alcohol use and abuse (Mothers against drunk driving, MADD, 2009). MADD reports that three in every ten Americans will be involved in an alcohol-related crash in their lives (MADD, 2009).

The National Institute on Alcohol Abuse and Alcoholism's, NIAAA, (2009) mission and values are to "provide leadership in the national effort to reduce alcohol-related problems" and to "support and promote the best science on alcohol and health for the benefit of all" (p. 1).

Purpose of the Study

The purpose of this study is to understand the connection between substance abuse court mandated treatment programs and Alcoholics Anonymous (A.A.). In San Bernardino County there are a variety of sentencing options for those who commit crimes related to substance abuse, e.g. drug court, inpatient and outpatient

treatment programs, D.U.I. classes and mandated A.A. participation. These drug diversion programs offer a variety of treatment techniques and may require different levels of participation in A.A.

Significance of the Project for Social Work

As we come to understand A.A. and its relation to court mandated treatment programs we can better assist our clients in their recovery. The National Highway Traffic Safety Administration (2008) recently reported that repeat offenders of DUIs constituted one-third of all people arrested for DUI. This is just one example of how the current system we are using to mitigate alcoholism is not effective.

This study will assist us in evaluating whether or not our current practices with court mandated treatment programs and A.A. are useful. In using the generalist social work model one will be able to assess, implement and evaluate this in their social work practice. According to the National Association of Social Workers Code of Ethics (1999) we need to be competent in the services we provide. By gaining a better understanding of

A.A. through the generalist model we can gain the competence we need in our practice.

The research question is "Does participation in court mandated treatments lead to continued participation in Alcoholic Anonymous?"

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter will cover literature relevant to substance use abuse, with a focus on alcohol, and its effects on our society. Literature on alcohol, court mandated treatments, Alcoholics Anonymous (A.A.) and theories guiding conceptualization will also be covered

Effect on Society

The National Highway Traffic Safety Administration, NHTSA, (2008) found that in 2008, 37,261 people died in alcohol-related car accidents versus 41,259 fatalities in 2007. Even though fatalities have decreased, alcohol abuse is still greatly affecting our society. "Thirty-one percent of all fatal crashes involved alcohol-impaired driving, where the highest blood alcohol concentration (BAC) among drivers involved in the crash was .08 grams per deciliter (g/dl) or higher" (NHTSA, 2008, p. 45)." The percent of alcohol related fatal accidents increase to 64% from midnight to 3 a.m. (NHTSA, 2008). These statistics demonstrate the severity of alcohol abuse and

its high cost to our society in lives; both the substance abuser and the innocent.

Alcohol

"Alcoholics" have been defined as those who view alcohol as an important part of their life (DUI Foundation, 2008). There are multiple areas that have legal repercussion for alcohol abuse in our society. One of these is driving under the influence and driving while intoxicated. Driving under the influence and driving while intoxicated, like substance abuse itself, crosses all socioeconomic, and age groups, race, gender and political persuasion (Jackson & Bonacker, 2006; Wells-Parker, Anderson, McMillen & Landrum, 1989).

The American Medical Association and the British Medical Association, as well as other doctors in the field, believe that alcoholism is an illness, just like Alcoholics Anonymous (A.A.). A.A. believes that because alcoholics are ill in both the mind and body, they cannot control their drinking and alcoholism will progressively gets worsen as time goes on (Alcoholics Anonymous World Services, Inc., 1972).

When using alcohol, the offender's judgment is affected and their rational thinking becomes impaired which can affect the high recidivism rates of DUI/DWI. Yu, Evans and Clark (2006) argue:

> That when offenders are addicted to one or several substances (in the current case, alcohol), their rational thinking process tends to be interrupted, and they are likely to commit multiple offenses regardless of their past experiences with certain, severe, and swift punishments for the crime (p. 166)

These researchers looked into deterrence and "the conception of crime deterrence postulates that human beings weigh both positive and negative consequences of their actions and take advantage of criminal opportunities only if it is in their self-interest to do so" (Yu et al., 2006, p. 165).

According to NIDA, (2007) in *The Science of Addiction*, those who "abuse drugs often have problems thinking clearly, remembering, and paying attention; they often develop poor social behaviors, and their work performance and personal relationships suffer" as a result of their drug abuse (p.3). Alcoholics Anonymous reports some of the symptoms, thoughts or actions of an alcoholic

are "only alcohol can make them feel self-confident and at ease with other people," "drink at work or in school," "drink alone," "drink in the morning," or "have convulsions when they withdrawal from liquor" (Alcoholics Anonymous World Services, Inc., 1972, p.6).

Court Treatment Programs

DUI/DWI has a variety of sanctions or punishments which vary from jail time, to revoking a driver license, mandated treatment, educational classes, community services and fines (Jackson & Bonacker, 2006). Court treatment programs can be assigned to offenses which involve substance use or abuse, such as buying/selling illegal drugs or being under the influence while committing a crime. However, court treatment programs are usually reserved for first or second time non-violent offenders.

