

MANDATED TREATMENT, 12-STEP SUPPORT GROUPS, AND CRIMINAL
RECIDIVISM POLICY IMPLICATIONS AND PERSPECTIVE

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Abstract

THOMAS P. BRITTON: Mandated Treatment, 12-Step Support Groups, and Criminal
Recidivism Policy Implications and Perspective
(Under the direction of Dr. Peggy Leatt)

An estimated 23 million people in the USA are currently struggling with chemical dependence or abuse. There are 7 million people active in the judicial system, 5 million of which committed a crime related to their use of drugs and alcohol. Mandates to 12-step programs are a key tool in the judicial system but there is a 40-80% drop out rate leading to increased criminal activity and incarceration. Research clearly demonstrates that mandated treatment and 12-step fellowships reduce recidivism and addiction rates. This research conducted 42 case study interviews in Buncombe County NC. 38 of the subjects were incarcerated in the county jail with a history of court mandate to attend Narcotics Anonymous (NA). 4 of the subjects were active in the local NA fellowship. Subjects were males between the ages of 18-66 with varied backgrounds as discussed in the results section. A total engagement score was assigned to each subject based on their involvement in the five core components of NA including sponsorship, literature reading, service work in NA, obtaining a homegroup and step-work. Engagement scores were compared to categorical and quantitative data to evaluate the strength of specific relationships between variables. The use of SAS validated the narrative outcomes indicating that treatment engagement, hope that recovery is possible, desire to quit using and positive expectations for NA. Outcomes

indicate the need for a program specifically designed to increase hope, desire and expectations in a treatment environment. A program model has been recommended as a test pilot in the County of the research. Success at a local level will set the stage for a larger implementation of the program. Addiction is estimated to have a financial impact of \$270 billion on America's economy.

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Chapter One - The Topic

Statement of the Issue

Addiction is the most expensive and deadly public health issue in the United States at this time. Addiction is currently being addressed as a problem of crime rather than a bio/psycho/social pandemic (1). Over the last 100 years, drug policy in the United States has attempted to reduce addiction through the criminal justice system acting on the premise that punishment will reduce the use of drugs and consequently reduce drug related crime. With the highest rates of incarceration in the world and an estimated 23 million people needing treatment for substance use, a significant policy change and new direction is required to reduce addiction, drug related crime, and incarceration.

Assuming that the national data is accurate on rates of addiction in the adjudicated population, 5 million people involved in the legal system need treatment for drug and/or alcohol problems. It is the working hypothesis of this paper that early intervention and treatment will reduce recidivism compared to a punishment based approach. Treatment throughout this paper will be used as a term to describe any combination of counseling including individual, group, and family counseling in both inpatient and outpatient settings. Treatment may also include the advent of participation in a 12-step fellowship like Alcoholics or Narcotics Anonymous. The large majority of offenders are either incarcerated or placed into a community based program designed to treat addiction with the premise that

the individual will not commit crimes if their addiction is arrested and they maintain abstinence from all drugs.

Community based judicial programs include probation, frequent court appearances, urine drug screens, residential housing, and any variation of substance abuse counseling. The majority of individuals involved in court structured treatment models, probation, or counseling program are ordered to participate in mutual support program such as Narcotics Anonymous (NA) as a condition of their release from incarceration. Although a deeper explanation is provided later in this paper, NA is a free peer run support groups that utilize the concepts found in the 12-steps to teach people how to live without the use of drugs and alcohol. The core philosophy of NA is that addiction is not simply the use of drugs but a spiritual, physical, and mental disease. The 12 steps can be found on Page 48. NA utilizes a set of 12 traditions that are designed to teach people how to better live with each other and they can be found on Page 49.

12-Step recovery programs have played an integral role in the treatment of addicted persons in the USA since 1935 with a growing presence of addicted persons in court ordered peer led support groups. A recent federal survey estimated that an average of 5 million people attend 12-step support groups annually with more than 2/3 being regular attendees (46). The literature is clear that participation in a 12-step support group significantly reduces relapse and recidivism and when successfully paired with traditional counseling, results in unparalleled rates of abstinence and reduced recidivism. Offenders are imprisoned if they do not comply with their mandated treatment and there is a 40-80% drop-out for 12-step

referrals leading to re-incarceration and increased recidivism **(28)**. Little is known about why people drop-out of 12-step programs and there is a significant need for helping professionals and members of the judicial system to have access to the skills, knowledge, and ability to successfully place individuals in 12-step programs **(29)**.

The problem facing the legal system and treatment providers that support it is a lack of clear information about how to treat mandated offenders in a way that most effectively reduces relapse, recidivism, and ultimately rates of incarceration. Despite the lack of clarity and insight, research literature consistently demonstrates that criminal offenders mandated to drug and/or alcohol treatment significantly reduce their substance use and criminal recidivism. In order to guide and influence policy, research is needed to better understand what does and does not increase abstinence in mandated offenders.

In an effort to address this problem, the literature review will specifically assess the efficacy of community based judicial programs provided to substance users both in and out of jail settings including drug courts, TASC (Treatment Alternatives to Street Crime), mandated outpatient treatment, DART (Drug and Alcohol Rehabilitation Treatment), and more. Each judicial model has unique characteristics designed to support the offender in maintaining abstinence and recovering from addiction. The review will explore and assess the efficacy of 12-step support programs as an adjunct to traditional treatment as defined above. The review will attempt to identify literature that determines why people drop out of 12-step programs while identifying what specific personal characteristics lead to abstinence and recovery for those who continue to participate in 12-step fellowships.

Background of the Issue

Drug problems in the USA

The World Health Organization attributes 3.6% of the world disease burden to substance use and multiple references site the complex relationships between drug use and primary health problems including cancer, hypertension, stroke, diabetes, heart disease, and other general medical conditions indicating that the true disease burden is likely to be significantly higher **(1)**. For the purpose of this review a distinction will be made between addiction and abuse. The consensus in the field of addiction treatment defines addiction as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences **(2)**.

Addiction can include physical dependency to drugs like alcohol and heroin and it can include drugs without physical dependence like cocaine and methamphetamine. Substance abuse is defined as a maladaptive pattern of substance use leading to legal, financial, and relationship problems among others **(2)**. The primary distinction between the two is that dependence is a deeper pattern of use that is pervasive across all domains of one's life and has progressed to include severe physical and social consequences. Addiction is a lifestyle disease much like obesity, heart disease, or diabetes. Risk factors that predict and contribute to problems with drug and alcohol use have been proven to include a combination of genetic and environmental factors increasing or decreasing the propensity of problematic use.

The Substance Abuse and Mental Health Administration estimates that roughly 22.3 million people or 1 out of 12 people in the United States are addicted to substances including illicit drugs and alcohol **(3)**. Statistically this suggests that all people are impacted directly or indirectly by an individual experiencing problematic substance use. The direct and indirect economic cost associated with addiction is estimated to be \$276 billion dollars or \$1000/person in the United States. Cost impacts include medical care, incarceration, lost work productivity, law enforcement, the judicial system, and crime. The potentially larger and immeasurable cost is to the addicted persons themselves and the neglect of social, family, and parenting responsibilities. The use of illicit drugs is not restricted to adults, 19.6 % of eighth graders have used illicit drugs and 47.4% of 12th graders with a large percent using regularly **(4)**. Although the use of certain drugs including marijuana and cocaine has decreased in recent years, prescription drugs are currently the largest growing abused substances **(4)**. For the first time, the geriatric population has significantly increased levels of addiction, primarily with the over-prescribing and abuse of prescription medication.

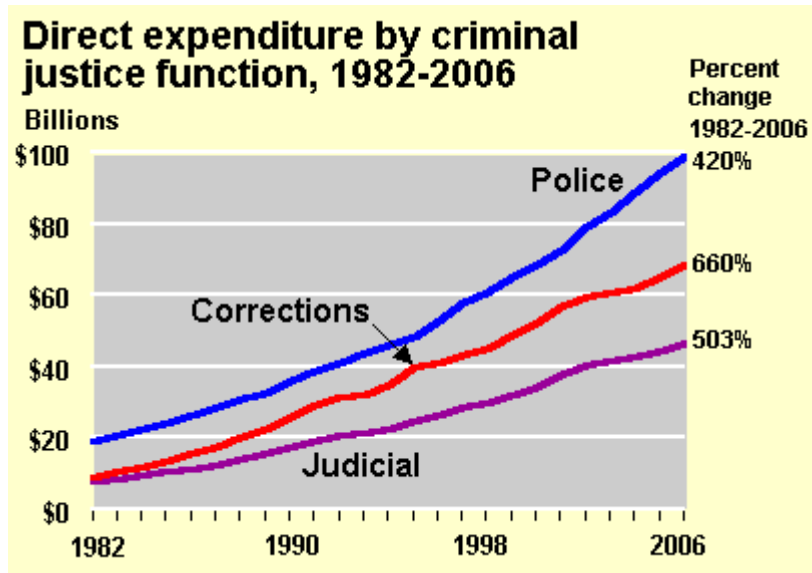


Figure 1

<http://www.ojp.usdoj.gov/bjs/glance.htm> Accessed 6/20/09

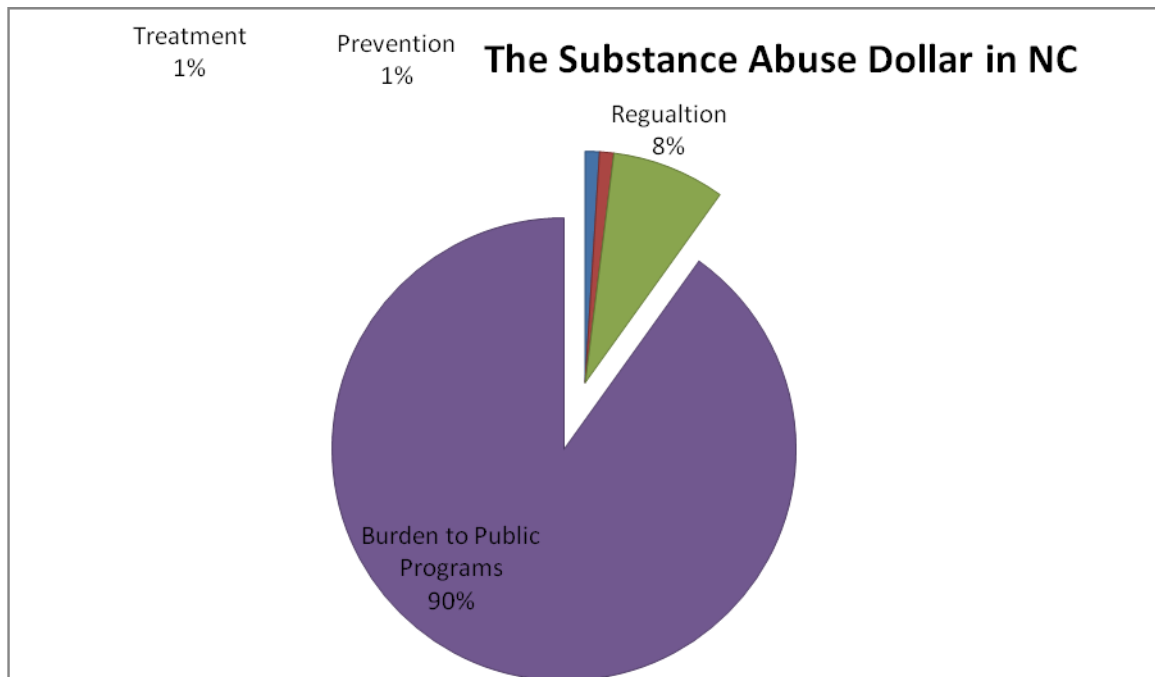


Figure 2

SDUH, Accessed 6/20/09. <http://oas.samhsa.gov/2k8/selfHelp/selfHelp.htm>

Throughout history, drug policy has been tightly woven into the judicial system with the stated intention of reducing the perceived problems that drug and alcohol use present to the nation or effected areas. The most famous restriction on substance use is the Volstead Act of 1917 where the possession, manufacturing, and distribution of alcohol became illegal. Many cite this law as the genesis of organized crime in the US and since that time substance use and the law have gone hand in hand. From the repeal of the Volstead Act in 1933 until the late 60's, local and state government created over 50 different pieces of legislation primarily focused on various forms of punishment for substance use, sale, and manufacture (5). Reviewing the legislature enacted prior to 1970 one can see evidence of what drugs were perceived as problematic. The challenge in the first three quarters of the 21st century as it related to drug policy was the inconsistency and disunity between the various branches of government. States, counties, cities, congress, and the Supreme Court all participated independently in developing and implementing legislature designed to regulate, sanction, and tax substances. Because of the disorganized evolution of policy, the law often contradicted itself and had removed all ability for individual judges to make decisions from the bench that met the crime and the person who committed them. An example of this challenge included mandatory sentencing guidelines requiring up to 10 years in prison for possession of marijuana.

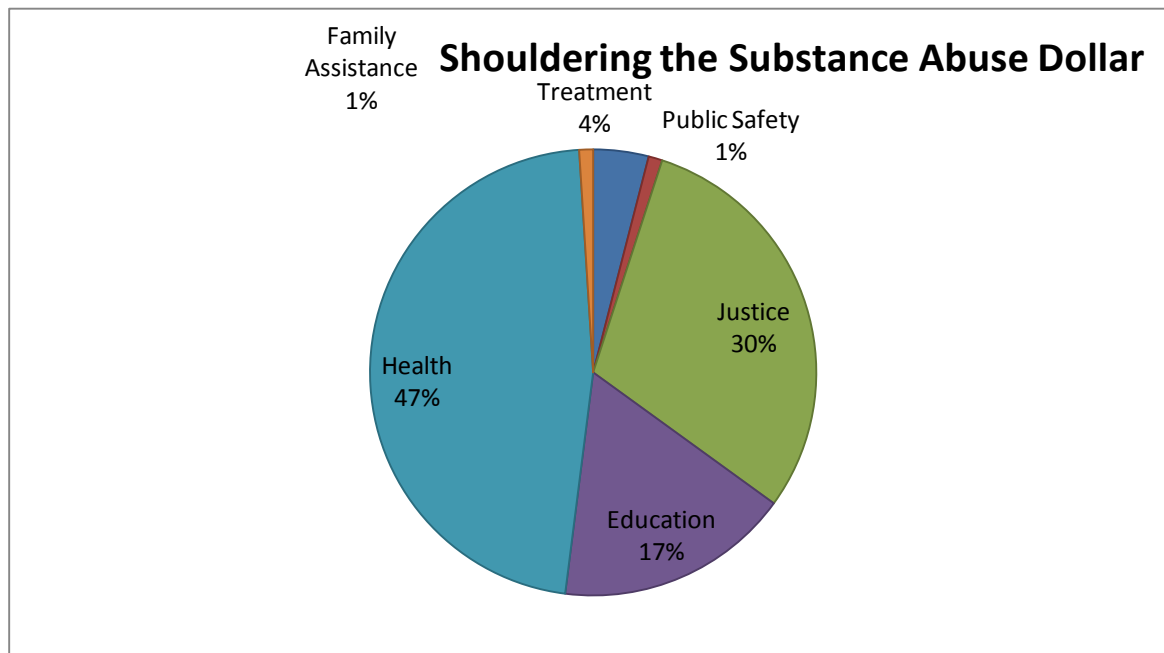


Figure 3

SDUH, Accessed 6/20/09. <http://oas.samhsa.gov/2k8/selfHelp/selfHelp.htm>

With the influx of heroin in the United States as the Vietnam War escalated, the US drug problem moved into a new and more serious stage where drug use entered mainstream America. Soldiers were returning from Vietnam physically dependent on opiates and mentally scarred from their combat experience. Drug use among young adults had skyrocketed with easy access to hallucinogenics, marijuana, and prescription drugs. Many have coined the time as the, “Drug Years”. President Nixon based his 1968 presidential campaign on the social problems of the time and labeled drugs as enemy number one. The drug policies and legislature in place were not effective in reducing the drug problem and Nixon called for a new approach to the problem that became law in 1970 with the implementation of the Controlled Substances Act (CSA) of 1970 (6). Nixon was careful to couch his approach to drugs as a public health problem and developed a 10 point plan to address the problems of drug addiction and abuse. Points 1-5 were focused primarily on

restricting supply and punishing those responsible for selling and manufacturing substances. A departure from the policy at the time was evident in points 6-10 that focused on treatment, education, and research. Nixon made a point of telling the people that we can not punish the kids for using as much as target those who prey upon them through the sale and distribution of illicit drugs.

The CSA laid out two primary objectives. The first was to consolidate drug related law enforcement agencies into one focused and well funded body that later became the Drug Enforcement Agency. The second and more influential goal was to streamline policy and give judges the latitude to sentence appropriately turning over the draconian sentencing guidelines that had been implemented in the 1956 Narcotics Control Act. The CSA had no minimum sentencing requirements aside from those that applied specifically to high level drug traffickers. Judges now had the option of giving probation to first time offenders and mandating treatment. It was this legislature that created drug treatment as we know it today. Nixon identified a dearth of treatment alternatives for substance users and invested heavily into the development of a national treatment infrastructure that continues today. The Substance Abuse and Mental Health Services Administration (SAMSHA) and the National Institute on Drug Abuse (NIDA), two of the largest centralized research agencies in the world continue to maintain the most comprehensive and up to date information on drug abuse trends, prevalence, and treatment approaches.

Due to major drug problems in the country, much of the gains of the CSA have eroded and been replaced since its implementation. The belief that the solution for drug and

alcohol use is punishment resurfaced in policy acting on the premise that the harsher the punishment the better the cure. Punishment continued its focus on suppliers but drastically increased the punishment of drug users. Much of the impetus for this change can be attributed to the specific drug problems during the 80's. When crack cocaine hit the streets, it completely changed the face of drug addiction in the US because of its high profile impact on our people. Almost overnight, cocaine went from an exclusive club drug to a blight ravaging the streets and homes of every day people. From the late 90's until 2005 Methamphetamine became the largest drug problem and today, prescription drugs present the greatest threat to the health and wellness of our people. Legislators and public opinion led to a repeal of the therapeutic public health approach of the CSA.

Law has consistently been modified over the past 40 years to require harsh punishment and has restricted or removed the ability of judges to apply their judgment to the level or type of sentencing for criminal behavior stemming from addiction or mental illness. Minimum sentencing requirements went back into law with among others the "three strikes your out" ruling in 1994. The intention of the three strikes rule was to present a serious threat to offenders to not re-offend but the poorly written law had many challenges. The minimum sentence for someone with three strikes is 25 years in prison and many of the people subjected to it were non-violent substance using offenders. A famous case representing the flaws in the legislature involved a man with previous felonies who shoplifted bread from a local market for his family and was facing 25 years in prison. The belief that punishment reduces crime has been demonstrated to be ineffective at best if not deleterious. Many professionals in the field believe that the fear of punishment presents a

barrier for those seeking treatment resulting in a recursive relationship between increased severity in drug use and increased rates of crime. Increases in incarcerated populations in the US indicate that this policy has not met its intended result and instead has created the most expensive and comprehensive judicial, law enforcement, and penal system in the world.

Arrest rates have increased 700% since 1970 and the United States has the highest number of incarcerated people in the world with more people behind bars in the United States than any other country (7). As of 2006, a record 7 million people were either incarcerated, on probation, or on parole. Of the seven million, 2.2 million were incarcerated. The People's Republic of China ranks second in the world with 1.5 million despite having over four times the population of the US. The average cost to incarcerate someone in the United States is \$24,000/year. The cost for judicial and correctional systems in the US is estimated to be \$116 billion dollars a year, more than our entire welfare system. As mentioned earlier, what can't be quantified is the emotional and mental impact incarceration has on the individual and their family. It is estimated that 60-70% of offenders involved in the legal system committed their crime either for drugs or under the influence of drugs and or alcohol and 50% of people on probation need help with drug and or alcohol use (8). There is a direct correlation between recidivism and substance abuse with 41% of 1st offenders, 61% of 2nd time offenders, and 81% of those with 5 or more convictions being substance abusers.

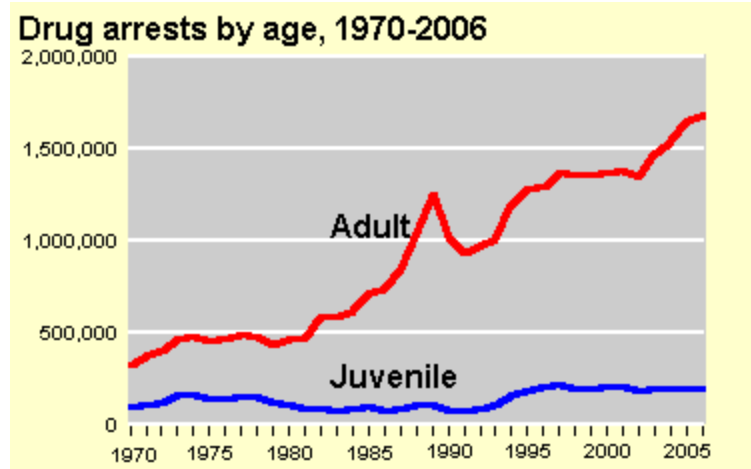


Figure 4

<http://www.ojp.usdoj.gov/bjs/glance.htm> Accessed 6/20/09

12-Step Programs and their Influence

12-Step support programs including Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) are the most popular and well known 12-Step groups in the world spanning over 100 countries each in as many as languages but are not this country's first experience with peer led support (75, 76). Peer led support groups designed to reduce the consumption of alcohol first took prominence in 1840 with the Washingtonians. The Washingtonians was founded by a group of six self-proclaimed "drunkards" in 1840 (29, 77). The Washingtonians practiced a very similar practice to what is seen in AA meetings today in a shared commitment not to drink. The group was not religious despite the large focus of Christianity of the times and at its crest claimed tens of thousands of men who committed to total abstinence. Members of the Washingtonians were very similar in their stories to what we hear today. They were men who had lost all control over their drinking, bringing great ruin to their lives. A Mr. John Hawkins was the primary individual considered to be the

leader of the movement. Following Mr. Hawkins death in 1858, the movement lost its momentum and was not reported on after 1860.

The next group to carry a message of abstinence began in the early 1920's with the Oxford Group and the founder of Alcoholics Anonymous (AA), Bill W. **(29)**. The Oxford Group lost favor and was shunned by mainstream America, becoming a political body. AA was established in 1935 and is currently the largest and most successful entity helping addicted persons recover from alcoholism with an estimated membership of 2 million persons with 116,000 active groups **(78)**. AA was co-founded by a doctor named Bob S. and a stockbroker named Bill W. Both were men that had lost all hope that they would be able to stop drinking and in many ways had resigned themselves to a slow death by alcoholism. In what was later described as an intervention by a power greater than themselves. The men were brought together and developed an approach to treat alcoholism that acted on the principle that there was no more powerful intervention than the power of one alcoholic helping another alcoholic to recover. AA describes itself as a spiritual not religious program. The program is organized and governed by 12 Traditions that guide the behavior of the group and its members. With the support of assorted literature including the Big Book, members of the group work and live a set of 12-steps that are designed to help them work through their demons of addiction while finding a new way of life **(76)**. The program has literally helped millions of people to abstain from alcohol and change their lives.

As narcotics and illicit drugs took hold in the fifties, there grew a group of individuals that found it harder and harder to relate to the principles and approach of AA. These

individuals self-proclaimed as addicts were supported by members of AA to build a new fellowship called Narcotics Anonymous (NA). NA split off from AA in 1955 to support people specifically dependent on illicit drugs and currently offers more than 50,000 meetings weekly in the US and has a presence in 128 countries (75). NA works from the same steps and traditions of AA, with the substitution of the word addiction for alcoholic and alcoholism. There is a significant difference between the philosophies of the two programs that presents challenges in researching the fellowships either together or as if they were the same. Rather than identifying one's problem as alcohol and alcoholism, NA identifies their problem as addiction. NA literature describes addiction as a spiritual, mental, and emotional disease. Although complete abstinence is a hallmark of the program, the work is designed to change one's self and the way they live in the world. With sporadic growth in larger cities, NA has grown into a fellowship with a presence in most communities across the USA.

NA and AA are available as a free resource, available at times when traditional treatment resources are difficult to access including nights and weekends. The fellowships have no leaders or governance. They have no rules or expectations, they only encourage people to try their way of life and offer a message of hope and the promise of freedom from active addiction. The literature and meetings are filled with inspirational quotes that drive people in their recovery including, "Meeting makers make it", "Don't leave before the miracle happens", "It works if you work it", "If you don't have a home group you are homeless", and "If you don't have a sponsor and are sponsoring yourself than you have a fool for a sponsor". Interestingly, the literature review of this paper supports each of these claims. At the end of this paper you will find an explanation of these terms but in short, a miracle

does appear to happen where people find a new way to live and become productive members of their societies.

Today there are 12-step fellowships in most countries, presenting an easily accessible and free source of support to recover from addiction. 12-step fellowships are spiritual not religious programs that have no leaders or guides and believe that recovery happens from the therapeutic value of one addict helping another. 12-step fellowships are one of the primary and most accessible recovery based resources for criminal offenders and are typically court ordered components to sentencing.

Intention of Research

This proposal identifies a key piece of vital information that if explored, understood, and applied could begin the process of reducing rates of active addiction in the US while ultimately reducing recidivism and the threat that addiction presents to the public health of the United States. As the literature review demonstrates, mandated treatment works and when referral to 12-step group participation is successfully facilitated, recovery rates increase exponentially. Although information exists that identify personal characteristics that increase retention rates in 12-step fellowships, no research can be found that explores the “why” of how 12-step programs work and the “why” of what contributes to retention or successful referrals. This research will explore these specific questions with the long term intention of developing a clinical tool that can be used to assess and increase readiness for the successful referral of mandated offenders to 12-step fellowships.

Research Question

How can mandated substance abuse offenders be more effectively linked to the 12-step support community?

Importance of Research

- Historically, the majority of substance abuse counselors were in recovery and included 12-step approaches as primary helping tools. These treatment providers used their own experience in the 12-step community to coach and support clients in their engagement of 12-step programs. Changes in licensure requirements and the professionalization of the counseling field has reduced percentages of recovering professionals and left many counselors unprepared to support their consumers in 12-step programs.
- Treatment is very short in duration and expensive to the consumer. 12-step fellowships are free, readily available, and adapt to the individual while offering a long-term aftercare solution.
- Many counselors, court officials, law enforcement, and helping professionals hold prejudices towards 12-step fellowships reducing the likelihood of referral.

- ⦿ Education and coaching of counselors, court officials, law enforcement, and helping professionals will empower and prepare them to utilize the 12-step community as a valuable tool in the recovery of their consumers.
- ⦿ A simple and easy but valid screening tool will allow counselors, court officials, law enforcement, and helping professionals to place consumers in 12-step fellowships only when ready and able to succeed.
- ⦿ Increasing successful referrals to 12-step groups as evidenced by long term retention will increase counselor's, court officials, law enforcement, and helping professional's comfort level in referring to 12-step programs and therefore increase referrals and utilization of community based support groups.
- ⦿ Increasing successful referral to 12-step fellowships will increase abstinence, consequently reducing recidivism and incarceration.
- ⦿ Increasing abstinence and reducing recidivism will improve public health.

Chapter Two - Literature Review

To effectively explore the relationship between crime, addiction, 12-step participation, and treatment one must review literature from the fields of health, law, policy, and addiction counseling. This review will utilize search strategies adapted to the unique qualities of each field and each search resource. Baseline data on prevalence rates of addiction and crime is most readily available in large public databases including the Bureau of Justice, SAMSHA, NIDA, and the World Health Organization (WHO). These public sources of point in time data will be used as a larger backdrop for the scope and nature of crime in the United States and punishment guidelines, illustrating the potential scope of benefit from policy change. In reflection of limitations in the literature, this review has been completed in two stages with two search strategies. Stage one of the review was completed using an organic process that specifically targeted a niche of the literature using key informant interviews and search vehicles to identify seminal works on the subject of mandated referrals to 12-step support groups. Stage two of the review is a rigorous and empirical exploration of the relationship between recidivism and mandated treatment, utilizing common literature review techniques.

Stage One – 12-Step Support Group Participation

Initial searches using Psych Info and other behavioral health related search vehicles found no articles specifically focused on mandated 12-step group participation. In broadening the scope, the researcher was able to identify articles specific to the efficacy and applicability of 12-step support groups as they relate to reducing recidivism and rates of active addiction. The researcher intentionally identified articles that did not include reference to 12-step literature or support groups but referenced the primary components of 12-step support groups including hope, social support, and general addiction related literature. The researcher identified two authors who are highly prolific in the research of 12-step support groups and interviewed them to gain further insight into the literature. A total of 45 articles and 5 books were included in the final development of this section of the literature review.

Stage Two – Mandated Treatment

Initial searches utilizing the search terms “crime” and “addiction” brought between 18 and 4895 citations in sources ranging from Pub Med to Global Health. Consequently, due to the narrow focus of this research, specific search techniques were developed for each vehicle to maximize successful returns of applicable research. Various combinations of search terms were found to yield different results within the same search vehicle leading to multiple search strings applied within them. When available, citation referencing techniques were used heavily to identify relevant material for the review. Specific search vehicles

below provide the opportunity to review the reference sections of identified articles in an attempt to immediately find similar articles. Search vehicles of this type offer hyperlinks taking you directly to the article in question. This review utilized this method to identify and include articles not identified in the initial search. Please see the table below, demonstrating initial findings and search variables.

Table 1

Source	Variables	Citations
Psych Info	Drug Addiction AND Crime AND Drug Laws	13
Psych Info	Drug Addiction AND Crime AND Recidivism	11
Psych Info	Drug Addiction AND Crime AND Law Enforcement	11
Psych Info	Drug Addiction AND Crime AND Treatment AND Sentence	5
Psych Info	Drug Addiction AND Crime AND Treatment	142
Science Direct	crime AND addiction AND mandated AND non-violent AND treatment AND recidivism	49
Global Health	Drug Addiction AND Crime	19
Journal of Drug and Alcohol Dependence	Offender AND Treatment AND Recidivism	36
Journal of Drug and Alcohol Dependence	Sentencing AND Treatment AND Recidivism	9
Journal of Drug and Alcohol Dependence	Mandated AND Treatment AND Recidivism	10
Journal of Substance Abuse Treatment	Crime AND Addiction AND Recidivism AND Non-Violent	15
Journal of Substance Abuse Treatment	Crime AND Addiction AND Recidivism AND Mandated	8
Journal of Substance Abuse Treatment	Crime AND Addiction AND Recidivism	69
Academic One File	Crime AND Addiction	18
Academic One File	Recidivism AND Addiction	9

Academic Search Premier	Crime AND Addiction AND Recidivism	18
Academic Search Premier	Addiction AND Crime AND Treatment AND Mandated	8
PubMed	Crime AND Drug Addiction AND Recidivism NOT Sex NOT Domestic	89
NIDA	Crime AND Addiction And Treatment AND Non-Violent	47

As this literature search progressed, it was determined that there existed bodies of research similar to the intended topic but different enough to be excluded. An example of one such issue included research on severely mentally ill drug users and court ordered treatment. Although there is a significant overlap of mental illness and addiction, the response rates to specific treatment models and forms of coerced treatment were deemed unique enough to be excluded from this research. In an effort to maintain validity to the constructs measured in this review, the following specific determinants were utilized to exclude and include articles for use in the review.

The following are exclusionary criteria:

1. Articles including issues of mental illness in addition to addiction.
2. Articles referencing addictions outside of drugs and alcohol including sex.
3. Articles referencing violent crime offenders.
4. Articles including reference to variables outside of treatment as indicators of reduced recidivism including public health efforts like needle exchange.
5. Articles focusing specifically on currently incarcerated individuals.

6. Articles not referencing a treatment intervention.
7. Interventions solely focused on pharmaceutical intervention including Methadone or Suboxone.

The following are inclusionary criteria:

1. Articles focusing on non-violent offenders.
2. Articles including treatment interventions prior to or as a substitute of incarceration.
3. Articles referencing interventions utilized in countries outside of the US.
4. Articles indicating mandatory treatment
5. Policy related articles.
6. Studies utilizing empirical research designs and interventions.
7. Articles referencing recidivism.

An initial review by title was the first stage of review for any article clearly falling into either inclusion or exclusion as defined above. Articles with titles that do not automatically exclude them were included in the second stage of review. The second stage of review included a thorough reading of the abstract and if appropriate the article included in the final stage or excluded from the review. The final stage of the literature review included reading the entire article. A cataloguing procedure was used throughout each stage to track outcomes and relevant information.

Results Section

A thorough review of published literature related to the relationship between drug treatment and recidivism identified the relevant areas of focus for the development and

implementation of future policy. The search terms identified in the methods section of this review identified a total of 586 articles for further review. Table 1 identifies the number of articles excluded from each stage of this literature review, including the reason for exclusion. Sixteen articles were identified and included in the final development of the results section of this review.

Table 2

Reason for Exclusion	Excluded Title	Excluded Abstract	Excluded Full Article
Mental Illness	18	5	0
Violent Crime	20	3	1
Jail or Prison based Intervention	31	10	3
Unavailable Article	20	0	0
Sexual Addiction	14	2	0
Unrelated to Topic	61	41	21
Opiate Replacement Intervention	36	8	1
No Treatment Intervention	12	40	28
Duplicate Study	77	6	0
Non-English Reference	3	0	0
Editorial Non-Research Based	53	0	6
Totals	395	115	60

Analyses

Six themes emerged from this review, contributing to a better understanding of the benefits and relationship between mandated treatment, 12-step support groups, and reduced recidivism for substance using offenders. The first section explores the question of whether or not mandated treatment is an effective component in reducing recidivism in the substance using offender. The second question in developing protocols is identifying who is and who is not a candidate who could benefit from mandated treatment. The third issue addressed by

this study is what treatment variables most improve outcomes for the mandated, non-violent, and substance using offender.

The review explored the three issues most relevant to the role that 12-step support groups can have on reducing recidivism in mandated offenders. The first section explores what individual characteristics impact successful referral and benefits of 12-step group participation. The second section answers the relevant question of whether or not 12-step participation is effective in reducing drug use and improving quality of life. The third and potentially most important question as one considers future research and policy design is what specific factors contribute to individuals dropping out or not following-up with 12-step support group referrals. Table 2 is a brief summary of the findings and a deeper explanation follows.

Table 3

Author	Demographic	Sample Size	Research Design	Independent Variable	Dependent Variable	Outcome
Young et al.	Male offenders in long term tx.	350	Prospective Cohort Study	Coercive Model	Recidivism	Higher perceived mandate = reduced recidivism
Evans et al.	Non-violent offenders	1465	Prospective Cohort Study	Offenders choosing treatment versus those who didn't	Recidivism	Untreated higher recidivism
Prendergast et al.	18 year old methamphetamine users with three or less arrests currently in drug court	163	Randomized Control Trial	Contingency Management Model	Treatment Engagement	Contingencies reduced recidivism
Messina et al.	Individuals seeking or mandated to treatment	412	Randomized Control Trial	Antisocial Personality Disorder vs. not	Treatment Engagement and Recidivism	Personality didn't impact treatment

						retention
Perro n & Bright	Individuals involved in NTIES	2694	Retrospective Cohort Study	Coercion and Length of Treatment	Dropout Rate	Coercion increased length of treatment
McIntosh et al.	Participants in DORIS	1033	Retrospective Cohort Study	Treatment	Acquisitive Crime	Treatment correlated with reduced crime
Taxman	DWI offenders in Maryland 1985-93	3711	Retrospective Cohort Study	Treatment, Type of offender, and Punishment	Recidivism	More treatment episodes decreased recidivism
Hubbard et al.	Outpatient and residential males in 3 categories of legal involvement	2435	Retrospective Cohort Study	Level of mandate including TASC, criminal justice, and voluntary	Recidivism employment and treatment retention	TASC demonstrates best outcomes and voluntary poorest outcomes
Author	Demographic	Sample Size	Research Design	Independent Variable	Dependent Variable	Outcome
Kelly et al.	Males in Veteran's Administration 21 and 28 day residential treatment	2095	Prospective Cohort Study	Level of court involvement	Abstinence, recidivism, and remission	Mandated clients improved across the board as compared to voluntary with exceptions
Ventura & Lambert	Clients involved in Lucas County Alcohol and Drug Addiction Service	263	Randomized Control Trial	Treatment received	Recidivism and Abstinence	IOP and residential treatment best outcomes
Krebs et al.	Drug Court and non Drug Court clients in Hillsborough	475	Prospective Cohort Study	Drug Court status	Recidivism	Drug Court clients improved between 12 + 18 months but poor outcomes

						during other periods
Warner & Kramer	Mandated clients involved with treatment in PA	3290	Retrospective Cohort Study	Treatment versus Incarceration and Probation	Recidivism	Mixed
Evans et al.	Mandated clients	926	Retrospective Cohort Study	Treatment	Drop out rate	Drop outs more likely to reoffend and multiple variables increased drop out rates
Broome et al.	Probationers	279	Retrospective Case Study	Self-esteem, perception of counselor, and perception of peers	Recidivism	Treatment variables have higher predictability rates of outcomes than demographic variables
Merrill et al.	VA residential patients	308	Retrospective Cohort Study	Number of treatment episodes	Recidivism	More treatment equals less recidivism
Author	Demographic	Sample Size	Research Design	Independent Variable	Dependent Variable	Outcome
Burke et al.	Outpatient	289	Prospective	Mandatory Tx	Multiple	Readiness for change no impact on abstinence
Best et al.	Graduates from inpatient treatment	200	Prospective Cohort	Drug of choice	Investment in 12-step	Drug users more open to 12-step than etoh users
Hser et al.	Proposition 36 participants	1104	Retrospective Cohort Study	Treatment type and demographics	Recidivism and abstinence	Shorter treatment leads to increased recidivism and demographic variables lead to increased abstinence

Witbr odt et al.	Treatment participants	302	Randomized control study	Drug of choice	12-step participation	Service best indicator of abstinence and quality of life
Schnei der et al.	Outpatients VA Hospital	265	Prospective Cohort	History of sexual abuse	Abstinence and engagement in 12-step fellowship	No difference found in outcomes between participants with hx of abuse
Gosso p et al.	Graduates of residential treatment center	142	Longitudinal Prospective	Meeting attendance	Abstinence	Increased attendance resulted in increased abstinence
Christ o et al.	Participants in 8 treatment centers	101	Prospective Cohort	Level of spirituality	Attendance and acceptance of program	Level of spiritual belief did not indicate abstinence or outcome
Kelly et al.	VA graduates	2778	Prospective Design	Multiple variables	Follow-up with 12-step fellowship	Self- identificatio n as addict, African- American, religious, obtained sponsor, built sober network, and read literature were less likely to drop-out
Fioren tine & Hillho use	TCTP participants	419	Prospective Design	Self-Efficacy Model	Abstinence	Those with increased view of self as addict, negative expectancy of drug use, and expectancy of losing control contributed to significant levels of

						abstinence.
Fioretti & Hillhouse	TCTP participants	419	Prospective Design	Recovery activities	Abstinence	All recovery activities increased abstinence rates but 12-step more so than others
Fiorentine	Outpatient consumers	359	Prospective Longitudinal	12-step involvement	Abstinence	27% used who attended versus 44% who did not
Hillhouse	Women and minorities	356	Prospective	Gender and ethnicity	Benefit from 12-step	No difference was observed in the benefit of 12-step for those of varied gender and ethnicity
Timko et al.	Male VA tx participants	345	Prospective	Multiple variable	Abstinence	Whites, unemployed, and religious more likely to attend and the more one attends the more likely they are to stay clean
Timko	Outpatient treatment patients	345	Randomized Control Trial	Type of referral	12-step engagement	Those linked with person in 12-step rather than provided meeting list more likely to attend
Kelly	Aftercare	227	Randomized Control Trial	Level of attendance	Mutual self-help	More attended, more abstinence and decreased amount of use

Does Mandated Treatment Work?

Evans et al. (25) utilized participants of Proposition 36 to explore motivations for patient drop out and its impact on recidivism. Proposition 36 is an initiative in California to provide funding for individuals as an alternative to incarceration. \$120 million dollars is invested annually with a total of 50,000 individuals served. Eligibility requirements include any non-violent offender committing a drug related crime regardless of severity of substance use or motivation level. The majority of individuals are offered three chances to succeed in the program before expulsion and incarceration. The benefit to the offender is an elimination of charges from one's record. The primary intention of the study was to explore recidivism rates for the 25% of individuals who do not choose to accept treatment compared to the 75% of offenders who accept treatment. The study gathered subjects randomly from 30 sites in 5 counties, representing the diversity of Proposition 36 participants. The data utilized was found in an ongoing database on all Proposition 36 participants called the TSI. 1588 subjects were used in the study with 1465 successfully completing treatment, 48 were incarcerated, and 3 died during the treatment period. Analysis was conducted to assess potential differences between those who accepted or didn't accept treatment to measure and eliminate the impact of any confounding variables. The only significant difference between the groups was evidenced in dropouts having had arrests at earlier ages, more lifetime arrests, and increased years incarcerated prior to the offer of treatment. Results demonstrated that recidivism was significantly less for individuals participating in treatment. 32.8% of treatment participants exhibited recidivism versus 46.3% of non-participants, and 60.3% of non-participants were re-incarcerated versus 45.6% of participants.

McIntosh et al. **(11)** completed a study on the incidence of acquisition crimes committed to obtain drugs following treatment. The study utilized the Longitudinal Drug Outcome Research in Scotland (DORIS) to obtain the necessary data to complete the study. DORIS began in 2001 and interviewed participants at 8, 16, and 33 months post treatment. 33 different centers were utilized to measure a sample of male and female offenders with an average age of 28. 70% of participants were successfully interviewed throughout the study. The study used a logistic regression model to test the independent effect of 22 co-variables upon the commission of an acquisition crime. The results indicated substantial reductions in acquisition crimes for those involved in treatment with 35.1% reporting having committed a crime and 25.3% having been incarcerated. Participants were 7 times more likely to have remained abstinent from drug use than those not mandated to treatment. The study reports out of the 22 co-variables tested, reduced drug use was the primary indicator for reduced recidivism. The study design was not set up to directly connect treatment and recidivism and instead indicated significant reduction in use of drugs for those who participated in treatment. The study reports that because treatment reduced drug use, it indirectly reduces crime.