An important aspect of court mandated treatment programs is the need to treat not just the offender, but the whole person and to assess other needs, such as mental health (Nelson, LaPlante, Peller, Labride, Caro & Shaffer, 2007). Treatment programs do not always take into account one's culture; there is a format and

curriculum with the belief that one size fits all. Wells-Parker et al., (1989) discuss how unlikely it is that one treatment strategy would be effective across a people of diverse groups. One's culture can play a significant part in recovery and the variety of A.A. groups can help members find one that fits their needs best.

Alcoholics Anonymous

Even though A.A. is voluntary they welcome those who are mandated by court or treatment programs. A.A. reports that many members first started with the program because they were forced by something or someone, e.g. courts, treatment programs, family, work or various other reasons (Alcoholics Anonymous World Services, Inc, 2009). Most A.A. groups have found a way for mandated members to bring proof of attendance by having an attendance sheet signed off by someone in leadership of the group. "A.A. members do not report to court professionals on the 'progress' of another member because it is 'strictly outside the scope of what AA does" (Alcoholics Anonymous World Services, Inc, 2009, p.2).

The anonymity of A.A. is also their largest downfall when it comes to gathering correct and accurate data for

research (Tonigan, 2009). It is hard to see the effectiveness of A.A. in our society for this reason. One study reports that about 3% of the populations have been exposed to A.A or a form of it in their life time (Kaskutas, Ye, Greenfield, Witbrodt, & Bond, 2009, p.280). The question is, is that number accurate since data is so hard to gather?

Alcoholics Anonymous teaches that all members are "powerless over alcohol" and should abstain from drinking. Members of A.A. who have not had a drink in months or years are still alcoholics and have lost the ability to control their drinking and can never be sure of drinking safely. A.A. never uses the word "cure", but focus on "sobriety" and being a "recovered alcoholic" (Alcoholics Anonymous World Services, Inc., 1972). This powerless concept may seem disempowering to some, but it is not. Alcoholics Anonymous' twelve steps program as a whole is empowering by encouraging the member with their individual strengths to going out and help others in their recovery (Kurtz, Fisher, 2003). "Twelve-step fellowships are true mutual aid societies; there is no "leader" running the organization or making decisions for the membership" Laudet, 2008, p.80).

Theories Guiding Conceptualization

Lesser and Pope (2007) explain that person in the environment theory focuses on the individual and also the environment in which they live. Offenders, like everyone else, are affected by the environment in which they live. Their environment affects how much they drink, with whom, and where they go. Each individual is different and needs to be looked at in terms of their needs and not just the requirements necessary to complete their mandated court program. Without looking at the relationship A.A. plays in court mandated treatment programs, we cannot know the significance A.A. may play in the program.

Court mandated substance abuse programs are impacted by systems theory because it is one of the systems the client is involved in. (Lesser and Pope, 2007). The client has violated the "legal system" and then is sent to the "court system" which has decided that, as the law states, they must go to a mandated treatment programs which is its own system. The mandated treatment programs have to work within their own system, providing what services they can. The client is also affected by the restaurant/bar system in which some are more effective at "cutting" one off from alcohol before the individual is

too incapacitated to drive or think clearly. These systems are interlocking and greatly affect one another. Without cooperation, the systems cannot effectively change. They must work together to create and sustain change.

Summary

When one places themselves behind the wheel while intoxicated, they are not only placing themselves at risk but also those around them. Substance abuse has no bounds and crosses all socioeconomic status, gender, cultures and political views. Due to the vast variety of people abusing alcohol, we need to understand A.A.'s involvement in the recovery process.

CHAPTER THREE

METHODS

Introduction

This research project is an exploratory study into whether court mandated treatments lead to continued participation in Alcoholics Anonymous. The survey contains qualitative and quantitative questions in order to gather the most appropriate information. This study's goal was to evaluate if court mandated treatment programs sent clients to Alcoholics Anonymous and its effectiveness in doing so.

Study Design

The surveys contained both quantitative and qualitative questions. Participants were provided with a survey and a self addressed, pre-stamped envelope. Participants were also able to take the survey online at www.questionpro.com. This allowed participants to fill out the survey at their leisure and at their own level of privacy. Surveys submitted online are anonymous, IP addresses were not gathered. Those who participated by mail returned the survey to the researcher's P.O. Box.

The study's objective was to find out if the participants' participation in A.A. groups has been affected by attendance in court mandated treatments. The study explored which type of mandated treatment program were helpful and if it lead to their participation in A.A. This was done by gathering data regarding A.A. participation and information regarding the court mandated program(s) they have attended. This is a single group study design with qualitative and quantitative questions. The quantitative part of the survey will use nominal, scale, and ordinal type questions. A Likert scale will be used for the majority of questions to make comparison easier. The qualitative portion will have open ended questions designed in order to gather additional insight into the participants' views.

Sampling

The goal of the study was to survey 40 to 50 people. At the end of the process 20 people had completed surveys. Three people chose to fill it out online and 17 mailed surveys in. The participants were recruited from multiple Alcoholic Anonymous meetings. Participants were also recruited from A.A. members known to the researcher.

These members then provided the surveys to other A.A. members in the community, creating a snowball sample.

The study looked at both males and females who are over the age of eighteen currently participating in A.A. and have participated in the past. The surveys were given to A.A. members regardless of their involvement in court mandated substance abuse treatment programs.