Kelly et al. **(12)** completed a prospective cohort study exploring rates of recidivism between populations graduating from a residential treatment program sponsored by The Veteran's Administration. Out of 3698 original clients, 2095 clients were successfully assessed at 1 and 5 years post treatment at a residential program operated by the Veteran's Hospital across 15 sites. 3 cohorts were assessed including a mandated population, court involved population, and voluntary population. Regression statistical methods were used to assess populations, removing demographic differences as applied to outcomes. Two

demographic differences were noted in the mandated population that could threaten validity of the research conclusion. Higher percentages of African American and younger clients were found to have been sentenced to mandatory treatment than the other two cohorts. Questionnaires were used to assess satisfaction with treatment at discharge and level of motivation prior to treatment. Mandated clients were found to have lower motivation at admission but all populations reported similar satisfaction at discharge. Controlling for demographics, results demonstrated that the mandated population demonstrated the lowest levels of recidivism, voluntary clients were in the middle, and judicially involved had the highest recidivism. Although abstinence rates dropped for mandated clients at 1 year by 15%, it was the highest of the three groups at year 5. Mandated clients had the largest percentage of individuals in full sustained remission from drug use at 5 years.

Krebs et al. (13) used a prospective cohort study to assess the outcomes of clients mandated to treatment coordinated by Drug Treatment Court versus those assigned to general probation that was self-described as quasi-experimental. 475 offenders were included in the study, 274 of which were Drug Court participants and 201 straight probationers. Drug Court is a treatment based court specific for drug and alcohol offenders. Drug Courts typically have one specific judge who knows all the offenders and a specially trained group of probation officers who coordinate with the treatment providers to assure treatment compliance. Positive drug screens or other variables of poor treatment compliance result in fines, incarceration, or expulsion from Drug Court. The study did not report treatment participation of the control population and did not discriminate what level of Drug Court the offenders were in. Efforts were made to minimize differences in populations during

recruitment phase restricting number of previous offenses and treatment history. Despite the study's report of significant data collection issues, it found that Drug Court participants had improved outcomes between 12-18 months, but demonstrated poor outcomes for the first 12 months and after 18 months post treatment.

Kramer & Warner (14) explored the impact of a Pennsylvania based model of treatment used as an alternative to incarceration and probation. 3290 subjects were used, 1552 receiving treatment and 1738 not. The sample population was representative of the treatment population and sentenced to one year of incarceration instead of treatment. Treatment methods included halfway houses, house arrest, and outpatient treatment. Cox proportional hazards were utilized to analyze outcomes at 12, 24, and 36 months controlling for demographic and sentencing differences. Treatment mandated subjects were 20% less likely to reoffend compared to incarcerated group but differences in recidivism were demonstrated dependent on the type of incarceration received. Treatment subjects had 64% less recidivism than probationers, 44% less than those sentenced to county jail and 5% higher recidivism rates than those incarcerated in state prison. The study identifies that no data was gathered regarding level of treatment in state incarcerated facilities.

Who is Appropriate for Mandated Treatment?

Messina et al. (15) explored the relationship between Antisocial Personality Disorder (APD), recidivism, and treatment completion. APD is a diagnostic category found within the DSM-IV used to describe individuals demonstrating a lack of empathy or concern for others,

excessive criminal behavior, and the taking of pleasure from causing pain to animals and people from an early age. There is much controversy surrounding APD and addiction due to the overlap of criminal behavior designed to acquire and use substances. Many individuals are diagnosed incorrectly and some question the validity of the diagnosis as it is written. This study used the Structured Clinical Interview Diagnosis (SCID) instrument to identify individuals as APD and the study sample identified roughly 50% as APD. The study followed the individuals through treatment and following discharge to assess treatment compliance and recidivism. The hypothesis was that APD individuals would be less likely to complete treatment and more likely to re-offend. The results of the study demonstrated no difference between population outcomes. The researchers postulate that the failure is attributable to problems of validity in the SCID and diagnosis of APD.

Evans et al. (10) researched variables impacting retention in treatment for mandated offenders. 1588 offenders were randomly selected out of a treatment population for Proposition 36 participants across 30 treatment sites. 926 total participants were maintained throughout the study to include 1 year follow-up with 542 completers and 384 drop outs. Data indicated that increased psychiatric severity, decreased employment, decreased dependents, increased criminal history, early age of use, and decreased motivation significantly increased drop-out rates. Drop-outs were more likely to have received more services, especially focused on psychiatric care. Reported reasons for drop-out included 46.2% for motivation, 20% because it was too hard, and smaller numbers for multiple reasons. Although both populations had improved outcomes, 62.9% of drop-outs and 28.9% of completers reoffended.

Taxman (16) completed a retrospective cohort study utilizing the Maryland DMV database to assess the relationship between number of offenses, form of punishment, and reconviction rates for DWI offenders. The study used 3711 offenders with a 3 year follow-up period. A Cox Proportional Hazard Model was used to measure multiple variables in predicting recidivism. 87% of original offenders were able to be followed up on and 67% of offenders were first time DWI offenders. Results indicated that first time offenders had 12% recidivism and multiple offenders had a 16% recidivism rate. Individuals receiving alcohol education experienced 22% less recidivism than those receiving punishment only and those receiving treatment experienced 17% less. The primary indicator of recidivism was positively related to the previous number of DWI violations. Researchers identified weakness in data due to limited information in DWI database. Available databases did not indicate length of probation, length of treatment, or compliance with recommendation.

Broome et al. (17) surveyed and interviewed 279 probationers from 1992-1993 in Texas to assess for the impact of treatment variables on recidivism. The article identifies that much of the research focused on offender rather than treatment variables, neglecting the individual's treatment modality. The research design utilized the *Structured Intake Form*, an 86 item questionnaire that assesses participant self-esteem, confidence in competency of the counselor, and level of perceived peer support. The questionnaire was sent out 6 months, 1 year, and 2 years after treatment completion. An overall 36% of participants were rearrested 47% of which were arrested within 6 months of discharge. 91% of those not arrested within first year were also not arrested in 2nd year post-discharge. Wilcoxon testing was utilized to do regression analysis of various demographic variable and treatment perception issues. The

research indicated that the strongest variables in reducing recidivism included high self-esteem, high perceptions of competency, and high peer support.

Merrill et al. **(18)** utilized data gathered by The University of Pennsylvania studying 308 opiate abusing probationers mandated to a one year program at the VA Treatment Center from 1992-1993. The data included point in time arrest rates at 2 years post discharge, utilizing logistic analysis to do regression studies related to treatment episodes. Prior to the study, participants received 12 months of treatment. Cohort 1 had no previous treatment prior to this episode and cohort 2 had treatment histories. Analysis demonstrated that with each historical treatment episode, the probability of recidivism was reduced by 25%. Individuals with 6 or more treatment episodes had an average of .2 arrests at 2 years where those with no treatment history had an average of .88 arrests. The study makes the overall claim that the more treatment a person receives has a direct impact on reducing recidivism.

What Model is Most Effective with Mandated Consumers?

Young et al. **(19)** conducted a prospective cohort study to explore and measure the impact of varied levels of coercion on long term reduced rates of recidivism. 350 individuals were monitored in a long term residential therapeutic community setting who had been court ordered through three sources. The first group was ordered by Treatment Alternatives to Street Crime (TASC), a case management agency coordinating between the justice division and therapeutic providers. The second group was ordered by the Drug Treatment Alternatives to Prison (DTAP), a group offering non-violent offenders treatment in lieu of

prison. The final group included direct court ordered individuals often referred by a judge for probation violations including re-arrest or positive urine drug screens. An instrument was designed to assess the perceived legal pressure to participate in treatment. Multivariate analysis was utilized to eliminate differences in demographic influences on recidivism and confounding variable including crime committed, age of first use, drug of choice, and various individual characteristics of the offender. No significant differences were found between groups. Recidivism rates over an average of 3.6 years resulted in 28.1% for TASC clients, 30% for DTAP clients, and 55.6% for general court mandated consumers. The study also indicated that those with higher rates of employment and higher levels of education demonstrated reduced recidivism.

Prendergast et al. (20) studied the impact of contingency management on the successful treatment engagement of 163 clients participating in a Drug Court model of treatment over a 26 week period. The Drug Court model was a highly structured treatment model for early offenders including a three stage monitoring system, MATRIX outpatient therapy and in-court contingency management. According to progress including positive social behaviors and clean urine drug screens participants were either given incentives or received fines and incarceration. MATRIX is a highly structured best practice counseling model designed to treat stimulant addicts. Contingency management has been widely demonstrated as effective in outpatient substance abuse treatment but has not been attempted as an adjunct to drug court. Individuals were randomly divided into one of three groups. The first group included individuals who received contingencies for clean UDS. The second group received contingencies for treatment engagement, and the third group received

contingencies for both UDS and treatment engagement. Although outcomes were not significantly different between cohorts, higher levels of success were seen in the group receiving contingencies strictly for clean urine drug screens. The researchers postulate that the lack of statistical difference is attributable to the specific judge and may have outweighed any true treatment differences. The study indicated that it did not gather and compare data of different judges, instead combining them in one group.

Perron & Bright **(21)** utilized the larger data set available in the National Treatment Improvement Evaluation Study to explore the impact of coercion on dropout rates. The study acted on the hypothesis and historically proven trend that increased length of stay leads to increased abstinence and reduced recidivism. Three groups were identified with 756 in short-term treatment, 757 in long term treatment, and 1181 in outpatient treatment. Outpatient and short term treatment groups shared demographics however long term treatment participants demonstrated increased severity of addiction and primary drug of choice being cocaine. Although drop-out rates were lower for all coerced groups than voluntary groups, outpatient groups had a 64.8% dropout where short term and long term had a 27.7% and 43.9% rate respectively. The researchers identified that potential confounding variables could include the observed differences in defined length of stay, controls for demographic variables, and readiness for change for coerced versus voluntary participants.

Hubbard et al. **(22)** utilized TOPS data combined with client interview to assess the impact that the type of mandate has on recidivism, treatment retention, and employment. The study randomly identified 2435 individuals from 10 cities and 41 different treatment

programs including outpatient and residential care. TOPS is an assessment instrument commonly used to assess multiple domains from treatment history to crime. Clients were interviewed at 3 months, 1 year, 2 year, 3 year, and 5 years post treatment. Data was compared to data from year prior to treatment as an established baseline. Multiple statistical modeling was utilized to validate data including multivariate analysis. The three groups included 502 clients referred by TASC, 855 clients referred by the criminal justice system, and 1078 voluntary clients. Multivariate analysis indicated no significant demographic difference between populations. Although crime did decrease in all populations and employment increased in all populations, TASC clients demonstrated the lowest levels of recidivism, increased treatment retention, and increased employment and voluntary clients demonstrated the least progress in all categories.

Ventura and Lambert (23) studied the impact of treatment modality on recidivism and abstinence using a randomized control trial. 263 clients were randomly assigned to a variety of treatment modalities including IOP, case management, residential, detoxification, UDS, group counseling, and individual counseling. 62% of sample had previous criminal histories, 60% were white, 51% received case management, 36% received group counseling, 35% received individual counseling, 6% received residential, and 31% received IOP. The article made no distinction between clients receiving multiple services. 75% of clients were not arrested for the year period and 81% of those arrested had committed previous crimes. The study used logistic regression and found that higher income and gender (female) were the only demographic variables statistically lowering recidivism. IOP and residential treatment

had the highest abstinence rates and lowest recidivism. The article does not indicate treatment duration.

Hser et al. (24) utilized data from the *Short Term Treatment Outcomes* information collected on all proposition 36 participants. The design randomly selected 1104 participants from 5 counties assessing the impact that type of treatment, gender, employment, psychiatric stability, and the use of UDS on abstinence and recidivism. The study found that women, employed persons, those receiving residential treatment, reduced psychiatric acuity, those receiving UDS, and those having longer treatment episodes all demonstrated increased rates of abstinence independently. The only indicator of recidivism was length of treatment with longer treatment leading to decreased recidivism. 35% of the sample used substances during the treatment and 17% were arrested.

What variables impact outcomes of participants in 12-step fellowships?

Burke (51) used a prospective research design on 289 participants and graduates from 5 outpatient programs in Ohio to assess and identify specific variables that contribute to increased abstinence from drugs and alcohol. Contrary to expectations, Burke's research demonstrated that a participant's readiness for change did not impact abstinence rates for 12-step participants. The research indicated that those with increased severity of addiction had 2.8 times higher abstinence rates than those with lower severity. Burke was not able to establish why more acute patients had better outcomes and disproved her hypothesis that increased readiness for change would increase abstinence rates. Researchers Dittman (71),

Hoffman (72), and Heather (42) also confirmed that Prochaska's Stages of Change did not significantly predict benefit from 12-step or acceptance of 12-step principles.

Best (52) recruited 100 primary drug users and 100 primary alcohol users to assess acceptance levels for 12-step recovery models. Best's research indicated that individuals who used primarily drugs had significantly higher positive expectations and acceptance of 12-step programs and the 12-steps themselves. Drug users indicated significantly higher rates of projected participation in 12-step recovery programs at discharge than their alcohol using peers. Alcohol users attributed much of their dislike for the AA fellowship to the high religious components of the program and identified the content of the steps as prohibitive, again identifying the use of the word "God" as prohibitive.

Witbrodt (50) employed a randomized control trial for treatment graduates to determine the key indicators of success in 12-step fellowships. 1/3 of participants were alcohol dependent, 1/3 were drug dependent, and 1/3 were dually diagnosed with both alcohol and drug dependence. The study found that drug users and drug/alcohol users identified the level of service one conducted in the fellowship, number of meetings attended, and the utilization of a sponsor as the key indicators of success whereas alcohol users demonstrated that sponsorship and service were the only variables impacting abstinence. The final indicator of abstinence in drug users was that those having had a "spiritual awakening" had increased rates of abstinence. The study notably did not indicate what fellowship was attended.

Schneider (49) explored the impact of a history of sexual abuse on successful outcomes in 12-step with the hypothesis that those with increased abuse histories would experience increased challenges in joining 12-step fellowships. 46% of participants reported a history of sexual abuse with 1/3 of the men and 1/2 of the women self-identified as abuse survivors. The study indicated no significant difference in outcomes between those with sexual abuse histories and those without. The study instead indicated that those with increased meeting attendance, those who read the literature, and those with a sponsor demonstrated significantly higher rates of abstinence regardless of abuse history.

Christo (48) developed the hypothesis that those with increased levels of religious beliefs would have improved outcomes in 12-step fellowships because they would more easily accept the spiritual elements of the program. It was further postulated that increased rates of spirituality would predict and reduce dropout from 12-step fellowships. The study found no benefit from increased spiritual beliefs, suggesting that atheists and agnostics would benefit equally to 12-step fellowships. The study also predicted that those with strong spiritual beliefs would struggle with accepting personal responsibility for their actions and demonstrate an externalized locus of control. This hypothesis was also disproved and the study found the only indicator of decreased abstinence was a positive association with alcohol. In contradiction, Galaif (66) found that those with negative associations with religion experienced decreased outcomes.

Fiorentine & Hillhouse (34) completed research to better understand indicators of improved post treatment success utilizing the Addicted Self Model. The model hypothesizes

that persons who identify themselves as addicts, expect negative consequences of using, and predict a loss of control if they use drugs/alcohol will have significant increases in abstinence. This information is included in this review because of the theoretical similarities with 12-step programs. 12-step programs reinforce the concept that addicts are powerless over their using, that using makes their life unmanageable, and that the admission that one is an addict is an essential step towards recovery. The study reinforced the hypothesis of the model but found that the perceived loss of control of using was the primary variable compared to negative consequence expectations for drug dependent versus drug abusers respectively. Not surprisingly, this is consistent with the definition of dependence and abuse as outlined by the DSM-IV (2). The research was also validated by Skinner et al (58).

Hillhouse (35) studied the impact of gender and ethnicity on successful engagement and outcomes for 12-step attendees. The research predicted that women and minorities may have significant challenges in engaging with 12-step fellowships but the research indicated no significant difference in participation or recovery. Although there was a concern that the message of powerlessness would present a barrier to those in the American culture who have had less power, the study did not bear out the hypothesis.

Kelly (30) completed research that showed that gender, mental illness, religious preference, and prior 12-step participation did not contribute to poorer outcomes in 12-step fellowships. Kelly demonstrated that level of education, severity of addiction, and race could increase or decrease positive outcomes with educated Caucasians with increased severity of addiction demonstrating higher rates of abstinence.

Donovan (41) completed research that demonstrated that members who abused primarily methamphetamine had equal rates of recovery compared to those with other drugs of choice.

Are 12-step fellowships effective in reducing drug use and improving quality of life?

Gossop (47) completed a 5 year longitudinal prospective cohort study to assess the efficacy of 12-step fellowship participation. Gossop's research indicated significant increases in abstinence for opiate and alcohol users throughout the study with opiate users 3-4 times more likely to be clean when attending Narcotics Anonymous meetings and alcohol users 4-5 times more likely to be sober when attending Alcoholics Anonymous meetings. Stimulant users demonstrated significant increases in abstinence at one year but not 3 and 5 year follow-up points. At every point in the study those with higher attendance rates demonstrated higher rates of abstinence than those with lower attendance and those attending less than one time a week had identical rates to those who didn't participate at all.

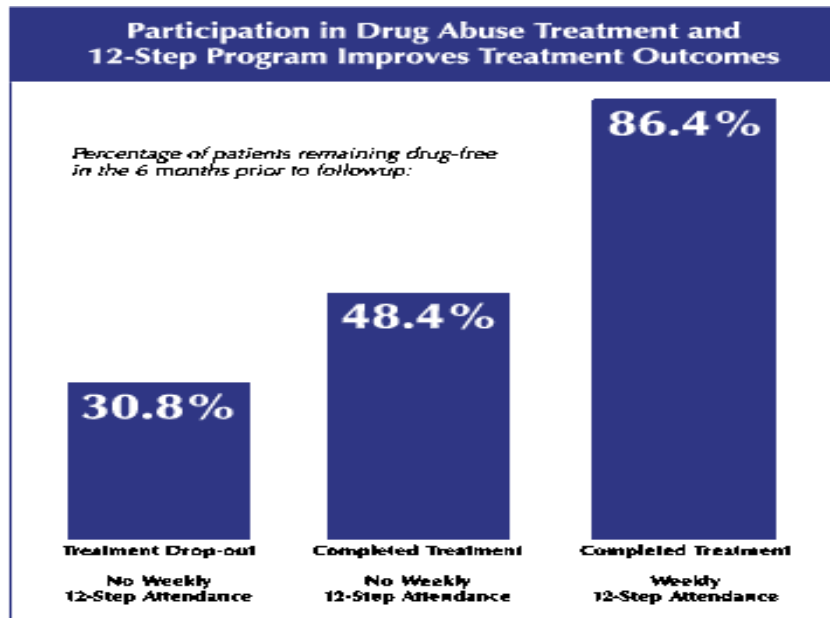


Figure 5

Percentages of Past Month Abstinence from Alcohol and Illicit Drug Use among Persons Aged 12 or Older, by Substances for Which They Attended Self-Help Group*: 2006 and 2007**

Litt (27) conducted research to explore the impact of 12-step participation on the development of social support and resulting abstinence rates. Litt demonstrated that those with high rates of peers with drug use increased relapse potential and those with increased recovery networks had reduced use of drugs and alcohol. Litt demonstrated the impact of 12-step fellowships on building and maintaining positive peer networks that support the individual in maintaining abstinence from drugs and alcohol. Litt showed that individuals build positive peer networks in treatment and when they leave treatment and join the 12-step fellowships, maintain healthy peer networks. Those who do not attend meetings and rejoin their previous networks show increase levels of drug and alcohol use. Later research by Groh (43) supported the theory that increased social support is a side effect of 12-step participation and increased recovery.

Hillhouse & Fiorentine **(32)** utilized the Addicted Self Model to explore the relationship of acceptance of general 12-step principles with continued abstinence, referring to it as, “natural recovery”. The study found that those with an increased identification of self as addict were significantly more likely to remain abstinent regardless of attending 12-step meetings but that those who did attend meetings had significantly increased rates of abstinence. The authors attribute the improvement to the ability of the 12-step community in reminding addicts that they are addicts and that any return to using will result in negative consequences and a loss of control over one’s using. In a later study they discovered that 12-step attendance confirmed and mirrored all aspects of their theory and contributed to long term abstinence **(26)**. The research specifically identified that addicts who maintain the belief that they can’t use successfully stay clean and that the 12-step fellowship supports this better than any therapy. The design also indicated that the more meetings one attends the better the outcome experienced.

Fiorentine **(34)** explored the impact of 12-step attendance with sustained abstinence from drugs and alcohol. The study found that the more meetings one attended the better their rates of abstinence were with increasingly greater rates as the number of meetings attended increased. The study showed that those who attended less than one meeting per week received no benefit. Fiorentine did identify that there was variance from meeting to meeting, underlying the fact that not all meetings have equal qualities of recovery. The study revealed that alcohol use went up to 61% for those who did not attend meetings versus 32% of those who did.

Schneider found that attendees of 12-step fellowships demonstrated decreased rates of depression and increased interpersonal functioning **(49)**. Participants in 12-step fellowships who take the suggestions of increased meeting attendance, sponsorship, 12-step literature study, and service had significantly higher rates of abstinence and quality of life **(49, 47)**.

Timko **(36)** completed a prospective study on 345 participants in 12-step fellowships. The study demonstrated that people who attended meetings experienced significant increases in abstinence compared to those who didn't with an exponential increase as meeting attendance increased. Timko found that one is more likely to attend if they are white, unemployed, and religious. Gains in abstinence were observed in those who worked more steps, were cognitively clear, and older. Further research found that those who continued attending 12-step treatment following treatment completion had significantly higher rates of abstinence from alcohol and drugs **(62, 63, 64, 65, 66, 67, 68)**.

Why do people drop out of 12-step fellowships?

Kelly **(28)** researched the drop-out rates of 2778 graduates from 15 VA treatment centers. Drop out was defined as any person who attended at least one meeting before treatment and no meetings for at least 3 months post treatment. The study showed an overall 12-step drop-out rate of 40% with the probability of drop-outs having used 3 times more than 12-step participants. Kelly identified Caucasians, unmotivated persons, no religious background, little previous experience with 12-step, and no belief in the disease model of addiction as key indicators of drop-out. Kelly also revealed that those who obtained a

sponsor, built networks in the fellowship and read the literature were significantly more likely to remain in the fellowship. Kelly identified a need to better understand the intrinsic variable that contributed to motivation and follow-up with 12-step fellowships.

Timko (37) explored specific indicators contributing to follow-up with 12-step self help groups. The study indicated significant improvements in follow through to 12-step when the individual was directly linked to a member of the 12-step community while in treatment compared to those who were simply provided a meeting list. The study also demonstrated that those connected showed increased levels of involvement in service, identification with the group, and reading of literature. This literature was supported by Sisson's (57) research validating the influence of a personal introduction to 12-step fellowships.

Laudet (39) researched specific factors that contributed to retention in 12-step fellowships. The study indicated increased retention in those with more lifetime arrests, lack of psychiatric medication, higher rates of substance abuse than mental illness, self-efficacy, and supported housing. The study suggested that those who took psychiatric medicine felt shunned in meetings and as a result dropped out but it is of note that this represents specifically members of AA.

Ouimette (56) found that patients with views that more closely matched 12-step philosophy were more likely to remain active members of the fellowship following treatment completion than those who were not. The study specifically identified belief in addiction as a

disease as a primary indicator in engagement and retention. Other research however suggest that group composition and group differences may be a significant contributor to drop-out or “fit” (69, 70).

To the knowledge of this writer, Kelly (31), is the only researcher to have developed a tool that assesses the expectancies of individuals referred to 12-step fellowships. The tool was influenced by the decision making model that attests that people develop both positive and negative expectancies to make a conscious appraisal of what to do or not do. The study included 48 patients in a detox setting with severe dependence and a significant history of 12-step involvement. The study found that some felt embarrassed to attend, some found the meetings boring, some didn’t have transportation, and some simply felt hopeless. The tool was found to successfully predict meeting attendance. It is important to note that the efficacy of the tool would be better measured in a larger sample of individuals with no or little exposure or experience to the 12-step fellowship.

Discussion Section

As stated earlier in this review, the United States incarcerates more people than any other country independent of population and because research has demonstrated that addiction is the primary cause of the commission of crimes in the US, this literature review has explored the efficacy of mandated treatment as a strategy to reduce crime and incarceration. The review has synthesized the available literature to determine if mandating drug treatment rather than incarceration, probation, and monetary fines is a more effective

intervention to reduce criminal recidivism. The literature demonstrates that mandated treatment is more effective than punishment, suggesting that a change in our court system would reduce crime and incarceration but at the same time lacks the breadth to invest in change without further study. The review then explored research and literature on the efficacy, variables impacting outcomes, and barriers that may contribute to dropout or reduce attraction to 12-step support groups as an adjunct to mainstream treatment. The review revealed the fact that combining traditional counseling programs with 12-step recovery programs results in significantly higher rates of recovery and abstinence from drugs and alcohol.

Treatment in the general population has been proven to reduce the use of drugs and alcohol, demonstrating a financial return on investment of 7:1 **(9)**. Over a 12 month period, treatment 40% of recipients receiving 90 days or less of treatment, 60% of recipients receiving 9 months of treatment, and 80% of recipients receiving 12 months of treatment continue to be abstinent for 1 year and experience longer sustained abstinence rates post-treatment **(9)**. The literature included in this review provided evidence that confirmed that mandated treatment produces similar benefits and significantly reduced recidivism in offenders with problems of substance use and abuse **(11, 12, 14, 15, 16, 18, 19)**. Study results demonstrated that recidivism in offenders receiving treatment was as much as 64% lower than offenders assigned to probation without treatment **(20)**. Furthermore, the literature demonstrated that previous treatment and high arrest rates either had no impact on success or actually increased the success of the individual's treatment **(11, 12, 14, 15, 16, 18)**.

In addition to demonstrating that treatment is effective in reducing recidivism in mandated patients, the literature identified specific demographic characteristics that contributed to improved outcomes and reduced recidivism. Individuals who were employed, had families, higher self esteem, increased peer support, confidence in their counselor and are of higher socioeconomic status experienced higher rates of sustained abstinence and reduced recidivism **(17, 10)**. To achieve maximum efficacy, mandated treatment should incorporate treatment components that will support participants in achieving and building increased employment, family reunification, peer support, counselor rapport, and financial support.

To best develop policy and procedure for the treatment assigned to individuals, one must better understand and identify the most effective treatment modality for mandated populations. The literature review assessed and compared the effectiveness of Intensive Outpatient, Outpatient, and Residential Treatment to determine what was most effective for participants. In addition, the literature review assessed and compared the benefits of judicial models including Drug Court, DART, probation, and TASC. Although study designs were strong with large sample sizes that ruled out the impact of demographics like gender, income, race, and the like, results from study to study were contradictory identifying no one program or model as most effective or “best practice”. A weakness of available literature was that no one study assessed or explored the relationships between severity of addiction, level of training of counselor, hope and motivation of the offender, the process in which treatment assignments were made, type of crime committed, counseling philosophy of the program, participation in 12-step support groups, and most importantly the synergistic effects of combining the variables above. A lack of measuring the impact these variables played in the

results of the studies may have significantly confounded the data and reduced internal and external validity. It is this researcher's observation that no one treatment will be effective for all offenders and instead, a successful matching of treatment to the individual will lead to higher rates of recovery and reduced recidivism.

The conclusions of stage 2 of this review need be limited due to challenges in the design of inclusionary and exclusionary criteria as well as external factors. A primary limitation of the review is that 12 of the 16 studies addressing mandated treatment utilized large public data collections that were either retrospective or prospective. Secondary data can be limited in its quality and scope forcing researchers to be dependent upon the assumption that the data is complete, valid, and representative of the population. Although this reviewer found extensive research on the subject prior to 1985, outcomes were excluded due to changes in the chemical and usage patterns of the drugs of choice, training and methods of treatment, and culture shift further limiting the breadth of available literature. The review was also limited by the intentional exclusion of research including jail based populations, mentally ill substance abusers, and methadone patients. Although there are significant issues that could impact outcomes if these factors were included, further review may benefit from determining if those factors do in fact create different outcomes or can be safely included in further review.

This review has identified several gaps in the research that left unfilled present challenges to persuade policy makers and the public to transition from a punishment model to a treatment model of intervention for criminal offenders with addiction and substance abuse.

However, the review draws an important conclusion that opens the door to the inclusion of a secondary body of literature. Extensive research has been done demonstrating what types of addiction treatment brings the highest rates of recovery, identifying best practice approaches to treatment. The review has identified foremost that mandated treatment works. It has also provided evidence that factors including peer support, hope, optimism, mental stability, and financial stability contribute to reduced recidivism. The review has indicated that longer treatment leads to extended abstinence and that extended abstinence leads to reduced recidivism. The review indicates that it is not known at this time what components included in the various judicial models including Drug Court, TASC, and others specifically causes abstinence and reduced recidivism. The findings in this review present strong indications of the future direction that research should be conducted and successfully flushes out our understanding of how treatment impacts recidivism.

As this researcher progressed through the literature, a common and striking theme emerged that reflected a significant compromise in data. The majority of court mandated treatment protocols include some component of participation in 12-step support groups and yet few studies measured and included the impact that 12-step involvement may have had on study outcomes **(53)**. The National Survey on Drug Use and Health reported that over 5,000,000 people attended AA or NA in 2008 and identified that “two thirds of persons aged 12 or older who received any alcohol or illicit drug use specialty treatment in the past year also attended a self-help group in the same time frame. Three fourths (75.6 percent) of the persons who received specialty treatment for both alcohol and illicit drug use also attended a self-help group compared with 65.8 percent of those who received specialty treatment for

illicit drug use only and 63.6 percent of those who received specialty treatment for alcohol use only” (53). The study reported that although not all 12-step members are criminals, most criminals have been 12-step participants. 11% of AA attendees (54) and between 47-71% of NA attendees reported to be court ordered (55). Among others, Peele reported in his 1997 research that 93% of 450 treatment centers included in the study referred patients to 12-step fellowships (55, 73, 74). Finally, the literature reports that those who participate in 12-step and traditional treatment have significant improvements in abstinence rates and reduced recidivism (59, 60, 61). The level of referral to 12-step fellowships through the courts and treatment providers begs the question of how valid the research included in this review is without identifying 12-step participation as a key variable in successful outcomes.

Although some findings were consistent in 12-step research, others existed with significant contradictory findings. The literature is consistent that individuals who obtained a sponsor, worked steps, attended meetings, did service, and believed in the disease concept of addiction were more likely to remain abstinent and report an improved quality of life (26, 27, 32, 34, 36, 47, 49, 62-68). The literature, however, was inconsistent in identifying the unique variables of the individual that contribute to positive outcomes including religion, race, education, exposure to 12-steps, etc (30, 34, 35, 41, 42, 48-52, 58, 66, 71, 72). There remain significant confounding variables in the literature including a lack of distinction between the reference of the 12-step model used in the studies being either NA or AA, whether the subjects were court ordered or not, unique qualities of the group, group composition, and more. The overwhelming observation in the literature is a significant paucity of research focusing on Narcotics Anonymous. It is also of note that despite the efficacy of 12-step

fellowships, there continues to be a 40% drop out rate and although there exists a modest amount of literature on identifying variables that contribute to drop-out, no research exists that indicates “why” people drop-out.

In reflection of the findings in this review, the larger question remains unanswered of what judicial and treatment model would warrant a transition of policy from a punishment based model to a treatment based model. Pointedly, the role that 12-step participation plays in recovery and reduced recidivism is overlooked and under-researched in the literature. Future researchers need to get creative in overcoming the ethical and practical challenges of incorporating primary data collection in their models to develop data that more adequately explains treatment and 12-step participation’s impact on reducing recidivism. A process of collecting primary data presents the opportunity to include all components of the treatment experience including judicial model, treatment modality, and treatment philosophy to better understand the causative factors contributing to treatment success and reduced recidivism. There appears to remain an unknown variable in the success or failure of mandated offenders independent of treatment assignment. Although qualitative research presents some limitations, it may present the best opportunity for the collection of reliable and valid data.

In conclusion, despite the proven efficacy of 12-step fellowships, this review revealed that little is known about how to increase attendance, retention, and successful referrals to 12-step fellowships. It is this writer’s hope that the field of public health will utilize its strength in epidemiology and surveillance to create the data and understanding necessary to influence public policy in a way that will address the root causes of criminal recidivism,

making available the financial and intangible resources to address the larger societal issues of addiction. A necessary step towards that goal is for this writer to complete qualitative research to provide greater insights into improving the referral process for mandated offenders to 12-step fellowships. The research should identify what specific variables impact successful referral, retention, and long term abstinence. That insight should then be used to develop materials to be used by referral sources to better assess readiness for referral while providing offenders the knowledge and skill to stay in 12-step fellowships while maintaining abstinence. Further quantitative research could then be implemented to assess the efficacy of the materials in maintaining long term retention and recovery rates of offenders mandated to 12-step fellowships. Ultimately, this information could be used to create policy and practice that will better treat addiction as a public health rather than criminal issue.

Chapter Three - Methodology

Subject Identification

The purpose of this study is (1) to identify and examine the factors associated with the linkage and long term retention of court ordered offenders to 12-step fellowships; (2) to develop a conceptual model of key indicators of readiness for 12-step participation and engagement; (3) to identify the necessary training and educational materials needed for referral sources and offenders to enter and maintain engagement and participation in 12-step communities; and (4) develop an appropriate intervention that will address all factors influencing engagement to create an environment that supportive of long term 12-step involvement. The goal of this research is hypothesis development rather than hypothesis testing. The primary research question is, “How can mandated substance abuse offenders more effectively be linked to the 12-step support community?” The analysis section will focus on the variables that likely increase or decrease participation and retention as well as the influence of contextual and demographic variables on retention and participation.

The research design utilized qualitative methods with an interpretive philosophy focusing on the development of an emergent design, requiring flexibility and openness to change as information and data takes shape. The research project utilized a multi-stage

method design beginning with 10 subjects who completed a dependence severity instrument (see below) and interview using a structured interview tool. To standardize responses, interviewers were trained to follow the interview tool exactly without asking exploratory questions. Stage one included 3 members of the local Narcotics Anonymous community with a history of court mandates to attend Narcotics Anonymous and at least 12 months of continued abstinence from all drugs including alcohol. Stage one also included 7 individuals with a history of court mandates to NA and subsequent relapse and drop out from NA. A single point-in-time interview (**Appendix D, E**) was conducted with each Stage 1 respondent without regard to age, race, severity of addiction and/or crime committed. To minimize confounding variables, the research was restricted to male participants only.

Stage 2 of the research design utilized the information and conclusions gathered in stage 1 to edit the interview tool with the development of improved and focused questions (**Appendix F, G**). An analysis of interview results indicated the need to change the interview format into one allowing the interviewers the opportunity to ask follow-up and open ended questions. Stage two began with the goal of identifying 10 additional members of the local Narcotics Anonymous community with a history of court mandates to attend Narcotics Anonymous and at least 12 months of continued abstinence from all drugs including alcohol. Recruitment issues led to a total of 4 12-step members being interviewed. Stage two included the interview of 1 individual engaged in NA and 32 individuals from the county jail with a history of court mandates to NA and subsequent relapse and drop out from NA.

A total sample population of 44 persons were recruited for participation and distributed into stages 1-2 as indicated below.

Stage 1

10 participants total were recruited as key informants. 7 inmates from the Buncombe County Detention Facility who failed at engagement and sustained recovery in Narcotics Anonymous and 3 persons successfully linked with the 12-step community following a mandated referral with a year of sustained abstinence from all drugs and alcohol.

Stage 2

33 participants total were recruited as key informants. 32 inmates from the Buncombe County Detention Facility were recruited who failed at engagement and sustained recovery in Narcotics Anonymous and 1 person was recruited who had successfully linked with the 12-step community following a mandated referral with a year of sustained abstinence from all drugs and alcohol.

The interview included structured closed ended questions to gain demographic material and open ended questions to gain insight into the phenomenological experience of the subjects with NA. The Leeds dependence severity index was incorporated into the structured component of the interview including the collection of demographic information that assessed the type of mandate, nature of crime, nature of sentence and drug of use. Concepts and questions in the interview were written based on existing knowledge identified in the completion of a thorough literature review of existing research. Reflective listening skills

were employed to assure that the assumptions truly reflect the account of test subjects throughout interviews and the collection of data. Reflective listening include the asking of clarifying questions, summarizing statements, and paraphrasing. Data from index and demographics will later be utilized to assess for factors contributing to outcomes.

Interviews with individuals who did not follow-up with their court mandate focused on specific factors identified in stage one that may have contributed to their lack of follow through while maintaining an organic process that allows for their own experience to come through. Interviews with those individuals active in the recovery community focused on what their personal experience was as a referred person and drew upon the larger range of their experience with individuals who have been referred and did not follow-up. With the permission of the interviewee, all interviews were audio taped for later transcription. At the request of the interviewee, audio taping did not occur and the PI depended on written notes to capture the essence of the interview. Following transcription, all information was de-identified using a numbering and coding system. The PI is the only individual with access to the data and is bound to maintain the confidentiality of all persons involved in the study and any identifying information that is generated throughout the study.

Subject Description

Active members of the 12-step community with successful engagement were identified and recruited through the community relationships of this researcher in the 12-step community of Asheville, NC. Interestingly, the researcher was not able to successfully recruit the anticipated 10 individuals involved in the 12-step community meeting the project's criteria. All but four available and willing participants meeting criteria were actively involved or had graduated from a structured treatment program. It was decided by the researcher that combining individuals who had come only from court referral with those in treatment programs would not meet empirical standards. It is important to note that the four individuals engaged in the 12-step fellowship had not stayed clean and active in NA after their mandate. Each individual came back to the program after further relapse. It was decided to include those engaged with NA in the "failed" subject group during data analyses because there was no difference in the outcome from being mandated to treatment. It would be interesting if possible to follow-up with the incarcerated population at a later date to see if they were able to get and stay clean.

The researcher and/or referral source began with the reading of a recruitment script to determine the subject's interest in hearing more about the project. The research assistant or jail counseling staff read the informed consent handout verbatim to any person who expressed interest to assess their level of willingness to participate explaining clearly the intentions of the research. To reduce any feeling of obligation or coercion, a clear explanation was given that there was no pressure to participate or not participate and clarified

with subjects that no person in the community will know if they agreed or did not agree to participate in the research.

Inmates from the detention center were recruited with the assistance of detention center staff on the day prior to the interviews. Standard detention center procedures identify inmates during the booking process as either having had substance abuse problems or not through a paper or verbal questioning process. Inmates are then asked if they would like to receive counseling support from jail personnel. Jail personnel link with inmates requesting assistance to identify community and jail based interventions that will assist them in staying clean and reducing future criminal behavior. Jail personnel were provided with a script that guided them in the recruitment of appropriate research subjects (**Appendix H**). The script included an explanation of the overall goal of the research and questions regarding their history of court mandate to NA and willingness to participate in the study. The researcher read the informed consent handout verbatim to identified and willing subjects, answering any questions they may have had to further assess willingness. Subjects were given the opportunity to opt out of the interview at that time.

Risk Management

Potential risks include the consequence of a breach in confidentiality or discomfort from sharing information related to their history of mandated involvement with NA. Following transcription, all information was de-identified. The PI is the only individual with access to the transcriptions and is bound by confidentiality rules. At the time of this writing, all audio tape has been destroyed.

Although only a moderate chance exists, participants may have experienced emotional stress or embarrassment as a result of discussing their experience in not following up with referrals and being incarcerated as a result. The interviewers are licensed and certified counselors, qualified to process any issues with participants as needed. The interviewer frequently assessed throughout the interview the well-being of the participant. All subjects were given the opportunity to review any documentation made during the interview or survey process and offered the opportunity to receive a finished copy at the end of the research process. An informal debriefing was conducted at the conclusion of interviews and the survey process to assess the well-being of the subject and any necessary steps were taken to support the subject. Debriefing included an informal questioning of how the individual felt and requested feedback of whether or not the individual may need follow up support. Follow-up resources were made available for participants as needed. No individual participating in the project indicated the need to receive support and many participants described the experience as cathartic.

All contact with detainees in the local detention facility was conducted directly by the interviewer and law enforcement personnel were not allowed access to any data. Jail personnel did not sit in on or observe interviews. Signatures were not obtained by inmates to reduce any chance of identifying information being linked to the individual.

No risk of legal or financial consequence was present due to the de-identification of personal information. All subjects are protected from potential legal consequence of provided data because criminal activity is not a focus or important detail of this study and demographic material did not include identifying information. Participants were instructed not to provide any information on criminal activities except for what they have been charged with.

Due to the researcher's experience and relationships in the 12-step community, there was the potential risk of participants feeling that their information may become public. Consequently, a research assistant not familiar with the 12-step community conducted all 12-step interviews. Full informed consent was provided that clarified the strength of the confidentiality agreement and no coercion occurred, allowing participants to opt out if they were uncomfortable. It is important to note that 7 individuals were referred to the interviewers for f/u and only 4 followed up with the interview. The researcher is not aware of who did or did not participate. Additionally, the 12-step community's strong oral tradition where deeply personal information is shared regularly will reduce the potential for social discomfort.

With any research, the perception of coercion is a risk to be minimized in study design. All participants were informed clearly that there would be no benefit or consequence for their participation. The researcher reinforced this clearly during the informed consent process and jail personnel were not to be informed if an inmate opted out of the study at any time. Members of the 12-step community or BCDF inmate went through two stages to assess willingness including the reading of a recruitment script and consequent full consent document.