Data Collection and Instruments

The data was collected from surveys which contained both quantitative and qualitative aspects. (See Appendix A.) The dependent variable is their level of participation in Alcoholics Anonymous and if they were participants in court mandated treatment.

The independent variables are the basic demographic questions covering age, ethnicity, income, incarceration, gender and how many mandated treatment programs they have been in; these are nominal levels of measurement. The survey also asked, questions pertaining to their participation in A.A., which is an ordinal level of measurement. There are a few qualitative questions throughout the survey to gain more insight into the participant's views.

Procedures

Data collection took place during a two month period in 2011. Participants were selected randomly by a snowball sample through individuals known to participate in A.A. If they desired each participant was able to hand out additional surveys to other A.A. members. Each participant was given the informed consent for the study. (See Appendix B.) The participants then received the survey or were provided a link to the survey at www.questionpro.com and were free to answer as they choose. The debriefing statement was attached to the end of each survey. (See Appendix C.) Each participant was allowed to fill out the survey at their own leisure.

Protection of Human Subjects

The first thing the participants were asked to do after volunteering for the study was to read the informed consent. The informed consent consists of the researcher's information, goal of the study, methods used, duration of the study, the voluntary nature of the study and participants' ability to withdraw at any time. It also included any foreseeable risks and whom they could contact if they had any questions.

The survey had no identifying markers on it in order to ensure confidentiality. A post office box was prepared where the individuals were able to mail a pre-addressed, pre-stamped envelope. The online survey did not track identifiable markers or IP addresses of the survey. This ensured the participant anonymity. I was the only person who held keys to the P.O. Box and retrieved surveys myself. The surveys were locked in a safe in my home to ensure confidentiality. The online website, www.questionpro.com, has their security system to maintain confidentiality. I was the only person who knew the password to retrieve survey responses.

The participants were provided with the debriefing statement after the survey was provided to them. Once the surveys were collected and the data analyzed the surveys were destroyed. The data was analyzed as a group which will minimize the risk identifying participants. Since multiple locations were surveyed this also reduced the risk of identifying participants. These findings will assist social workers in having an understanding of the importance of Alcoholics Anonymous in recovery and its involvement in court mandated treatment programs.

Data Analysis

The data from this study was analyzed using both qualitative and quantitative methods. The quantitative data was collected and analyzed. Frequencies and descriptive statics were run on the quantitative variables. Correlations were run on some of the Likert scale questions for comparison. A chi-squared test was not run due to the sample size. The mean, median, mode and standard deviations were also computed.

The qualitative information was transcribed in order to view it more effectively. The information was categorized into broad groups and then refined into more specific categories. These responses assisted in gaining further insight into the views of the participants and how A.A. and court mandated treatment programs are effective. Themes were found across the study and are discussed in the following chapter. The information was further analyzed by looking for the meaning and relationships within the study in chapter 5.

Summary

This chapter covered the general methods for the study. The study design and sampling gave an overview of

what took place. This chapter reviewed the data collection instruments, procedures, the protection of human subjects and how the data was analyze once the data was complied.

CHAPTER FOUR

RESULTS

Introduction

This chapter covers the finding of this research study. It explains the demographics of the participants surveyed and an analysis of the responses obtained consisting of both quantitative and qualitative data.

Presentation of the Findings

Table 1 entails the demographic characteristics of the participants of this research study. Of the 20 participants in the study, 55% were male and 45% were female. The age range was 33 to 66 years with a mean of 49 and Median of 51. The majority of the participants in this research study were Caucasian (85%). In the study all other ethnic groups were under represented as indicated by Hispanic (10%) and African American (5%).

Additional demographics of Table 1 are the annual income and marital status of the participants. In regards to annual household income of the study's participants, most participants made between $41,000- 80,000 (50%) annually. 30% of the participants made under $40,000

annually and 15% made over 80,000 annually with one participant choosing not to respond. The majority of the participants were single (35%) or married (35%). 20 % of the participants were cohabitated and 10% were either separated or divorced.

Table 1 describes the participants' length of time they have been participated in A.A. and been in recovery and how often the participants attend A.A. meetings. The research participants' participation time in A.A. varied from 21 days to 9855 days (27 years) with a mean of 3917 (10 years and almost 9 months) and a median of 2737 (about 7 and a half years). The length of time in recovery/sobriety ranges from 0 days to 27 years with a mean of 3726 days (10 years and almost 3 months) and a median of 3018 days (8 years and about 3 months). Of the research participants most attended A.A. meetings between 2-3 times per week (45%). Other participants attended A.A. meetings 4-7 times per week (35%) or one time or less per week (20%).

Table 2 describes information pertained to the 11 of the 20 research participants (55%) who participated in a court mandated treatment programs. The majority of the participants were court ordered to participate in

mandated treatment programs between 1-2 times (72%). Other participants were ordered to a court mandated treatment programs 3-4 times (28%). Of those participants who participated in court mandated treatment programs 55% were court order to A.A. participation and 82% were mandated A.A. participation by their treatment program; there is some overlap as some participants were both court order A.A. and mandated by their treatment program to go to A.A. they were court order to. 70% of the participants reported that the mandated treatment program was very helpful towards their recovery and 64% believed that the treatment program also greatly influenced their recovery. 73% of the participants strongly agreed that the mandated treatment program was useful.

Table 2 displays all the answers written down with 42% choosing inpatient treatment and 34% mandated A.A. participation were the most helpful programs. Drug court, outpatient and DUI classes were all only chosen once (8% each). Some participants chose multiple programs instead of just one as what was the most helpful treatment program and all responses were displayed.

Table 1. Demographic Characteristics of the Participants

Variable	Frequency (n)	Percentage (%)
Gender		
Male	11	55
Female	9	45
Ethnicity		
Hispanic	2	10
African American	1	5
Caucasian	17	85
Age Mean: 49	Median: 51	Range: 33
31-40	4	20
41-50	5	25
51-60	10	50
61-70	1	5
Marital Status		
Single	7	35
Married	7	35
Separated/Divorced	2	10
Cohabitated	4	20
Annual Income		
20,000 or less	3	15
21,000-40,000	3	15
41,000-60,000	5	25
61,000-80,000	5	25
81,000-100,000	2	10
101,000 or above	1	5
No response	1	5
Length of Time in A.A. participation		
Mean: 3917	Median: 2737	Range: 9855
21 days - 2.5years	7	35
4 years - 10 years	5	25
16 1/2 years - 27 years	8	40
Length of time in Recovery/Sobriety		
Mean: 3726	Median: 3018	Range: 9855
0 days - 2.5years	7	35
4 years - 10 years	6	30
16 years - 27 years	7	35
How often participants attend A.A. (N=20)		
1x per week or less	4	20
2-3x per week	9	45
4-7x per week	7	35

Table 2. Court Order Treatment Participant Responses

Variable	Frequency (n)	Percentage (%)
Participation in Court mandated treatment (N=20)		
Yes	11	55
No	9	45
Court ordered treatment programs (N=11)		
1-2 court treatment programs	8	72
3-4 court treatment programs	3	28
Court directed to participate in A.A.		
Yes	6	55
No	5	45
Court program mandated to participate in A.A.		
Yes	9	82
No	2	18
Program helpful towards their recovery (N=10)		
Not helpful	1	10
Somewhat helpful	1	10
Helpful	1	10
Very helpful	7	70
Program influence on their recovery		
Not influence	2	18
Influence	2	18
Greatly Influence	7	64
Program was useful		
Strongly disagree	1	9
Neutral	1	9
Agree	1	9
Strongly Agree	8	73
Most helpful mandated treatment program(s)		
Mandated A.A.	4	34
Inpatient Treatment	5	42
Outpatient Treatment	1	8
DUI Classes	1	8
Drug Court	1	8

Table 3 refers to what aspects of the treatment programs were most beneficial to the participants. The majority of the participants felt that the counselors (70%), sponsors (60%) and A.A. participation (60%) were the most beneficial aspects to their treatment programs. Videos/Movies (90%) and lecture (70%) were the least beneficial aspects to the treatment programs.

When ask an open-ended question if there were any other helpful areas of the treatment programs which were helpful to their recovery (survey question 25) only 4 participants responded. Participant 12 and 19 refer to the staff help and Participant 5 (personal communication, 2011) felt the "Camaraderie with other women" was helpful with Participant 4 referring to the structure and rules of the program.

Table 3. Ranking the Aspects of the Treatment Programs (1 most beneficial to 10 least beneficial)

Variable	Frequency (n)	Percentage (%)
Probation Officer (N=8)		
1-3	2	25
4-6	2	25
7-10	4	50
Counselors (N=10)		
1-3	7	70
4-6	3	30
Sponsor (N=10)		
1-3	6	60
4-6	3	30
7-10	1	10
Groups (N=10)		
1-3	5	50
4-6	3	30
7-10	2	20
Other participants (N=10)		
1-3	3	30
4-6	5	50
7-10	2	20
Follow-up services (N=8)		
1-3	1	12
4-6	3	38
7-10	4	50
Lecture (N=10)		
1-3	1	10
4-6	2	20
7-10	7	70
A.A. participation (N=10)		
1-3	6	60
4-6	2	20
7-10	2	20
Drug Testing (N=8)		
1-3	1	12
4-6	3	38
7-10	4	50
Videos/Movies (N=10)		
4-6	1	10
7-10	9	90

Table 4 correlates the length of all participants' participation in A.A. and their length of time in recovery. This was a significant correlation because of the similarity in the questions. This was not expected because some participants were thought have been participating in A.A. longer then they were in their recovery or vise versa. This may also be highly correlated depending up one's definition of "recovery".

Table 4. Length of Participation Correlated to Recovery

	Length in A.A. participation	Length in Recovery
Length in A.A. participation Pearson Correlation Sig. (2-tailed)	1	0.86
Length in Recovery Pearson Correlation Sig. (2-tailed)	0.86	1

Table 5 highly correlates the participants' positive view of the helpfulness of the mandated treatment program and the positive influence on their recovery. This was to be expected.