Consent

All participants were given written information related to the study and signed consent was obtained prior to any active participation in the study (**Appendix I**). Consent included a description of the purpose of the study, confidentiality, information on how data will be secured, the right and opportunity for participants to review any and all documentation, and available resources should the individual experience any type of duress during or after the study. Subjects signed or placed an “X” (participants may choose not to sign) on the consent form that they agree to the terms of the study and have received full information to provide their informed consent. A mental health worker in the local detention facility informed inmates that the interviewer was coming and explained the purpose of the research. No compensation or coercion was present and all subjects participated through their personal choice.

Analysis

The research design of this study is heavily qualitative and data analysis was an ongoing organic process using a combination of the experience and perception of the PI, quantitative software tools and qualitative research techniques. Data was amassed and examined using content analysis to identify recurring words, phrases, and concepts. Data analysis occurred in conjunction with data collection as themes emerged. A code table was created to identify the primary categories and themes within the data (**Appendix J**). In keeping with current process, no pre-existing coding system or themes were used to analyze the data. All codes came strictly from the subject's personal experience with having been mandated to Narcotics Anonymous. Cross case analysis was aided by the structure of the interview. Namely, all subjects were asked the same questions and thus differences and similarity in themes were easily identified. The discussion section of this paper compares identified themes from existing research to further understand possible conclusions.

The PI adapted Creswell's 8-step process below to create and apply a coding system that organized the data (**80**).

1. Read all source material to get a big picture sense of the whole.
2. Read interview by interview asking oneself, "what is this about".
3. Organize all subject response by question into one comprehensive document.
4. Create list of topics and cluster together in content groupings. Separate topics into columns based on shared themes.

5. Re-read the source material writing the code next to each passage relevant to the topic to see if new categories and themes emerge.
6. Find the most descriptive words for topics and turn them into categories. Reduce list to primary themes and identify relationships between themes.
7. Abbreviate by category and alphabetize codes.
8. Assemble data material by category and complete analysis.

Quantitative data was gathered using an empirically supported assessment tool called The Leeds Dependence Questionnaire. Demographic data was gathered including age, gender, age of first use, primary drug of use, and income. Categorical data was collected including desire to quit, belief that recovery was possible, belief that NA would help, orientation to NA by mandating body and involvement in various NA activities. Narrative data was gathered on multiple domains. All relevant quantitative and categorical data was entered into SAS for statistical analysis. ANOVAs were used to provide P-values indicating the relationship strength between themes and variables as identified in the code book. A combination of quantitative data and qualitative narrative resulted in a deeper analysis of the impact that spirituality, expectations of NA, desire to quit, hope that recovery was possible, severity of addiction and level of orientation to NA had on overall engagement with NA.

ANOVAs found statistical significance only between dependence severity and the reading of literature when run independently. Consequently, a total engagement score was developed to represent engagement in the five core 12-step activities including sponsorship, step-work, literature reading, service and home group. A point was assigned for each activity

reported. A score of zero indicates no engagement and 5 is complete engagement. Statistical results were used solely as a tool to explore more deeply conclusions drawn from narrative and is reported in graph format.

A form of pattern matching outlined by Yin was applied in the final generation of hypothesis development **(81)**. Explanatory process is inherently iterative in nature beginning with a possible explanation or answer to the research question from case study one. The potential explanation is then expanded and adapted as further case studies are reviewed. The code book and statistical analysis provided the PI with a roadmap to empirically develop an explanation that answers the question of what factors impact long term engagement in NA following a court mandate. In the case of this study, the initial hypothesis was not disproved but did not present as the primary factor impacting retention. All evidence was reviewed with the intention of identifying rival explanations for the phenomenon. Rival explanations are reported in this document relating to research weaknesses.

An abbreviated version of the process above was conducted on the first 10 interviews to improve the interview tool. Information presented related to social, spiritual, mental illness, previous treatment, hope and desire to quit using. Additional questions were added to the interview tool related to these potential answers to the research question and are reflected in the appendix.

Chapter Four – Results

Narrative content and quantitative analysis of interview results were consistent throughout the study lending validity and reliability to the conclusions drawn from the data. Trends emerged indicating that specific constructs like hope and desire had negative, positive and neutral impacts on the domains explored in this summary. Overall findings illustrate the primary impact of constructs on engagement with NA. Charts are presented that include quantitative data with supporting narrative to illustrate any explanation drawn from the data. Numerical values were assigned to categorical data to allow for statistical comparison and analysis. Numerical assignments were made through the interpretation of subject narrative and do not meet the typical rigor of quantitative empirical research. The analysis however is consistent with qualitative research methods.

5 primary NA activities were each assigned the value of one point allowing for a total engagement score of 0-5. Engagement scores were compared to categorical and quantitative data to evaluate the strength of specific relationships between variables. Overall P-values in the chart below indicate the statistical relationship between the engagement score and construct listed. A thorough outline follows the summary chart below. When combined and using the less conservative cut off of .1, statistical significance was found only with the level

of treatment engagement, desire to stop using drugs/alcohol, hope that recovery is possible and positive expectations of NA.

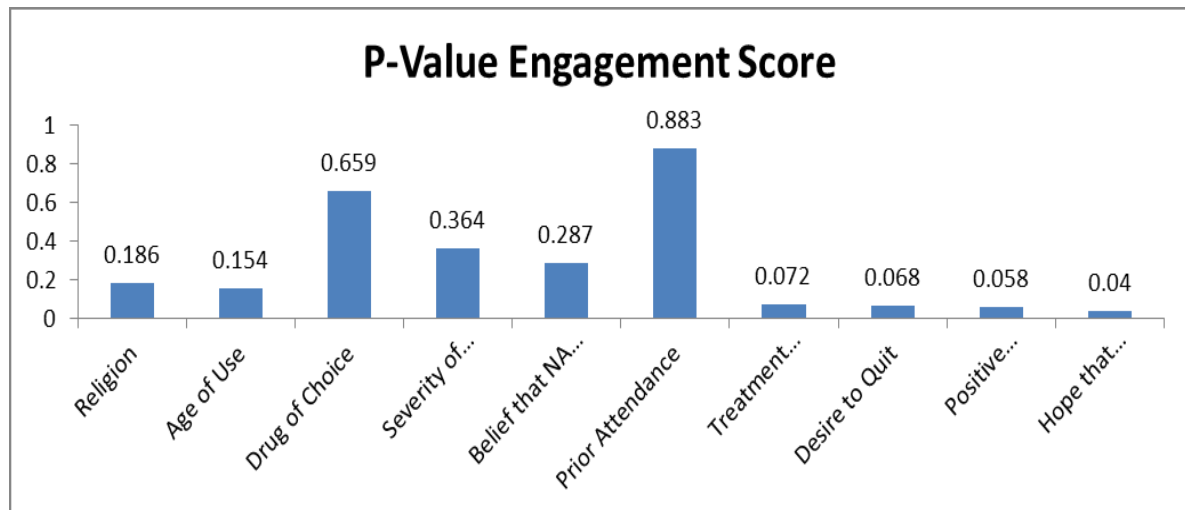


Figure 6

The existing body of 12-step related literature is not in agreement over the factors impacting retention and engagement, as outlined in the literature review of this project. This research found outcomes that both agreed and disagreed with previous findings. It is important to note that this is the first known study to focus specifically on individuals mandated to attend NA rather than AA, NA or a combination thereof. It is also one of the only studies that purposely didn't include subjects actively or recently graduated from a structured treatment program. Contrary to Evans, age of first use did not relate to engagement **(25)**. Contrary to Best, drug of choice did not appear related to engagement **(52)**. Consistent with Christo, spirituality did not appear related to engagement **(48)**. Contrary to Fiorentine, self-identification as an addict did not appear related to engagement **(32, 34)**.

Timko, Sesson and others reported that the level of orientation to NA directly impacted engagement **(36, 47)**. Orientation can be defined as receiving education about the program, having a speaker from the program or linking individuals directly with active members of the 12-step community. Unfortunately, only 4 individuals reported receiving orientation and no data was collected on what was included in their orientation. No statistically significant difference in engagement was noted between those reporting and not reporting orientation.

Subject Demographics

A total of 42 subjects were interviewed in this study. The bulk of participants were between the ages of 18-25 with an average income of \$5,000-\$15,000 a year. Drug of choice was widely distributed with the majority citing opiates or a combination of drugs as the primary drug used. 25 subjects identified themselves as addicts, 9 as alcoholics and 8 as neither. ANOVAs were run and found that engagement levels within the 12-step community following a mandate had no statistical relationship with age, drug of use or reported income. P-values were .154, .659 and .588 respectively.

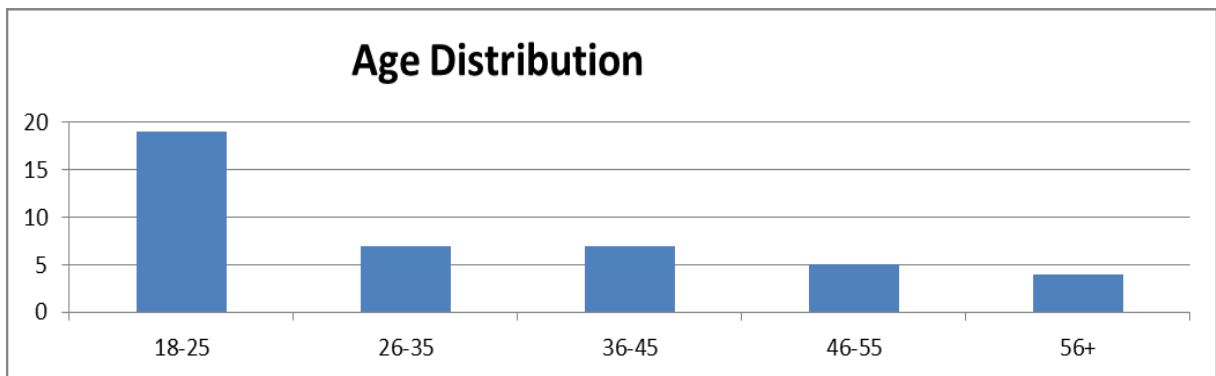


Figure 7

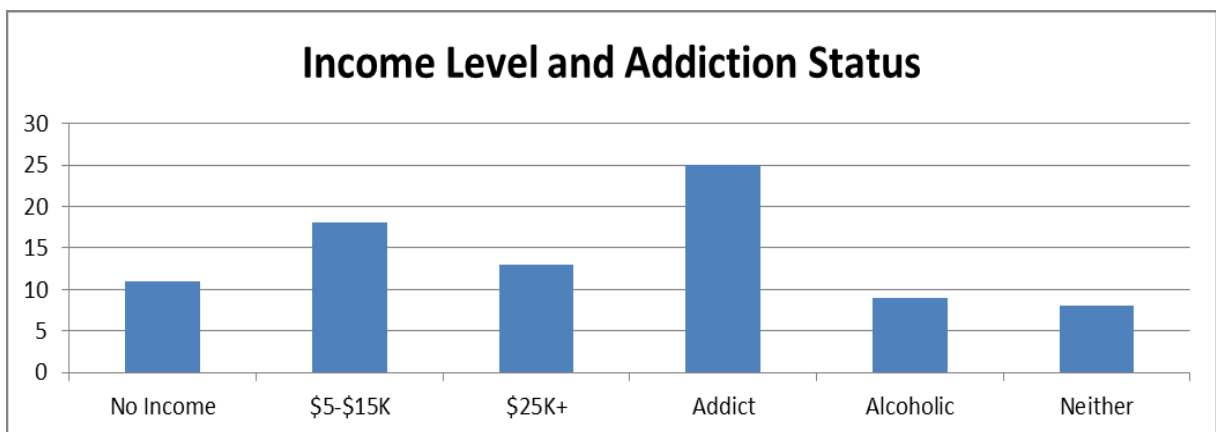


Figure 8

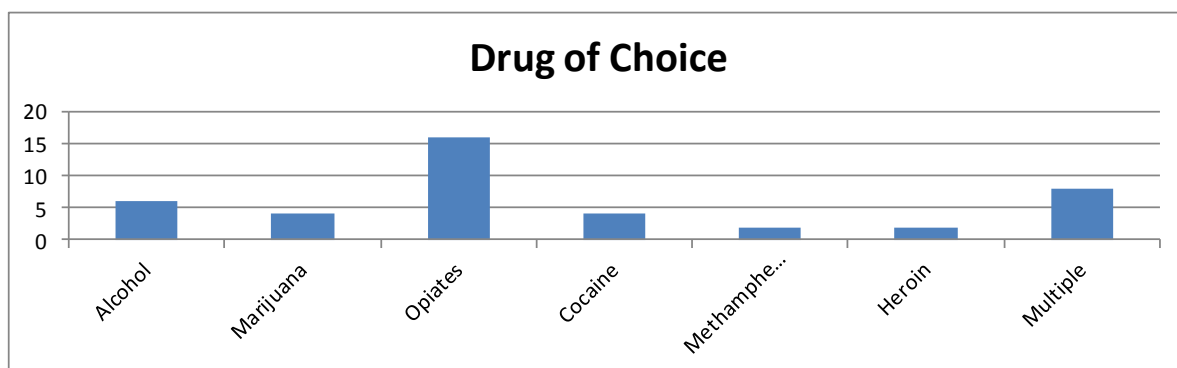


Figure 9

Severity and Criminal History

Subjects completed the Leeds Dependence Inventory and self-reported the severity of their addiction. The distribution of responses is seen in the chart below.

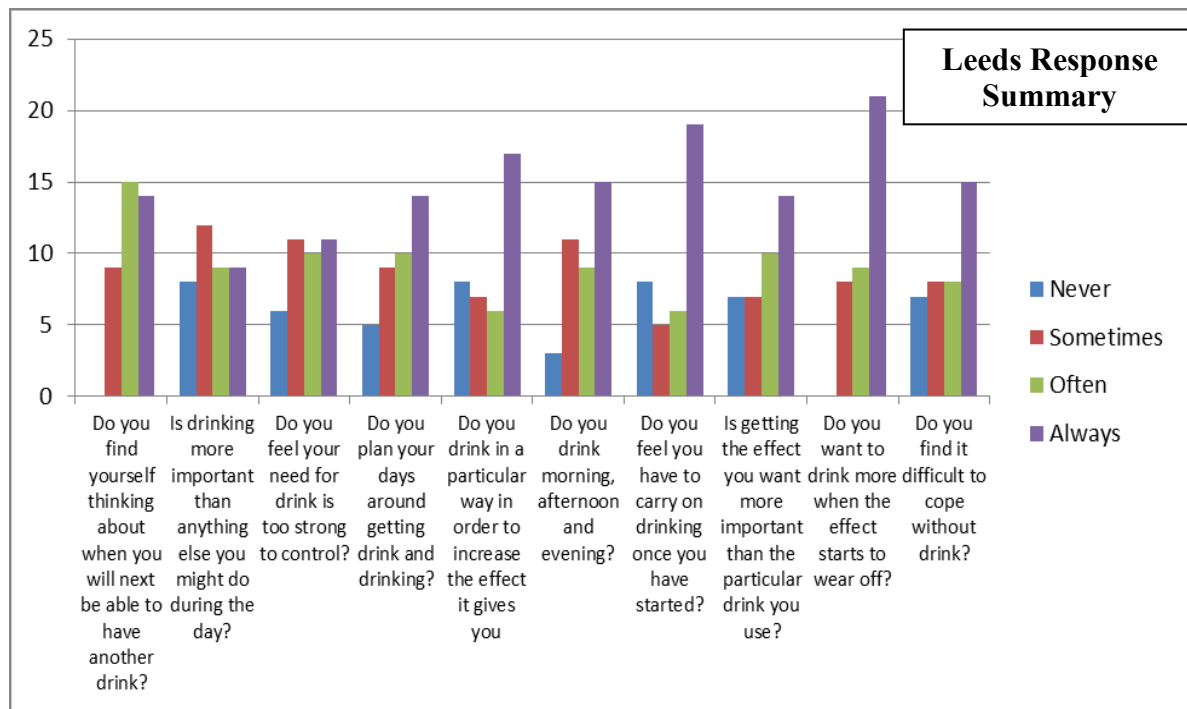


Figure 10

Self-reported addiction severity closely matched that of the formal and empirically supported Leeds Dependence Inventory. On balance, individuals self-reported higher levels of addiction severity than Leeds. No statistically significant relationship was found between severity of use and engagement with 12-step fellowships with a P-Value of .364. Leeds and self-reported severity of addiction directly correlated with the number of arrests and incarcerations as indicated in the chart below. It is important to note that all subjects

indicated that some percentages of their arrests were directly caused by their addiction. 16 subjects unprompted indicated that all of their arrests were caused by their using.

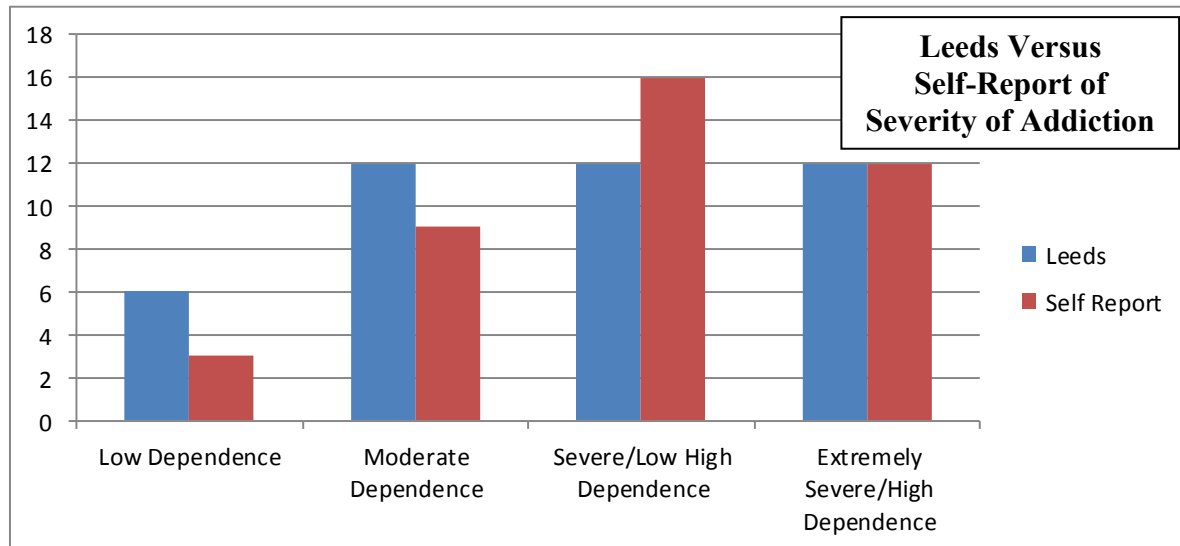


Figure 11

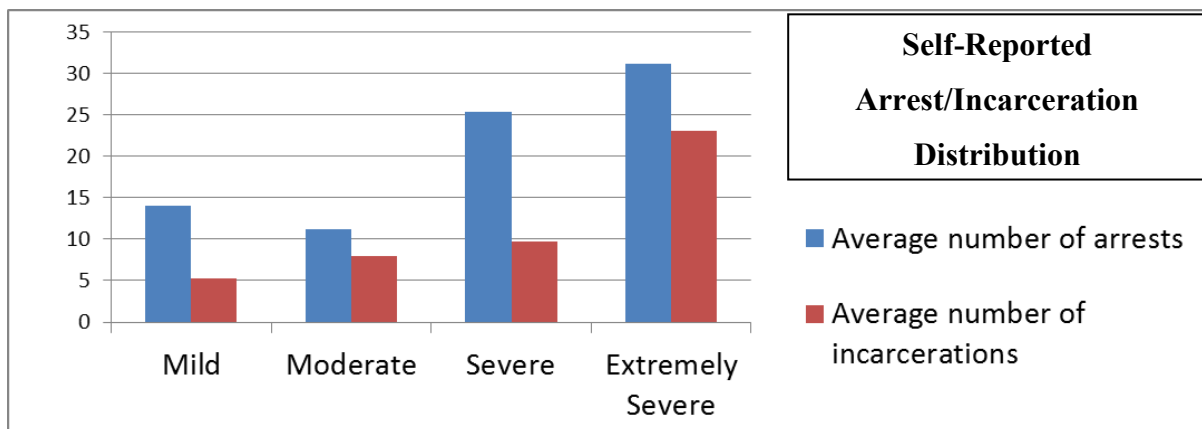


Figure 12

“Every arrest that I’ve ever had has been either for drug use or obtaining something you took drugs with, or assaulting someone under the influence of drugs or alcohol or both”

Spirituality and Religion

21 participants identified themselves as Christian in orientation, 7 as spiritual but not religious and 7 as not Christian but religious. 16 subjects indicated that their beliefs didn't impact their addiction in any way. 7 reported that their spiritual beliefs had a negative impact and 5 cited a positive impact. 15 subjects indicated that their spiritual beliefs didn't impact their participation with NA, 12 indicated a positive impact and 1 a negative impact. No statistical relationship was found between spiritual beliefs and engagement in NA with a P-value of .186.