Table 5. Helpfulness Correlated to Influence on Recovery

	Mandated treatment program helpful	Treatment influence on their recovery
Mandated treatment program helpful Pearson Correlation	1	0.86
Sig. (2-tailed)		
Treatment Influence on their recovery Pearson Correlation	0.86	1
Sig. (2-tailed)		

Qualitative Data

The qualitative data was analyzed and then categorized into themes. These themes are discussed below. The participants in this study felt there were many ways in which A.A. meetings were helpful in their recovery. Thirteen of the twenty participants' referenced the value of the support group when describing the fellowship, sharing opportunities and understanding gained from other members. These are only some of the many responses that pertain to their A.A. meetings which are in providing a good support group and as Participant 12 stated "the unity within A.A. Groups is very strong, and this is . . . a very strong bond . . ." (personal communication, March 2011).

Another theme from the participants is the intrinsic value it holds for its members on a personal level. Seven participants referred to it in different ways such as Participant 1 reported "tremendous feelings of well being" and keeping focus "on achieving sobriety" (personal communication, February 2011).

A less significant amount of participants referred to spirituality (3 participants), the 12 step program (3 participants) and accountability (3 participants). Spirituality was described as the power of God and God's purpose in individual lives. The 12 steps disclosed in the survey were as a part of implementing change into their lives. Other participants explained accountability from other members who are able to provide them feedback which was significant.

For those participants who participated in court mandated treatment programs the majority felt the mandated treatment program was helpful to their recovery. Of the 8 that responded to this question 20, 5 of them referred to importance of learning tools, such as Participant 10 stated "Because I had to learn how to love myself before I could love my children and got to work on my issues" (personal communication, February 2011). Three

participants referred to how they would not be in recovery/sobriety today without the mandated treatment program. Participant 19 wrote "If not for that treatment program I . . . probably would have died out there using; I owe them my life in more ways than one" (personal communication, March 2011). Participants 8 and 5 reported that some treatment programs were not helpful to their recovery.

In discussing question 22 on the survey regarding how the treatment program influenced their recovery, even though this is similar to the previous question, it assisted in gaining further insight into the participants' perceptions. Key themes was the sobriety gained and what they have been taught and again how two participants felt the programs did not influence their recovery. Participant 18 and 20 valued being away from other addicts during the treatment process. Participants 4, 9, 10, 12 and 17 referred to the things they had learned and tools they gained while participating in A.A. For Participant 12 and 19 they express how they would not be in the same place today if they hadn't started their recovery process. Participant 12 reported it gave him

"the motivation to want to stay sober and out of prison" (personal communication, March 2011).

Summary

This chapter covered both the quantitative and the qualitative findings of the survey. The demographic frequencies of the participants and the main qualitative themes were provided. All of these participants were able to clearly describe why A.A. was helpful and the participants who participated in court ordered treatment services were able to provide insights into why A.A. participation was influential to their recovery.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter explores the meaning behind this research and what was discovered. This will focus on the qualitative data extrapolated from the study. The limitations and recommendations for social work practice, policy and research will be addressed.

Discussion

This study found that the relationship between persons in recovery and the length of participation in A.A. were significantly correlated. Recovery may have meant different things to different individuals, from having the occasional relapses on the way or never having a relapse at all. Since the concept of recovery varies, it is hard to know if relapse has occurred but what we do know is that the participants are in recovery. A.A. has taught its members that not all is lost if relapse occurs, but that they need to strive towards recovery no matter what.

These participants showed how each individual travels differently through recovery with different levels of involvement needed in A.A. Participant 13 wrote "I used to drink every day, so why not go to a meeting every day" (personal communication, February 2011). 45% of the participants attending A.A. 2-3 times weekly and 35% attending more than 4 times in a week shows the connection to its members and the value they hold to one's personal recovery process. This shows the value of the A.A. support system, especially since over half of the participants were married or cohabitated. This could lead one to believe they had a support system in the home with their family.

A.A. is an important part of the recovery process for many people and provides a significant support network for those in recovery (Longabaugh, Wirtz, Zweben & Stout, 1998). This exploratory study provided insights into why participants felt A.A. was helpful to their recovery. One of the themes discussed was group support and the concept of self-help mutual aid. Self help mutual aid is the "communication and interaction among members" in a group who are "helping one another as they think things through" (Steinberg, 2004, p.3). This means that the participants

felt that the group gave them a connection to one another; a new social support network. Fisher and Harrison (2009) describe the need for those in recovery to develop a new support system that does not contain the same individuals who abuse substances themselves. An example of this is from Participant 5, who stated "talk about issues, gain understanding from members" (personal communication, February 2011). Self-help mutual aid is about the feedback and the helpfulness of others who have experienced the same things.

Shared experiences are core to A.A. meetings and create a bond that can become as strong, if not stronger, than family. The power of having a sense of belonging, acceptance and maybe even love within a group that one has participated in for many years is significant to their recovery. With the support system being as a family the members are held accountable for their actions and help each other in the recovery process. Participant 10 says it best "Because when I'm going through something someone else is going through the same thing and I like to be of service" (personal communication, February 2011).

Seven of the participants also discussed the intrinsic value A.A. holds for its members on a personal

level such as the focus it can bring and developing a sense of being. These participants were trying to describe how important A.A. is to them and its significance in their life. Participant 15 stated "Gave me a foundation to build a new life" (personal communication, February 2011). This sense of well being and foundation A.A. provides are the building blocks for one to push forward on the road to recovery.

Other themes that were touched on and would need to be further explored are the significance of spirituality and accountability in the 12 step program. These are major aspects of the 12 step program which the participants clung to. This displays the power of A.A. in the participants' lives.

Since the majority of the participants who participated in court mandated treatments only attended 1-2 court treatment programs and are still in recovery this leads me to believe that when a relationship is built in either A.A. or in the mandated treatment program that one's recovery can last. They learned from their experiences and continued with their recovery.

The mandated treatment programs were helpful and useful to influencing them in their recovery process.

Table 3, which addresses the most helpful aspects of treatment services, lets us know that working with others one-on-one or in a group setting provides the additional support necessary for recovery. This means the connection between individuals is significant to grasping what recovery is and showing one the way through the program. The connection and relationship between the counselor and the client or the client and other clients develops an attachment which is vital. This validates the shared experiences participants described which are essential to feeling that others understand and relate to them. Without the personal interaction and link to others, one's recovery may be harder to obtain.

Participants discovered and developed new tools and skills and gained sobriety in their mandated treatment program. One skill developed was learning how to love yourself. This is not about being arrogant and thinking "I am the best". There can be such self-degradation with individuals who experience substance abuse, that they need to develop a sense of dignity and self worth before they can make a change in their life. Without having hope it is hard to have the faith that one can change for the better.

Sobriety was a major theme for the participants. Participant 4 reported he "wouldn't have got into recovery otherwise" (personal communication, February 2011). The participants were grateful for their sobriety and what the mandated treatment program did for them. They seemed to understand the values and the importance the treatment program had on their sobriety. The skills learned while there have kept them going forward in their recovery process. Participant 19 wrote "I owe them my life in more ways than one" (personal communication, March 2011).

The mandated treatment program was so helpful that it greatly influenced the participants' recovery; this lead to a greater understanding of the substance abuse treatment programs. Again, sobriety was emphasized as a vital component of the program. Without sobriety it is hard to make change and once sobriety is achieved we can think clearly and utilize the tools learned. Two of the participants in an inpatient treatment program valued being away from their previous lives which were entrenched in addiction. The fact that the programs were mandated helped give Participant 12 "the motivation to want to stay sober and out of prison" (personal communication, March 2011). This gave the participants a

chance for a new life and allowed a restructuring of their goals and desires to become something else and not feel they have to settle for what they were. These new values and way of thinking changed their core belief system. The structure of A.A. taught them to strive to become more than what they were and how to see things differently. This means that the court treatment programs with A.A. were able to enlighten members to transform themselves for the better.

Limitations

There are multiple limitations to this study. First is the sample size (N = 20) which limited the type of tests able to analyze and evaluate the findings. This small sample size limits its ability to have the findings generalized over larger populations. The survey questions have not been evaluated for reliability and validity. There needed to be clarification on how one even defined "recovery". There was no comparison studied that evaluated the views of those who participated in court mandated treatment programs but not A.A. meetings. This study also mostly comprised of Caucasians and it needs to be evaluated with a more diverse population.

Recommendations for Social Work Practice, Policy and Research

This study shows the significance of A.A. groups and their value. As social workers we might not always understand A.A.'s impact because there are no "experts" providing services, yet it works because of the peer support system within the group. We need to encourage our clients who participate in court mandated treatment to implement A.A. as part of their recovery. A.A. provides support and a connection to assist client through their road to recovery.

Macro social workers can create change in policies and procedures in substance abuse treatment programs and laws pertaining to individuals who are in need of recovery services. Understanding the value of the social support A.A. offers and the structure of inpatient treatment programs will help give weight to the need to make positive changes in the system.

This study needs to be further explored on a larger scale to ensure these findings are the norm and not outliers. A control group is needed consisting of participants court mandated to substance abuse treatment programs without A.A. participation involvement. This

will enable for a comparison study to be completed to further analyze the impact of A.A. on participants.

Conclusions

This study provides a building block for future studies to further explore the meanings of A.A. and what makes it work. Court mandated treatments can be effective but when coupled with A.A. participation there can be more success and longevity in the recovery process. The court mandated participants valued their participation in A.A. and the foundation it gave them as well as inpatient treatment settings. The goal of court mandated programs should not be the short term "cures" but the long term success of the participants, which A.A. provides.

APPENDIX A

QUESTIONNAIRE

Questionnaire

General questions regarding your participation in Alcoholics Anonymous (AA)

1. How long have you been participating in Alcoholics Anonymous?

   _____

2. How often do you attend Alcoholics Anonymous meetings?

   _____

3. In what way are Alcoholics Anonymous meetings helpful to you in your recovery?

   _____

   _____

   _____

   _____

4. How were you introduced into Alcoholics Anonymous?

   Check all that apply.