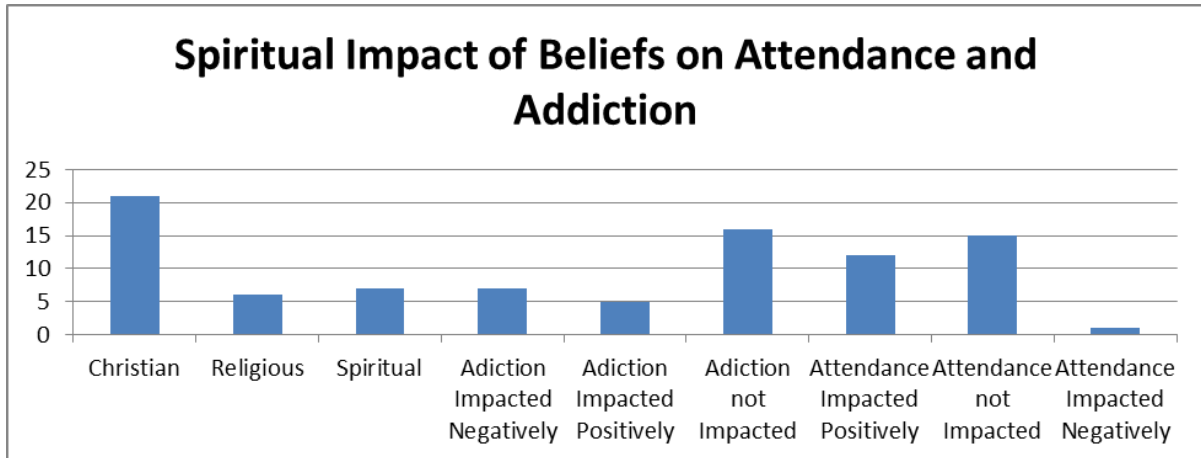


Figure 13

Negative

Do you think that your spiritual beliefs impact you in attending or being mandated to attend 12-step fellowship? “Yeah I do; because a lot of them are held in churches, and I get kind of funny in churches, ‘cause a lot of churches are all the holy rollers and all that stuff and, you know, I shy away from that kind of thing. I’m not saying that they’re not doing a good thing or it’s not the way or anything like that; it’s just I don’t really feel that that’s my way.” ***You feel pressured into that way because of being in a church?*** “Somewhat, yeah”

Positive

Do you think that your spiritual beliefs impact you in attending or being mandated to attend 12-step fellowship? “Yeah, I think it did. I was clean for about 6 months about 2 years ago & my spirituality was a big part of my going to 12-Step meetings for sure. The whole part of being able to turn it over to a power higher than yourself was what made me want to go to 12-Step meetings”

Treatment Engagement

Consistent with existing literature, treatment had a positive impact on engagement with NA. 19 out of 38 subjects engaged in treatment. 15 indicated that their treatment experience increased their engagement level with NA. 4 subjects indicated that treatment didn't have a positive or negative impact on engagement. Subject narrative suggested that their counseling team's understanding of 12-step programs was the primary factor impacting attendance. Subjects also cited counselors being addicts, encouragement received, increased desire to stop, increased belief that NA could help, explanations provided of NA, going to a meeting with other clients, NA speakers coming into group and normalization of addiction as motivators to go to and engage with the program.

Do you feel the counselor or the program contributed to your going or not going to NA

“Yes - they understood & they contributed to my going. They really helped me & they were there like cheering me on – they understood me and they helped me any way they could. I was like a trash can. They did whatever they could to help me stay clean. They encouraged me”

“They contributed to me going. It made me realize a little bit more of what the program was designed to do. It wasn't everybody telling me what was wrong and things like that. I realized I was actually there as a therapy type thing – for support”

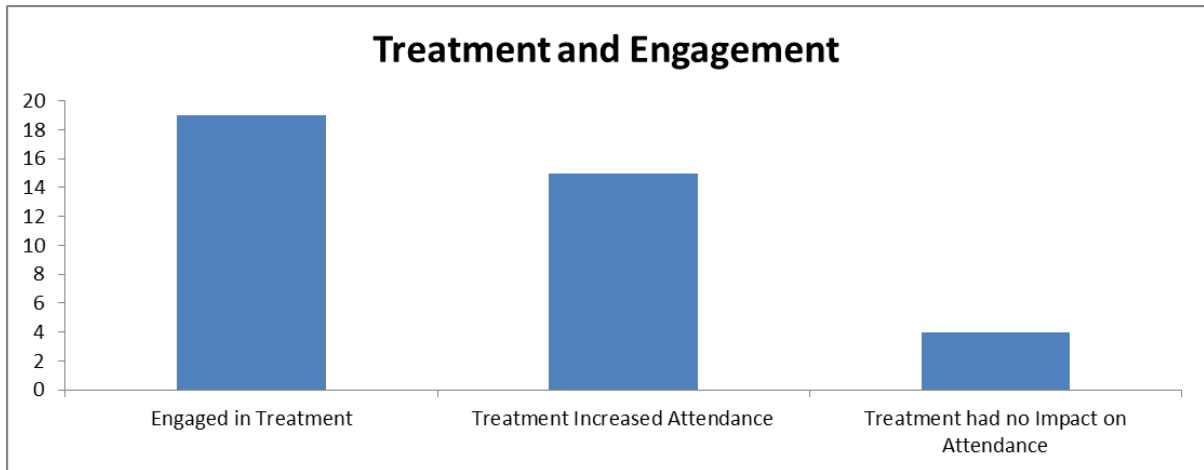


Figure 13

Social Factors

Subject narrative indicated that social factors increased engagement for some and decreased it for others. ANOVAs showed no statistical significance in either direction between engagement and social factors. Many subjects indicated fear of judgment from others, shame and embarrassment because of being mandated, suspicion that others were using, and not feeling a sense of belonging as factors that increased or decreased their level of engagement. Individuals cited embarrassment of being seen, shyness, not liking to talk in front of others and not knowing anyone as impacting their comfort level at meetings. Subjects also indicated that feeling understood, “being a part of,” feelings of acceptance, laughing, going out after meetings and seeing people like themselves were factors that increased their comfort levels with the fellowship. On balance, only 15% of subjects indicated making any social connections within the fellowship outside of peers from treatment or their judicial program.

Negative

How do you think that the social part of the 12-Step fellowship impacted you? “It was a good thing. After the meetings, people go out for coffee if they want to. They go out to eat. There’s some really good people, really people that’s sincere, really good-hearted people. That’s what it’s about, man, is helping somebody and once you get help you reach out to somebody else. That’s the whole thing”

Positive

Did you have any specific fears about going to NA? “Yeah, I thought people was going to make fun of me. Thought my friends that was getting’ high wasn’t going to talk to me anymore. And I thought the drug dealers was going to think I was a snitch and shoot me.... “

12-Step Engagement

As seen in the table below, a minority of individuals reported participation in activities within the 12-step community above and beyond the requirements of their mandate. Subjects were asked if they worked steps, read literature, obtained a homegroup, did service and/or had a sponsor. The majority of individuals reported and demonstrated a lack of understanding of the core elements of Narcotics Anonymous including step work, literature, service, home group and sponsorship. Sponsorship is the backbone of 12-step programs. A sponsor helps newer members to work steps, find a homegroup and grow in their recovery. Although 8 subjects indicated obtaining a sponsor, only 3 indicated that they actively used that sponsor. It is important to note that the 12-step community identifies having a sponsor as necessary to work steps even though significantly more subjects reported working steps than having a sponsor. Narrative is provided below that demonstrates the lack of understanding in subjects of 12-step activities.

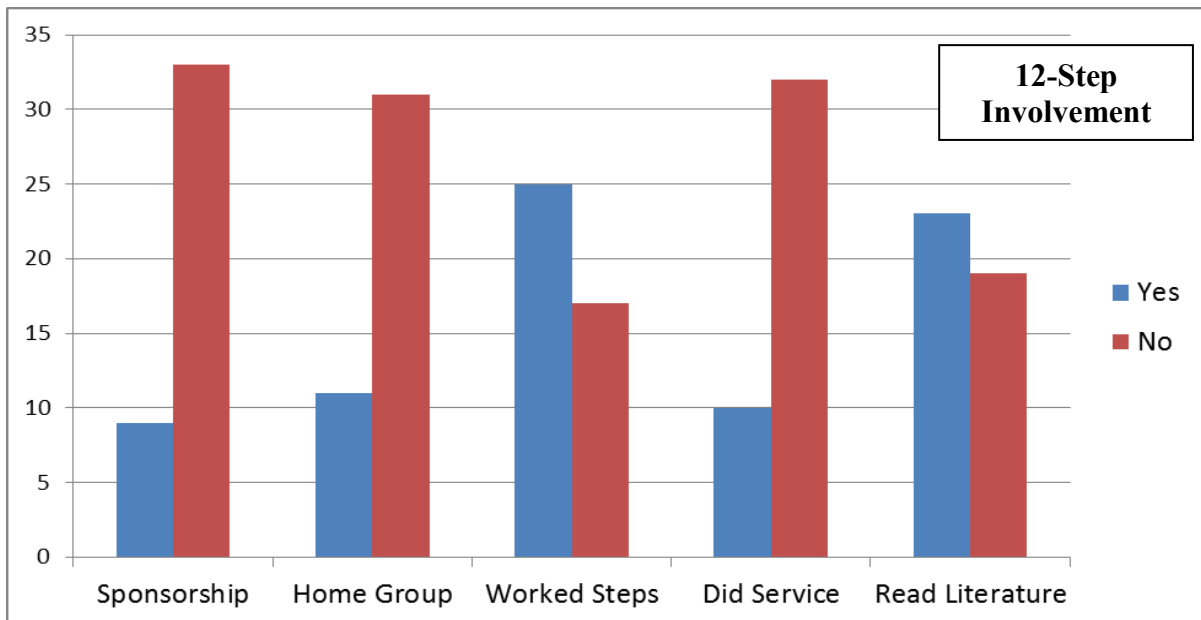


Figure 14

Lack of Understanding

Only 3 subjects indicated that they continued going to meetings for an extended period of time following their mandate, but 22 indicated that they would have gone for their own reasons had they not been mandated. The large majority described their experience as overwhelmingly positive. This begs the question of why they stopped going.

How often did you read the literature? “I tried to read something every time, but if they had already got through the reading.” – ***When you were outside the meetings did you read it?*** “No.”

Point: subject thought that literature meant the readings in the meetings rather than printed books individuals use to work steps and engage in the program.

Did you work any steps? “Yeah” - ***How often would you say that you worked any steps?*** “At least every other day.” ***What’s the highest step that you worked?*** “I practiced all 12 of them. In the groups you read steps. I’d just read them. The ones I’d do on that day.”

Point: Individual thought that working steps meant to consciously think about the steps throughout the day rather than to discuss each step in order with a sponsor over time, to better understand yourself and build recovery.

Hope and Desire

The level of desire for recovery and belief that recovery is possible was assessed for all stage 2 participants. The chart below reflects the fact that hope and desire was distributed into 4 primary groupings. A total of 14 participants had no hope that recovery was possible. 11 subjects reported a desire to quit but no hope that it was possible. 9 subjects reported hope and desire. 3 subjects indicated that they had no hope or desire to recover. ANOVAs indicate that there was a statistically significant relationship between engagement and desire to quit as well as hope that recovery was possible. P-values were .068 and .04 respectively. Narrative communicated clearly that watching other people succeed, past experience of success, past experience of NA working, counselor's encouragement and faith in God all contributed to increased levels of hope. Desperation and suffering were the primary factors communicated consistently that led to a desire to stop using.

Would you have attended for your own reasons while you were attending the program?

"Yes. I would say after about 3 weeks, I did. Because I started meeting some people and it was helping me. And I started sharing, & I seen that when I started sharing these things with people, things that was going on, cause I was the type of person that didn't open up, cause I was taught you're gonna hold in, you don't show emotion, telling people things that were within me. Once I did start sharing that stuff going on within me, I felt better. Cause I found people to relate. Cause a lot of people don't relate because they've never been there. But a lot of people could relate, & they were like, "Look, here's how you do." And I would try it, and it worked. It's a really good thing, but like I said, you've gotta be on the scent - Ain't no half-assin' it, 'scuse my language. If that's really want, well if you've been an alcoholic like myself, then either you're gonna die or you're gonna come back to this place. It's just a good program. It can save your life and save your freedom."

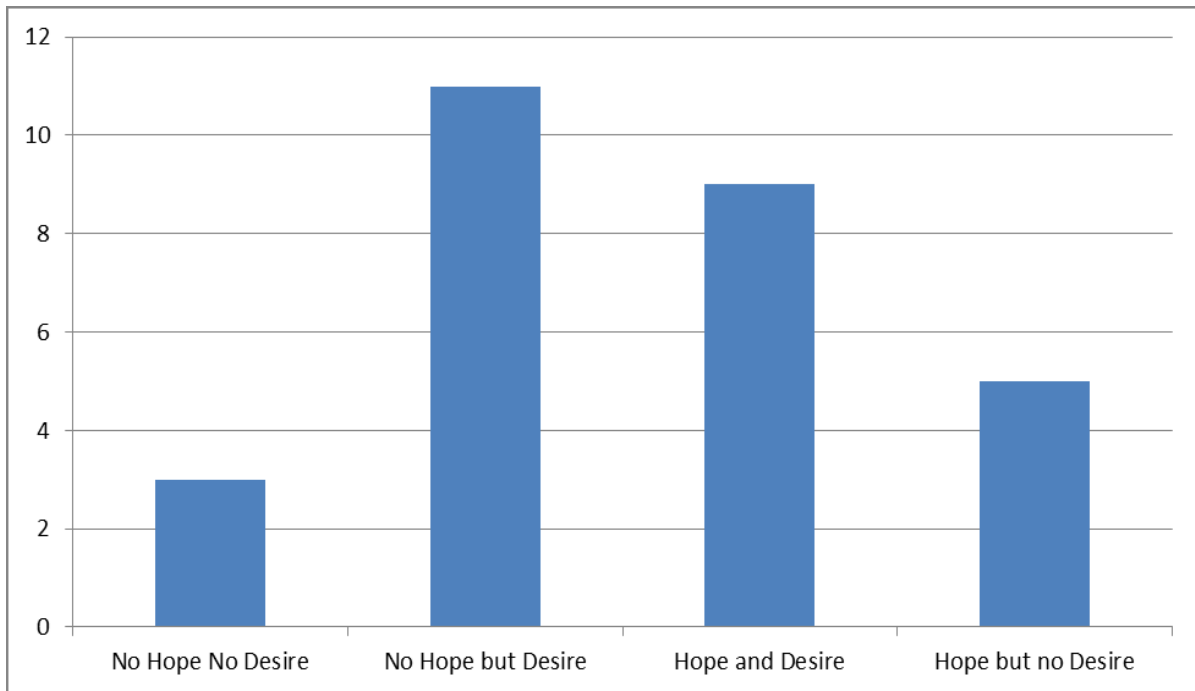


Figure 15

Desire

“But now I’m trying to get back into drug court. Like I say, that was 7 or 8 years ago. I wasn’t ready to quit. I hadn’t hit bottom yet, but now I’m pretty much at bottom. Scars and everything else. I always thought I wouldn’t be a shooter, but now I start shooting that’s when I’m locked up. So’ I’m ready. I want a normal life – whatever is normal, but I don’t want to be a junkie.”

Hope

Would you have attended for your own reasons while you were attending the program?

“I think at one time I went to a meeting because I walked by and there was somebody there that I seen.” ***So it was fellowship? So if there was somebody there that you felt like you had a relationship with, then you would be more likely to attend that meeting.*** “Yeah. Like somebody that I was smoking with or doing drugs with on the street – that I hadn’t seen no more. Yeah, I would. In fact, this meeting I went to recently that I forgot about at A-Hope. One of the meetings I’ve been going to recently is because of that lady that goes there. I’m not even realizing that until just now. There was a lady I used to smoke drugs with over in the projects & she’s been sober for a while now, and she goes to their meetings every Tuesday. And now she’s got housing and everything. And that’s the reason why. She always waves at me and says, “Hey, you comin’ to the meeting today” And I’m sitting there like, “Hey, what’s up with this meeting.” ***So, when you were motivated to go to meetings on your own, it was because there were people that you had previously used with and you knew that they got clean and you wanted what they had. You wanted sobriety – and if they obtained it then maybe you could find out how they did it – is that right?*** “Well not just see how they did it, but just be part of it, because if they did it, then I can too. Cause these people to me – they were there and they had been there way before I had been there. And I’m lookin’ at them and I’m sayin’ “Man, if she can get sober, I know there’s some hope for me!” And she wasn’t really that bad off really – she just started it. She didn’t have to spend a dime on it.

Orientation, Motivation and Expectation

A statistically significant relationship was found between engagement and expectations of NA. 11 subjects indicated that they had no idea at all of what to expect. 11 reported not knowing what to expect but imagined that it included people sitting in a circle complaining or talking about their problems. 7 expected NA to be a negative place. Only 8 subjects expected NA to be helpful to them.

A total of two out of the 42 participants reported a formal introduction and orientation to Narcotics Anonymous. The majority of subjects were told simply to go to the meetings or go to jail. Over 50% of subjects were not provided with a list of meetings and no subject was educated about the specifics of 12-step involvement. 14 mandates came from a probation officer, 20 from a judge or judicial program and 3 from a court-ordered assessment. 22 referral sources were cited as not having done anything to help the person feel more comfortable about attending meetings. 7 subjects indicated that their mandating body made them feel more comfortable about attending meetings. Those subjects indicating that the mandating body made them feel uncomfortable identified mandated attendance as the cause of their discomfort. Subject narrative described a pattern of feeling uncomfortable in meetings. Many cited their lack of knowledge related to the meetings as their source of discomfort.

What were you told about NA by your PO? “That they’d be a good experience that would help me get off drugs and encourage me. That gave me hope, you know”

What did you expect to experience at your first meeting? “To be honest, I had bad anxiety about it. I had to take a couple of Xanax when I got there, cause I felt everything was closing in on me. I didn’t know what to say, I didn’t know how to react to what anybody said. I just felt like I didn’t belong there at first. At one point, I wanted to be there. At the same time, I was pissed off because I was there and I thought I didn’t need it. I just wanted to go home and go back to my regular routine to where I didn’t deal with stuff. Just kind of basically lost. I didn’t know what to do”

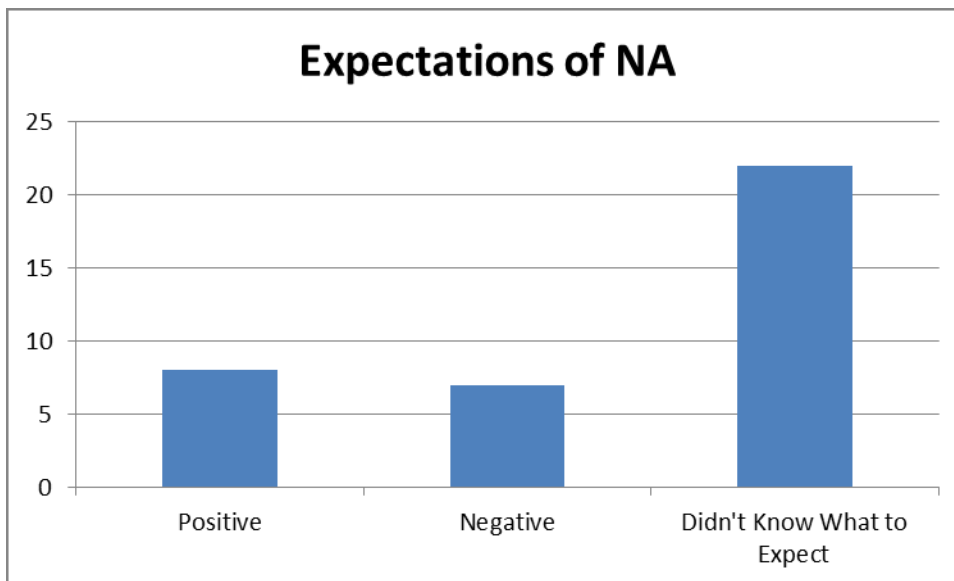


Figure 16

. Subjects were asked what referral sources should know and do in order to refer people to meetings in a way that would improve their experience and engagement. A large percentage of participants indicated that they would have done better if they had been told what to expect from the meetings. Subjects indicated their desire to have been given orientation materials as simple as a list of where meetings were held. Subjects indicated that referring sources should attend at least a few meetings so that they knew what they were sending people to. Subjects indicated their desire to have had someone from NA come in and talk to them prior to going so that they felt more comfortable. It was suggested multiple times that people should be told that there will be people just like them who won't judge them. Specific skills were referenced such as how to find a home group, how to find a sponsor, what step work means, etc. Many subjects indicated that they wished that referral sources knew about addiction and and/or were addicts.

“Well, I’d probably show them actually the 12 steps & explain what the program’s about – a little bit of description of each step; show them that there are people there who actually can help or are going through actually what you’re going through, and you know, you may think you’re alone, but you’re not. There’s a whole room full of people there to support you. I’d probably give them my number. Maybe show them a little thing on the internet of a little group session or something like that.”