   ☐Another A.A. Member ☐Friend

   ☐Self-Motivated ☐Court Ordered

   ☐Counseling Agency ☐Health Professional

   ☐Correctional Facility ☐Member of Clergy

   ☐Substance Abuse Treatment Facility ☐Internet

   ☐Employer or fellow Co-worker ☐Family

   ☐Other_____

5. How long have you been in recovery/sobriety?

   _____

This section of this questionnaire will be asking general information about you

6. What is your age? _____

7. Please check your gender: ☐male ☐female

8. Please check all that apply to the race/ethnicity that best describes you:

☐Hispanic ☐African American/Black

☐Asian ☐White/Caucasian

☐Other_____, _____, _____

9. Please check which of the following describes your marital status:

☐Single ☐Married ☐Separated/ Divorced ☐Widow

☐Cohabitated (living with a significant other)

10. Please circle the annual income of household in which you live in

a. 20,000 or less
b. 21,000 to 40,000
c. 41,000 to 60,000
d. 61,000 to 80,000
e. 81,000 to100,000
f. 101,000 or above

11. Have you ever participated in a court ordered substance use treatment program?

☐Yes ☐No

If you checked No, Thank you for your time in completing the survey you are done, turn to the last page.
If you checked Yes, please continue.

12. How many court mandated substance abuse treatment programs have you participated in?

_____

13. Which of the following court mandated substance abuse treatment programs have you be involved in? Check all that apply.

☐Driving Under the Influence Classes

☐Inpatient Treatment Program

☐Outpatient Treatment Program ☐ Drug Court

☐Mandated AA participation ☐Other_____

☐Other_____

☐Other_____

14. Have you ever been detained for a substance abuse related charges?

☐Yes ☐No (Go to question #16)

15. If **yes** to question 14, for how long? (If multiple times, please check the longest length of time)

☐1-30 days ☐31-90 days ☐3 - 6 months

☐6 months - 1 year ☐1 - 3 years ☐3-5 years

☐5 years or more

16. Did the courts direct you to participate in AA?

☐Yes ☐No

17. Did the mandated treatment program have you participate in AA?

☐Yes ☐No (Go to question #19)

18. If **yes** to question 16, was that participation?

☐Not Encouraged ☐Slightly Encouraged

☐Encouraged ☐Strongly Encouraged

☐Mandated by the program

19. Do you feel the mandated substance abuse treatment was _____ towards your recovery?

☐Not helpful ☐Somewhat helpful ☐Helpful

☐Very Helpful

20. If comfortable please explain your response to the question above (#19)?

_____

_____

_____

_____

21. Did the treatment program_____ your recovery:

☐Not Influence ☐Somewhat Influence ☐Influence

☐Greatly Influence

22. If comfortable please explain your response to the question above (#21)?

_____

_____

_____

23. Do you feel the mandated treatment program was useful?

☐Strongly Agree ☐Agree ☐Neutral ☐Disagree ☐Strongly Disagree

24. Please rank the following aspects of the treatment program in the order which you felt was most beneficial to you (1 being the most and 10 being the least):

_____ Counselors
_____ Groups
_____ Videos/Movies
_____ Other participants
_____ Probation/Parole Officer
_____ Follow-up services after treatment was completed
_____ AA participation
_____ Drug Testing
_____ Sponsor
_____ Lecture

25. Is there any other area of the treatment program that you found helpful that was not listed above?

_____

_____

_____

26. If you have been involved in multiple mandated treatment programs which was the most helpful program to you?

____Driving Under the Influence Classes
____Inpatient Treatment Programs
____Outpatient Treatment Programs
____Drug Court
____Mandated AA participation
____Other_____

Developed By: Ruth Guerrero

APPENDIX B

INFORMED CONSENT

Informed Consent

The purpose of this is study is to evaluate if court mandated treatment programs have led to current participation in Alcoholics Anonymous. This will be done by completing a survey regarding self reports of court mandated substance abuse treatments and current involvement in Alcoholics Anonymous. The survey will take approximately 15 minutes.

This study is being conducted by Ruth Guerrero under the supervision of Tom Davis, Associate Professor of Social Work, California State University, San Bernardino. This study has been approved by the School of Social Work Sub-Committee of the California State University, San Bernardino, Institutional Review Board.

I understand that my participation is voluntary, all information is confidential and my identity will not be revealed. The surveys will be locked in a safe to insure confidentiality. I understand that I have the right to refuse to participate in the study and that this will not affect my participation in Alcoholics Anonymous. I am free to withdraw consent at anytime and discontinue participation in this project without penalty or loss of benefits. There are no foreseeable risks in participating in the research.

If you have any questions or concerns about this study please feel free to contact my research supervisor Tom Davis, Associate Professor of Social Work, California State University, San Bernardino at (909) 537- 7584.

By checking the yes box below I acknowledge that I have been informed of any risks and I freely consent to participate. I acknowledge and understand the purpose of the study and I also acknowledge that I am at least 18 years of age.

I agree to participate in this study ☐ Yes

Today's Date _____

APPENDIX C

DEBRIEFING STATEMENT

Debriefing Statement

The research study you have just participated in was designed to investigate if court mandated treatment programs have lead to your participation in Alcoholics Anonymous. These findings will assist social workers to have an understanding of the importance of alcoholics anonymous and its involvement in court mandated treatment programs.