Participants indicated that the primary reason for disengagement from the 12-step community was relapse. 27 subjects specifically said that relapse was specifically responsible for their having stopped. 5 subjects indicated a lack of desire to stop using. 5 subjects said that they stopped attending only because their order ended. 4 subjects indicated that they stopped going because they relapsed due to a lack of engagement in NA.

“I think some people that refer ain’t never had a drug abuse or other problem, & it’s a lot harder for them to explain to people about the group meetings if they’ve never gone to one theirself. So they need to go to the meetings”

"I think that the people that go to the meetings are the ones that should tell you, because most of the probation officers don’t go to the meetings, and I really don’t think that they know that much about it. They’re doing it from a legal point of view, not a personal point of view.”

“I started using is why I quit. Relapsed. I even relapsed on what I don’t use. I smoked crack, and I don’t even smoke crack.”

“I figure there’s a lot of reasons. Of course relapse would be the most obvious one. Maybe some people think they just got the addiction beat – they don’t need it no more.”

Did you want to stop using? “Not at first. When I was mandated, I was just kinda going through the steps. That was what I had to do to stay out of jail. I didn’t even really wanna be clean. I just wanted to stay out of jail”

Chapter Five - Implementation Plan

The wide body of research cited in the literature review of this paper consistently demonstrates that individuals who engage in 12-step programs stay clean longer and commit fewer crimes. However, the literature review reveals a lack of consensus about what factors influence 12-step engagement. Factors that have been researched include education level, age of first use, self-identification as an addict and many others. Quantitative and descriptive data from this project indicate clearly that four primary factors influence engagement. The four factors include the belief that recovery from addiction is possible, a desire to quit using drugs, active treatment engagement and positive expectations of NA. At the same time, virtually no subject stayed clean or engaged with the 12-step program for any length of time. Consequently, a program needs to be designed and implemented that increases desire and hope while creating a positive expectation for the benefits of NA.

This researcher contends that a testable hypothesis has emerged from the data suggesting a specific way to increase hope, desire and positive expectations of NA through a treatment experience. The missing pieces from all but two subjects in the study were orientation and education about NA. It is this researcher's conclusion that mandated offenders would experience higher rates of long term engagement with NA if they coupled counseling with a comprehensive orientation to the principles and program prior to attending.

Subject narrative detailed two themes supporting this hypothesis. The first theme relates specifically to the discomfort that a lack of orientation to NA created. Subjects expressed their desire to have known more about what to expect from NA, where to go for meetings and how to talk or not talk in meetings. Subjects consistently shared that those who mandate offenders to NA need to actually understand it for themselves. The question was raised of how Probation Officers and Judges could refer to a program that they don't believe in or understand.

On balance, subjects were provided no introduction to NA and were told to go to meetings or go to jail. The majority of subjects indicated that their only motivation for attendance was to either stay out of jail or receive a reduced sentence. At best, discomfort and a lack of knowledge about NA didn't create positive expectations or hope that recovery was possible. At worst, ignorance of the program and social discomfort created a negative expectation and diminished hope. Eight subjects directly reported that they had a negative expectation because of the mandate itself. Consequently, many subjects indicated that they either never went to the meetings or felt very uncomfortable when they did. Subjects reported that their discomfort reduced their social involvement within the fellowship, long-term meeting attendance, service and exposure to the core elements of the program. It is reasonable to assume that significant discomfort and negative expectations present significant barriers to effective engagement.

The second theme and larger problem revealed in this study is the lack of understanding exhibited by subjects related to the core elements of NA. It this researcher's

belief that this lack of understanding relates to the lack of orientation. Instead, it is presumed that the lack of orientation contributed to subjects choosing not to participate in the program. This, in turn, may have prevented the level of involvement necessary to create engagement and understanding. All known research on 12-step programs consistently demonstrates the benefit of working steps, obtaining a sponsor, obtaining a homegroup and doing service within the fellowship. People who engage in these activities commit fewer crimes and remain abstinent for longer periods of time than those who do not. Additionally, treatment has been shown in this research as well as existing literature to decrease recidivism and relapse. It is the working hypothesis of this project that orientation combined with treatment would have a ripple effect: beginning with the building of hope and positive expectations and ending with desire and engagement.

Below is a model designed to increase engagement that can be delivered in three distinct but related stages. Stage One utilizes an existing treatment model that with modification presents the opportunity to positively influence the four domains identified in this research. Prime for Life is an evidence-based psycho-education model specifically designed for individuals struggling with insight into addiction, low motivation for recovery and no hope that recovery is possible **(82)**. Prime for Life incorporates Motivational Interviewing with educational content regarding addiction to provide participants the opportunity to explore their own use as it relates to recovery. The Prime for Life curriculum is affordable and delivered in 5 three-hour classes. Prime for Life has a specific curriculum designed for pre-treatment engagement that helps individuals to become ready for treatment and 12-step engagement.

Stage Two of the program involves direct education and orientation to NA by individuals actively involved in the fellowship. Part of the Stage Two message can come directly from NA and the second can come from employees with a history of addiction. The two service committees within NA that would educate participants about NA are “Hospitals and Institutions” (hereinafter “H+I”) and “Public Relations” (hereinafter “PR”). H+I is a group from the fellowship that goes to treatment programs, sharing the message of recovery found in NA. PR is a branch of service where people in NA speak to judges, probation officers and the community about NA.

The North Carolina Department of Health and Human Services has recently developed a billable state service, called Peer Support, that can provide education directly from one who has experienced addiction. Peer Support Specialists are individuals with a history of either addiction or mental illness who receive intensive training from the state to help others recover. The treatment team could purposely screen Peer Support staff who is actively engaged in NA without significant barriers. The Peer Support team would provide a series of educational and interactive classes about addiction and recovery from a personal perspective. Classes would include speakers from the NA community who would share their experience of how they use NA in their own lives to recover. Exposure to persons with a personal experience of addiction will increase the comfort level of participants while they are educated about the core elements of the NA including sponsorship, service, step-work and the reading of literature.

Stage three would include a one year therapy program that combines counseling with active and regular attendance at 12-step meetings. It is recommended to use the MATRIX Model as the program curriculum **(83)**. MATRIX is an evidence-based model that includes a 12 week intensive outpatient treatment program followed by moderate outpatient services for 38 weeks. MATRIX is an ideal choice to develop the four identified factors that increase 12-step engagement. MATRIX includes active involvement in NA and focuses specifically on generating hope and desire. Participants form close bonds and attend meetings together while doing counseling work to address the underlying contributors to addiction.

The challenge of implementing any program such as the one described above is in securing buy-in and the investment of resources from the surrounding community. All individuals and programs involved in the mandating of offenders need to be involved in the planning and implementation of programming to secure success. Specific energies need to be invested in having the probation officers and judges personally receive education to better refer and mandate attendance. The best case scenario of the program would be the required attendance of all referring bodies to a one day intensive on the program itself and curriculum taught.

Buncombe County, NC, is fertile ground to test this program's ability to increase engagement and retention. The majority of Probation Officers, treatment providers and judicial models in Buncombe County currently mandate offenders to mutual support groups. Most substance abuse treatment providers require attendance in 12-step fellowships. It is clear from this research that the majority of individuals involved in referring offenders to 12-step fellowships do not have the knowledge or tools to do so effectively. Buncombe County currently invests heavily in programs designed to reduce the impact of addiction on crime.

Unfortunately, current programs have varied and often conflicting agendas and philosophies. No one person or body has built an effective collaborative that focused all energies in one direction. The success of the program depends on the key players in Buncombe County coordinating efforts in a way that maximizes gains while reducing costs and political in-fighting.

Buncombe County has experienced significant increases in addiction related crime stemming from a combination of environmental factors and declining community treatment alternatives for the addicted person. As a result, the Buncombe County jail population increased dramatically over a five year period from 2003-2008 with an average jail census staying 100 over capacity -- necessitating the construction of a new detention facility that cost the county \$50 million. To address increased arrests and rates of incarceration the Buncombe County court system, jail and community providers implemented a series of initiatives targeting specific problems within the flow of arrested persons from arrest to booking to court. Each initiative has been successful in meeting its stated goal but the meeting of goals has come at a cost as will be discussed below. No initiative has explored the potential to integrate 12-step fellowships more effectively into treatment and judicial models.

This researcher has provided training on substance abuse and the use of 12-step support groups to over 700 officers, community members, treatment providers and court officials within the County. Despite growing insight into the disease aspect of addiction and consistent referrals to NA, people continue to have limited insight into the role and value of 12-step fellowships. It is the researcher's expectation that resistance will occur regarding the

investment of money, time and staff resources. It is likely that many communities across the country would have equal resistance to implementing programs regarding the facilitation of 12-step referrals.

The following proposal will introduce an implementation plan designed to bring together community partners with the use of conflict resolution and leadership change theory. If implemented, the following strategy will dissolve barriers to communication while building partnerships able to capitalize on the synergistic potential between initiatives. The plan will challenge participants to accept the return on investment that could be realized from more successfully referring individuals to Narcotics Anonymous.

The Key Players:

Justice Advisory Group (JAG)

(JAG) was introduced by the Buncombe County Behavioral Health Specialist to bring together the District Attorney's Office, Public Defender's Office, jail personnel, Pre-Trial Release and the jail treatment provider to reduce the time of incarceration between arrest and trial. Prior to JAG, offenders were arrested, booked and then awaited trial while remaining incarcerated for up to 4 months. Inmates went through several steps including 3-4 court appearances prior to the actual trial, which led to months in jail for minor offenses. At trial, the majority of individuals received a sentence that qualified their time served as a sufficient punishment for their crime and were released. The JAG developed a fast track system for individuals charged with minor offenses that moved them through the process in 1-2 weeks -- greatly reducing their time of incarceration. Community members indicate that JAG has

successfully decreased the amount of time offenders spend in jail. It is also reported that the offenders benefitting from the model are now being arrested more frequently. The literature referenced in this dissertation supports the theory that a lack of treatment is responsible for negative outcomes. At the time of this writing, no treatment or 12-step referral was made through JAG initiatives.

Pre-Trial Release

Pre-Trial Release is a program designed to work with offenders charged with drug related crimes to get them out of jail prior to sentencing with the expectation of receiving community treatment until sentencing. At the completion of treatment, the individual is presented for sentencing with the potential of a reduced or eliminated period of incarceration contingent upon the success of their treatment. Key indicators of success include treatment compliance, clean UDS and the payment of probation fees. Participants are required to have a sign-in sheet attesting to their attendance at a specified number of support group meetings weekly. No training has been provided on the referral process and follow-up is not completed to assess the legitimacy of signatures or benefits gained through attendance. Participants do not engage in therapy to address the reasons for their using and Pre-Trial programming does not collaborate with any community providers or the 12-step community.

Nuisance Court

The county is in the process of implementing a nuisance court designed to quickly book and arraign individuals for public intoxication and minor drug-related crimes. This initiative was specifically designed to divert the top 25 offenders in the county from incarceration who collectively averaged 24 arrests and 287 days in jail. The only action of

nuisance court is to quickly process individuals through the court system. The intention of the program is to quickly divert individuals from jail into treatment. However, to date treatment is not easily accessed and oversight is not available to monitor long-term participation in treatment. To date, the role of 12-step fellowships has not been discussed.

Treatment Community

Buncombe County has a large network of providers who participate in the delivery of outpatient, inpatient, residential and community based services. There is an identified lack of training and expertise in the area of addiction treatment, and benefits have been reduced substantially throughout the state budget crisis. There are currently 4 primary providers of addiction specific outpatient treatment. The four providers recommend or “mandate” attendance at meetings. All providers complete assessments for the Court that make specific recommendations for the treatment of mandated offenders. Most Court programs will go specifically on the recommendation of the treatment provider. Each of the four providers support different state and locally funded programs serving offenders. ARP/RHA is the primary substance provider in the area, with 85% of the County contracts. The providers do not partner well with each other and the program would need to be bid out and awarded based upon clinical and financial stability.

Western Highlands Network (WHN)

WHN is the Local Management Entity for Western North Carolina and is responsible to coordinate the crisis continuum of services and community providers. To date WHN has not successfully acted as a change agent bringing together all parties involved in the arrest and sentencing of persons experiencing addiction and mental illness. WHN does not take a

specific position on 12-step involvement or modality of treatment outside of requiring the use of evidence-based programming. WHN is the source of Peer Support Specialists trained in service provision with a personal history of mental illness and/or addiction. The WHN budget has been cut significantly and there will be challenges in selling the program even though it does fit their state mandate to pay for the services included in the treatment model.

St. Joseph Memorial Mission Hospital (SJMMH)

SJMMH is the community hospital resource providing hospital-based treatment assessment and intervention for individuals in crisis. The hospital has experienced dramatic increases in emergency department admissions and assessments of mentally ill and addicted persons. The hospital is overwhelmed by community need and has scarce resources to place individuals in the community. This leads to high state hospital utilization and incarceration. The hospital remains detached from community initiatives and only recently has begun attending community meetings to discuss the challenge and burden that behavioral health issues present to our community. Getting buy-in from the hospital will be invaluable in the success of the program. SJMMH is the largest employer in the city and county, holding political influence.

Buncombe County Detention Facility (BCDF)

Sheriff Duncan and the BCDF have been central in supporting community efforts to reduce rates of incarceration and have acted as a proponent for community-based alternatives to incarceration. Three employees are contracted to work in the jail to assess for mental illness and addiction. A function of their position is to find community treatment at release. The number of individuals in the jail needing services averages 325 persons a day and three

employees cannot adequately treat or place inmates into community options. Currently, the jail successfully refers a maximum of 20 out of 325 persons and has identified several barriers to treatment including a lack of resources and communication. Narcotics Anonymous provides a weekly 12-step meeting in the jail to a maximum of 25 inmates, despite greater demand.

Treatment Alternatives to Street Crimes (TASC)

TASC is a post sentencing program that expunges criminal charges at the successful completion of the program. TASC behavioral health specialists assess and refer individuals to community providers coordinating treatment and probation efforts. TASC frequently requires attendance at 12-step meetings but does not oversee or consistently discuss participant experiences with the 12-step programs. TASC would be within their mandate to act as the conduit for admission referrals.

12-Step Community

Buncombe County has a robust Narcotics Anonymous and Alcoholics Anonymous community with hundreds of members. National statistics estimate that 80% of participants in 12-step fellowships are court-ordered to attend. No communication is maintained between community providers, court related programs and the 12-step community. An active service structure exists in Buncombe of NA members who participate in H+I as well as PR.

The Asheville Buncombe County Drug Commission (ABCDC)

ABCDC was developed and implemented by City Council leader Carl Mumpower to address and reduce the negative impact of mental health reform on Asheville and Buncombe County. At inception, the ABCDC was a strong political body and included powerful

community leaders from the hospital, law enforcement, provider community and court systems. ABCDC has focused primarily on prescription drug use with youth for the past year. The original political power of the body has been lost but the committee could serve as a valuable partner.

The programs discussed above represent Buncombe County's investment in reducing the rate of incarceration and jail census in the county. The challenge is that although all of the programs and initiatives above share the goal of reducing the burden of crime on the community and court system, many of the programmatic outcomes impact the success of other programs. JAG manages to shorten incarceration rates but increases arrest rates and relapse. TASC treats those already through the system but does not reduce the escalation of addiction for those not currently needing their services. The nuisance court will divert individuals from the jail but will not provide lasting intervention for those involved in the system. Treatment providers do not have the knowledge or investment to facilitate referral to 12-step fellowships. Overall, all programs have benefit and positive intentions but do not use tools that will increase 12-step engagement.

Applying Leadership Theory:

Community collaboration needs to develop in order to systemically incorporate the proposed intervention model into the solution of reducing recidivism. Community programs can't restrict their focus to immediate arrest or jail census reductions. They must focus on variables that realize long term reductions in addiction rates that will affect all levels of the community. The system needs an architect or systemic thinker who will identify the bigger picture issue and develop a web between programs that supports all programs in reducing the

true problem. It is recommended to use the strategies and techniques of Gerzon to facilitate the building of and ongoing needs of a coalition and those of Kotter (20) to make a plan that changes the culture and approach of Buncombe County. For ease of communication, this researcher will present himself as the instigator of change. I will share how one person can work within a system to promote acceptance of a cultural shift leading to a community investment in 12-step facilitation.

Establish a sense of urgency

In the current state, there is no shared sense of urgency to modify existing programs. The community does not universally accept the belief that engaging individuals in 12-step fellowships reduces crime and recidivism. Each program sees only their small slice of the problem without tapping into the larger picture problem. Program leaders have a provincialism that interferes with cooperation between programs. It is this writer's opinion that a collaborative is the most effective manner to increase urgency and program buy-in. As Kotter makes clear in his writing, complacency overwhelms the need to make effective change without a sense of urgency.

The leader of the initiative needs to get a quick start that builds momentum and success from the very beginning. Michael Watkins details the pros and cons of a quick start by laying out the opportunities and pitfalls it represents in his book, *"The First 90 Days: Critical Success Strategies for New Leaders at All Levels"* (24). The author lays out the importance of achieving small successes right up front that can lend credibility to the leader's ability. He warns of trying to do too much too quickly and unbalancing the organization or environment with too much change too quick. It is not as important to hit the ground running

as it is to hit the ground running in a way that you don't do a face plant right into the pavement. A good leader should have done enough homework before assuming a role to identify the immediate needs and achieve short-term successes while laying out a clear plan towards the long-range vision. The first step in this case to create urgency between programs by delivering information on the results of this research and the systemic impact of effective 12-step referrals. Program leaders need to understand not only their own impact on the four variables identified in this research, they need to have hope themselves that the program can help them realize their mission. To deliver information successfully however, I will need the right champions that will lend legitimacy to the project.

Create a guiding coalition

Leadership writer Gergen sets the expectation that to be a good leader you need strong and prudent advisors. In the case of Buncombe County, this writer has access and relationships with each of the leaders, all of which have strong egos and ideas of how to deal with their own slice of the pie (21). Jim Collins in his book, *“Good to Great: Why Some Companies Make the Leap... and Others Don't”*, uses a bus as a metaphor to represent the building of a good team (22). He talks about getting the right people on the bus, then talks about getting those people into the right seats, and finally talks about getting the wrong people off the bus. One can follow this philosophy to build a community coalition that can achieve greatness. As a leader I need to be able to attract people that can bring the program to fruition.

A common failure of leaders is to bring the brightest people to the table and then put them in the wrong seats. Patrick Lencione gives an excellent example of the potential

success and failure of team composition and management in his book, *“The Five Dysfunctions of a Team: A Leadership Fable”* (23). I will use Kotter’s 4 principles of coalition building in putting the right people on the bus. They include position power, expertise, credibility and leadership. The primary players in Buncombe County include the sheriff, chief of police, district attorney, county behavioral health representative, WHN COO, BCDF Captain, Public Defender’s office and key treatment provider executives. Without communication and dialogue between parties, the project can’t get off the ground.

Dialogue

Gerzon defines dialogue as communicating in order to catalyze the human capacity for bridging and innovation. Dialogue in this situation will support each player in understanding the purpose and role that an improved 12-step referral process will play in helping their lives and jobs to be easier. The process will develop trust and break down stereotypes regarding addiction. In this case, it is not essential for all members of the coalition to have a shared construct of addiction and instead requires them to have a shared vision of how to improve the quality of 12-step referrals so that retention rates increase and criminal recidivism goes down. It will assume that each member has a piece of the solution and that together they can solve the bigger problem with the beneficial side effect of reducing addiction and its costs on the community. I will seek to use the ripple effect, uncover assumptions and hidden agendas, equalize power relationships, combine dialogue and action and use respect to dissolve stereotypes. It is through dialogue and understanding that people are able to step out of their role and see the system as a whole.

Systems Thinking

To best understand the problem and develop an effective solution the coalition needs to understand how their agencies perform in referring offenders to support groups. The coalition will need to support each other in creating a unique way to integrate the program into their respective agencies. The coalition will need to look at how they work together with offenders to best capitalize on the synergy a partnership would provide. In the dialogue stage of this intervention, the writer will facilitate the creation of a systemic graphic that represents the Buncombe County judicial system. It will track from start to finish how each offender enters the system in each program, tracking them to the end. It will explore how each program interfaces with the offender, each other and the community. The graphic will later be used to explore how best to integrate the treatment model into the continuum.

Presence

Presence is a required component to looking successfully at the system and moving into a solution. Many of the members of the coalition come to the table with strong prejudices towards their own agendas and that of their program. Few programs appreciate the benefits that 12-step treatment offers their programs. No program has a comprehensive approach to integrating mutual support groups in the treatment/adjudication process of their participants. Natural divisions exist between law enforcement and treatment, public defenders and district attorneys, the county and the city, and competing judicial treatment programs. The primary competing issue lies in competition for funding and philosophical differences between members. My recommendation will include team building exercises between members designed to reduce barriers and increase focus on the moment. Together the coalition will work to a place where they genuinely are interested in understanding the

problem through inquiry. As stated earlier, the program can be implemented with minimal investment on the part of community agencies.

Inquiry

Gerzon identifies inquiry as a process of asking the right questions to identify the key pieces necessary to unlock the solution and create genuine transformation. I will honor the collaborative principle that states that transformation will occur as a result of bringing the right people together and providing them with reliable information. I will work to help the members at the table to admit that they don't have the answer, ask the right questions, listen to the answers and then take action. The process of inquiry begins the building of bridges that join the various entities and objectives into a shared mission and philosophy.