Thank you for your participation in this study. If you have any questions about the study, please feel free to contact my, Ruth Guerrero, research supervisor Tom Davis, Associate Professor of Social Work, California State University, San Bernardino at (909) 537- 7584. If you would like to obtain a copy of the group results of this study, the results can be found at California State University, San Bernardino, campus library after September 2011. Thank you.

REFERENCES

Alcoholics Anonymous World Services, Inc. (1972). *A brief guide to Alcoholics Anonymous.* New York, NY: The A.A. Grapevine, Inc.

Alcoholics Anonymous World Services, Inc. (2009). *Alcoholics Anonymous as a resource for drug and alcohol court professionals.* Retrieved on February 6, 2011, from http://www.aa.org/lang/en/en pdfs/smf-177 en.pdf

Alcoholics Anonymous World Services, Inc. (2010). *Information on A.A.* Retrieved on February 6, 2011, from http://www.aa.org/lang/en/subpage.cfm?page=1

Bureau of Justice Statics. (2004). *FAQ detail.* Retrieved February 3, 2011, from http://bjs.ojp.usdoj.gov/index.cfm?ty=qa&iid= 419

Common Sense for Drug Policy. (2007). *Drug war facts.* Retrieved January 13, 2011 from http://www.drugwarfacts.org/factbook.pdf

DUI Foundation. (2008). *Drunk driving.* Retrieved November 23, 2009, from http://www.duifoundation.org/

Fisher, G. L., & Harrison, T. C. (2009). *Substance abuse: Information for school counselors, social workers, therapist, and counselors.* Reno, NV: Pearson Education, Inc.

Greenfield, L. A. (1998). *Alcohol and crime: An analysis of national data on the prevalence of alcohol involvement in crime.* Washington, DC. US Department of Justice, Bureau of Justice Statistics.

Jackson, A. L., & Bonacker, N. (2006). The effect of victim impact training programs on the development of guilt, shame and empathy among offenders. *International Review of Victimology, 13*(3), 301-324.

Kaskutas, L. A., Ye, Y., Greenfield, T. K., Witbrodt, J., & Bond, J. (2009). Epidemiology of Alcoholics Anonymous participation. *Recent Developments in Alcoholism, 18*(3), 1-22.

Kurtz, L. F., & Fisher, M. (2003). Participation in community life by AA and NA members. *Contemporary Drug Problems, 30*(4), 875-904.

Laudet, A. B. (2008). The impact of Alcoholics Anonymous on other substance abuse-related twelve-step programs. *Recent Development in Alcoholism, 18,* 71-89.

Lesser, J. G., & Pope, D. S. (2007). *Human behavior and the social environment: Theory and practice*. Boston, MA: Pearson Education, Inc.

Longabaugh, R. Wirtz, P. W., Zweben, A., & Stout, R. L. (1998). Network support for drinking, Alcoholics Anonymous and long-term matching effects. *Addiction, 93*(9), 1313-1333.

Mothers Against Drunk Driving. (2009). *Mission statement.* Retrieved December 3, 2009, from http://www.madd.org

National Association of Social Workers. (approved 1996, revised 1999). *Code of ethics of the national association of social workers*. Retrieved on February 3, 2010 from, http://www.socialworkers.org/pubs/code/code.asp.

National Highway Traffic Safety Administration. (2008). *Traffic safety facts 2008*. Retrieved December 2, 2009, from http://www-nrd.nhtsa.dot.gov/Pubs/81170.PDF

National Institute of Drug Abuse. (2007). *Science of addiction: Drugs, brains and behaviors* (NIH Pub No. 07-5605).

National Institute on Alcohol Abuse and Alcoholism. (2009). *Organizational information.* Retrieved December 2, 2009, from http://www.niaaa.nih.gov/AboutNIAAA/OrganizationalInformation/

Nelson S. E., LaPlante, D. A., Peller, A. J., Labride, R. A., Caro, G., & Shaffer, H. J. (2007). Implementation of a computerized assessment tool at a DUI treatment facility: A case example. *Administration Policy Mental Health, 34,* 489-493.

Steinberg, D. M. (2004). *The mutual-aid approach to working with groups: Helping people help one another.* Binghamton, NY: The Haworth Press, Inc.

Students Against Destructive Decisions. (2009). *SADD's mission.* Retrieved December 2, 2009, from http://sadd.org/mission.htm

Substance Abuse and Mental Health Services Administration (SAMHSA). (2008). *Results from the 2007 national survey on drug use and health: National findings.* Retrieved on February 1, 2010 from, http://www.oas.samhsa.gov/NSDUH/2k7NSDUH/2k7results.cfm#Ch3

Tonigan, J. S. (2009). Alcoholics Anonymous outcomes and benefits. *Recent Developments in Alcoholism, 18*(4), 1-16.

Wells-Parker, E., Anderson, B. J., McMillen, D. L., & Landrum, J. W. (1989). Interactions among DUI offender characteristics and traditional intervention modalities: A long-term recidivism follow-up. *British Journal of Addiction, 84*(4), 381-390.

Yu, J., Evans, P. C., & Clark, L. P. (2006). Alcohol addiction and perceived sanction risks: Deterring drinking drivers. *Journal of Criminal Justice, 34*(2), 165-174.