Bridging

Gerzon indicates that bridging is a process that builds actual partnerships and alliances that cross the borders that divide an organization or community. In its current state, the various members represent programs that act as isolated entities not respecting the needs or impact of the other programs. The primary component to bridging is a move from us to we. I will facilitate dialogue that generates new information, integrates the varied programs, launches joint discovery and develops a sense of shared ownership over the solution. My goal will be for the coalition to join in a community wide integration of the 12-step referral program.

Develop a vision

Vision is a shared belief system that drives behavior with an identified outcome. Vision sets an end point that all can buy in to and will guide all decisions to come. The strongest benefit to vision is that it will support the coalition in bypassing controversy and conflict when developing strategy. I believe that the members of the coalition do not have competing visions of reducing the impact of addiction on the community as it manifests in their distinct domains, they only have different understandings on how to get there. The challenge for the success of integrating this model is a worldview that does not prioritize investment in effective 12-step referrals. I will work with the coalition to find shared desired outcomes avoiding points of contention or disunity. As long as the vision is understandable to all and supports the goals of each member a strategy can be set.

Innovation and Transformation

A death nail for this program would be the creation of an environment of negotiation aimed at developing compromises to meet the goal. All negotiation leaves both sides losing something valuable. Rather, I will work with the coalition to utilize the partnering and visioning that has occurred thus far to step out of the norm and develop a completely unique and innovative approach integrating the program without undue financial burden. Well done, the solution will catalyze new relationships that create lasting systemic change and cooperation. We will work to develop a solution that has clear contingencies for commitments and involves a monitoring and dispute protocol to maintain progress towards the goal.

Anchor new approaches in the culture

The final goal of the coalition will be to cement change in the system with an ongoing commitment to maintaining and adjusting the solution as needed. The deliverable of this project and coalition is to develop a concrete and sustainable program that facilitates 12-step referrals in a manner that increases long term retention. My recommendation to the coalition will be to hold quarterly meetings to assess the progress of the program and adjust as needed to maintain the developed overarching mission of the project.

Chapter 6 - Discussion

The primary challenge of implementation for this program lies in the hypothetical. As it stands, this program is untested and based on the narrative report of a small sample of individuals. Qualitative data collection by design comes with challenges limiting the strength of the conclusions it draws. This research is no exception including potential challenges in subject characteristics, interviewer bias, voluntary bias, recency effects, data interpretation and the lack of subjects with a history of successful engagement following a mandate. The initial intention of the project was to compare a “successful” engagement group from the 12-step community with the “failed” engagement group in the jail. Subject recruitment didn’t identify any individual within the 12-step community who had remained clean following their mandate begging the question of whether a mandate to NA is appropriate at all. With all of that said, implemented, the program presents the potential to significantly reduce criminal recidivism caused by addiction. A testable hypothesis has been identified in this research that could be implemented at a relatively low cost with significant research potential to assess the viability of a larger scale roll out.

Cost is a significant barrier to success for most programs in NC at this time. As designed, the three stage program is almost completely billable within the state system. Any indigent individual with a diagnosable substance abuse disorder is eligible to receive fully

funded treatment. All but 6 participants in the study would be eligible for state funding, minimizing any investment on the part of community stakeholders. Any provider approved by a local LME is eligible to provide each of the three services within the model. This program could serve up to 60 participants a week with one program coordinator, three therapists, a case manager and 2 peer support specialists. The program revenue to serve 60 participants under the state system would be \$1.7 million. A \$1.5 million budget including an 18% administrative overhead would be sufficient to support the program. Research consistently indicates a \$7 to \$1 return on investment for addiction treatment and this model should be no different.

Return on investment approaches have not been shown sufficient to successfully create policy and implement changed programming. Programs and persons are often firmly rooted in tradition despite an apparent program failure. It will take great skill and finesse to successfully unite Buncombe County judicial and treatment programs to implement the proposed model. A cultural shift is needed to address addiction related crime and incarceration. The process will have to address the stigma of addiction and prejudice of law enforcement and the legal system. The process will need to broker relationships between contentious factions of ego with varied world views and economic goals. The process will require true creativity and flexibility in overcoming the system as it is with the goal of bringing it to what it can be.

Most importantly, the program needs to be universally accepted by all parties. There is no conflict of funding acquisition for the judicial programs as they are currently designed.

Treatment providers could all be eligible to offer the program as it is designed reducing any conflict between providers. WHN is able to fund any initiative as long as the individuals involved in the program meet eligibility guidelines. As designed, no individual would be referred who is likely to not meet funding guidelines. It is recommended that this writer partner with a qualified researcher to conduct empirical research to test the hypotheses that this program will increase engagement and consequently reduce recidivism on the part of the participants.

Appendix A - Data Dictionary

Variable	Operational Definition
Abstinence	The complete absence of the use of any mind altering substance for a minimum of 6 months.
Substance Abuse (75)	<p>A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:</p> <ol style="list-style-type: none"> 1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household) 2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use) 3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct) 4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)
Substance Dependence (75)	<p>A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:</p> <ol style="list-style-type: none"> 1) tolerance, as defined by either of the following: <ol style="list-style-type: none"> (a) a need for markedly increased amounts of the substance to achieve Intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of the substance (2) Withdrawal, as manifested by either of the following: <ol style="list-style-type: none"> (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances) (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms 3) the substance is often taken in larger amounts or over a

	<p>longer period than was intended</p> <p>(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use</p> <p>(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects</p> <p>(6) important social, occupational, or recreational activities are given up or reduced because of substance use</p> <p>(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)</p> <p><i>Specify if:</i> With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either Item 1 or 2 is present) Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither Item 1 nor 2 is present)</p>
Addiction	See Substance Dependence
Alcoholism	See Substance Dependence – primary drug of choice equals alcohol.
Drug Addict	See Substance Dependence – primary drug of choice equals prescription or illicit drug.
12-Step Program	Narcotics Anonymous or Alcoholics Anonymous
Narcotics Anonymous	Fellowship designed to support individuals attempting to recover from the maladaptive use of any drug including alcohol.
Alcoholics Anonymous	Fellowship designed to support individuals attempting to recover from the maladaptive use of alcohol.
Mandated	Coerced participation through a court or treatment provider as a condition of continued freedom of incarceration.
Recidivism	The arrest and/or conviction of any criminal offense during or post treatment.
Treatment History	The total number and type of treatments experienced by an individual throughout course of lifetime including 12-step participation.
Use History	The type and duration of the use of any mind altering substance including alcohol, prescription drugs, and/or illicit

	drug.
Aftercare	Participation in any lower level of care following intensive levels of treatment that may include outpatient counseling and/or 12-step participation
Service	Cleaning up and/or setting up for meetings, carrying the message to hospitals and institutions including jails and prison, participating in hosting recovery related activities, educating the public about 12-step fellowships, and sponsoring individuals.
Sponsorship	Providing or receiving guidance to work the 12-steps from someone with significant experience and recovery time to help someone grow in their recovery.
Spiritual Awakening	An end to the pain of active addiction, reduced loneliness, increased service, active application and understanding of spiritual principles, increased peace of mind, and a sense of direction and purpose in life.
Spiritual Principles.	Honesty, open-mindedness, willingness, faith, tolerance, surrender, belief, knowing, thought, humility, patience, surrender, love, etc.
12 Steps of NA	See Appendix B
12 Traditions of NA	See Appendix C

Appendix B - 12-Steps of Narcotics Anonymous

1. We admitted we were powerless over our addiction, that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed, and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to addicts, and to practice these principles in all our affairs.

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Appendix C -12 Traditions of Narcotics Anonymous

We keep what we have only with vigilance, and just as freedom for the individual comes from the Twelve Steps, so freedom for the group springs from our Traditions. As long as the ties that bind us together are stronger than those that would tear us apart, all will be well.

1. Our common welfare should come first; personal recovery depends on NA unity.
2. For our group purpose there is but one ultimate authority a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for membership is a desire to stop using.
4. Each group should be autonomous except in matters affecting other groups or NA as a whole.
5. Each group has but one primary purpose—to carry the message to the addict who still suffers.
6. An NA group ought never endorse, finance, or lend the NA name to any related facility or outside enterprise, lest problems of money, property, or prestige divert us from our primary purpose.
7. Every NA group ought to be fully self-supporting, declining outside contributions.
8. Narcotics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9. NA, as such, ought never be organized, but we may create service boards or committees directly responsible to those they serve.
10. Narcotics Anonymous has no opinion on outside issues; hence the NA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.

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Appendix D - Stage 1 Interview Drop-out

Substance use, court involvement, and the 12-Step Community
Interview Guide – Mandated but Dropped Out or Didn't Attend

Thank you for agreeing to participate in this study. The purpose of this study is to learn about people's experience with being court ordered to 12-step meetings. All of your answers are confidential and will not be shared with anyone. While answering the questions please indicate what choice best describes your experience and provide answers that explain your experience more thoroughly. You may stop the process at any time and I am available to answer any questions you have. Thank you for participating.

Age: (18-25) (26-35) (36-45) (46-55) (56 and up)

Gender: male/female

The Leeds Dependence Questionnaire

On this page there are questions about the importance of alcohol and/or other drugs in your life.

Thinking about your use of alcohol and other drugs during the last month that you were using them, answer each of the following questions.

1. In the last month that you were using did you find yourself thinking about when you will next be able to have another drink or take more drugs?

Never Sometimes Often Nearly always

2. In the last month that you were using was drinking or taking drugs more important than anything else you may have one during the day?

Never Sometimes Often Nearly always

3. In the last month that you were using did you feel that your need for drink or drugs was too strong to control?

Never Sometimes Often Nearly always

4. In the last month that you were using did you plan your days around getting and taking drink or drugs?

Never Sometimes Often Nearly always

5. In the last month that you were using did you drink or take drugs in a particular way in order to increase the effect it gave you?

Never Sometimes Often Nearly always

6. In the last month that you were using did you take drink or other drugs morning, afternoon and evening?

Never Sometimes Often Nearly always

7. In the last month that you were using did you feel you had to carry on drinking or taking drugs once you started?

Never Sometimes Often Nearly always

8. In the last month that you were using did you find that getting the effect you wanted more important than the particular drink or drug you use?

Never Sometimes Often Nearly always

9. In the last month that you were using did you want to take more drink or drugs when the effect started to wear off?

Never Sometimes Often Nearly always

10. In the last month that you were using did you find it difficult to cope with life without drink or drugs?

Never Sometimes Often Nearly always

General Interview Questions Begin Here

Do you consider yourself an addict/alcoholic/none of the above

Income for last year: (Unemployed) (\$5,000-\$15,000) (\$15,000-\$25,000) (\$25,000-\$35,000) (\$35,000 and up)

Do you consider yourself religious: yes/no

Do you believe in God or a higher power of some kind: yes/no

The highest grade I completed: (High School) (Some College) (Bachelor's Degree) (Master's or other higher degree)

Age of first drug use: ____ Drugs Used: _____ Drug of Choice:

How bad do you think your drug/alcohol use was: no problem/mild/moderate/severe/extremely severe

How many times have you been arrested _____ How many times have you been incarcerated _____

1. When you were ordered to attend 12-step meetings, please check the box of how you were mandated to attend 12-step meetings:

- ☐ Judge
- ☐ Probation or parole officer
- ☐ A substance abuse assessment that required you to attend 12-step meetings
- ☐ Other (please explain) _____

2. Had you attended 12-step meetings prior to being mandated to attend?

- ☐ yes
- ☐ no

2.a. Overall, was your experience positive or negative?

- ☐ positive
- ☐ negative

2.b. What about your experience was positive:

2.c. What about your experience was negative:

3. Prior to attending a 12-step meeting, overall were your expectations:

- ☐ positive
- ☐ negative

3.a. What about your expectation was positive:

3.b. What about your expectation was negative:

4. What do you think contributed to your continued participation in 12-step meetings?

5. Were 12-step programs explained to you when you were referred?

- ☐ yes
- ☐ no

5.a Please describe what you were told about 12-step meetings when you were referred:

6. Please describe specifically what it was like for you to attend your first meeting after receiving your court order:

7. Did you obtain a sponsor when you were court ordered to attend meetings?

- ☐ yes
- ☐ no

- 7.a If yes, how long was it before you obtained a sponsor:
- ☐ 1-14 days
 - ☐ 15-45 days
 - ☐ Other – please indicate how long _____
8. Did you obtain a home group when you were court ordered to attend meetings?
- ☐ yes
 - ☐ no
- 8.a If yes, how long was it before you obtained a home group:
- ☐ 1-14 days
 - ☐ 15-45 days
 - ☐ Other – please indicate how long _____
9. Did you begin doing service when you were court ordered to attend meetings?
- ☐ yes
 - ☐ no
- 9.a If yes, how long was it before you began doing service:
- ☐ 1-14 days
 - ☐ 15-45 days
 - ☐ Other – please indicate how long _____
- 9.b What types of services did you do (please check all that apply):
- ☐ work for home group
 - ☐ Hospitals and Institutions
 - ☐ Area service
 - ☐ Public Relations
 - ☐ Other – please explain
-
- 9.c. How often did you do service in the 12-step community?
- ☐ 0 times a week
 - ☐ 1 time a month
 - ☐ 2-4 times a month
 - ☐ weekly
10. Did you read 12-step literature?
- ☐ yes
 - ☐ no
- 10.a. If yes, how often did you read literature
- ☐ 0 times a week
 - ☐ 1 time a month
 - ☐ 2-4 times a month

- ☐ weekly
 - ☐ Daily
11. If you worked steps, how often did you work on them:
- ☐ 0 times a week
 - ☐ 1 time a month
 - ☐ 2-4 times a month
 - ☐ weekly
 - ☐ Daily
12. What is the highest step that you have worked _____
13. Why do you think people stop attending 12-step meetings:
14. Describe how you were prepared to attend 12-step meetings by the person/persons who mandated you to attend:
15. Is there anything that your referral source could have done to better prepare you to attend meetings:
16. What do you think can be done to prepare people to begin attending 12-step meetings:
17. What do you think people who refer offenders to 12-step meetings should know in order to help people be ready to enter the 12-step community:
18. What factors contributed to your ending your participation in a 12-step recovery program:
19. Did any of the following contribute to you dropping out: time, money, personalities, differences in spiritual beliefs, not working the program, work, a spouse or loved one not wanting you to attend, relapse, incarceration, transportation, not believing in the beliefs of the program, other _____
20. Is there anything you have not been asked that you would like to share?
21. How has this interview process been for you?
22. Has talking about this material brought up any pain or sadness for you?
23. Do you feel like you need any support to discuss how this interview may have made you feel?
24. If at any time you do feel the need to talk with someone, here are some resources you may use.

Thanks again for your participation

Appendix E - Stage 1 Interview Engaged

Substance use, court involvement, and the 12-Step Community
Interview Guide Engaged 12-Stepper

Thank you for agreeing to participate in this study. The purpose of this study is to learn about people's experience with being court ordered to 12-step meetings. All of your answers are confidential and will not be shared with anyone. While answering the questions please indicate what choice best describes your experience and provide answers that explain your experience more thoroughly. You may stop the process at any time and I am available to answer any questions you have. Thank you for participating.

Age: (18-25) (26-35) (36-45) (46-55) (56 and up)

Gender: male/female

The Leeds Dependence Questionnaire

On this page there are questions about the importance of alcohol and/or other drugs in your life.

Thinking about your use of alcohol and other drugs during the last month that you were using them, answer each of the following questions.

1. In the last month that you were using did you find yourself thinking about when you will next be able to have another drink or take more drugs?

Never Sometimes Often Nearly always

2. In the last month that you were using was drinking or taking drugs more important than anything else you may have one during the day?

Never Sometimes Often Nearly always

3. In the last month that you were using did you feel that your need for drink or drugs was too strong to control?

Never Sometimes Often Nearly always

4. In the last month that you were using did you plan your days around getting and taking drink or drugs?

Never Sometimes Often Nearly always

5. In the last month that you were using did you drink or take drugs in a particular way in order to increase the effect it gave you?

Never Sometimes Often Nearly always

6. In the last month that you were using did you take drink or other drugs morning, afternoon and evening?

Never Sometimes Often Nearly always

7. In the last month that you were using did you feel you had to carry on drinking or taking drugs once you started?

Never Sometimes Often Nearly always

8. In the last month that you were using did you find that getting the effect you wanted more important than the particular drink or drug you use?

Never Sometimes Often Nearly always

9. In the last month that you were using did you want to take more drink or drugs when the effect started to wear off?

Never Sometimes Often Nearly always

10. In the last month that you were using did you find it difficult to cope with life without drink or drugs?

Never Sometimes Often Nearly always

General Interview Questions Begin Here

Do you consider yourself an addict/alcoholic/none of the above

Income for last year: (Unemployed) (\$5,000-\$15,000) (\$15,000-\$25,000) (\$25,000-\$35,000) (\$35,000 and up)

Do you consider yourself religious: yes/no

Do you believe in God or a higher power of some kind: yes/no

The highest grade I completed: (High School) (Some College) (Bachelor's Degree) (Master's or other higher degree)

Age of first drug use: ____ Drugs Used: _____ Drug of Choice:

How bad do you think your drug/alcohol use was: no problem/mild/moderate/severe/extremely severe

How many times have you been arrested _____ How many times have you been incarcerated _____

1. When you were ordered to attend 12-step meetings, please check the box of how you were mandated to attend 12-step meetings:

- ☐ Judge
- ☐ Probation or parole officer
- ☐ A substance abuse assessment that required you to attend 12-step meetings
- ☐ Other (please explain) _____

2. Had you attended 12-step meetings prior to being mandated to attend?

- ☐ yes
- ☐ no

If you attended meetings in the past, please answer the following questions:

2.a. Overall, was your experience positive or negative?

- ☐ positive
- ☐ negative

2.b. What about your experience was positive:

2.c. What about your experience was negative:

3. Prior to attending a 12-step meeting, overall were your expectations:

- ☐ positive
- ☐ negative

3.a. What about your expectation was positive:

3.b. What about your expectation was negative:

4. What do you think contributed to your continued participation in 12-step meetings?

5. Were 12-step programs explained to you when you were referred?

- ☐ yes
- ☐ no

5.a Please describe what you were told about 12-step meetings when you were referred:

6. Please describe specifically what it was like for you to attend your first meeting after receiving your court order:

7. Did you obtain a sponsor when you were court ordered to attend meetings?

- ☐ yes
- ☐ no

- 7.a If yes, how long was it before you obtained a sponsor:
- ☐ 1-14 days
 - ☐ 15-45 days
 - ☐ Other – please indicate how long _____
8. Did you obtain a home group when you were court ordered to attend meetings?
- ☐ yes
 - ☐ no
- 8.a If yes, how long was it before you obtained a home group:
- ☐ 1-14 days
 - ☐ 15-45 days
 - ☐ Other – please indicate how long _____
9. Did you begin doing service when you were court ordered to attend meetings?
- ☐ yes
 - ☐ no
- 9.a If yes, how long was it before you began doing service:
- ☐ 1-14 days
 - ☐ 15-45 days
 - ☐ Other – please indicate how long _____
- 9.b What types of services did you do (please check all that apply):
- ☐ Work for home group
 - ☐ Hospitals and Institutions
 - ☐ Area service
 - ☐ Public Relations
 - ☐ Other – please explain
-
- 9.c. How often did you do service in the 12-step community?
- ☐ 0 times a week
 - ☐ 1 time a month
 - ☐ 2-4 times a month
 - ☐ weekly
10. Did you read 12-step literature?
- ☐ yes
 - ☐ no
- 10.a. If yes, how often did you read literature
- ☐ 0 times a week
 - ☐ 1 time a month
 - ☐ 2-4 times a month

- ☐ weekly
- ☐ Daily

11. If you worked steps, how often did you work on them:
 - ☐ 0 times a week
 - ☐ 1 time a month
 - ☐ 2-4 times a month
 - ☐ weekly
 - ☐ Daily
12. What is the highest step that you have worked _____
13. Why do you think people stop attending 12-step meetings:
14. Describe how you were prepared to attend 12-step meetings by the person/persons who mandated you to attend:
15. Is there anything that your referral source could have done to better prepare you to attend meetings:
16. What do you think can be done to prepare people to begin attending 12-step meetings:
17. What do you think people who refer offenders to 12-step meetings should know in order to help offenders be ready to enter the 12-step community:
18. Is there anything you have not been asked that you would like to share?
19. How has this interview process been for you?
20. Has talking about this material brought up any pain or sadness for you?
21. Do you feel like you need any support to discuss how this interview may have made you feel?
22. If at any time you do feel the need to talk with someone, here are some resources you may use.

Thanks again for your participation

Appendix F - Stage 2 Interview Engaged

Substance use, court involvement, and the 12-Step Community Interview Guide Engaged 12-Stepper

Thank you for agreeing to participate in this study. The purpose of this study is to learn about people's experience with being court ordered to 12-step meetings. All of your answers are confidential and will not be shared with anyone. While answering the questions please indicate what choice best describes your experience and provide answers that explain your experience more thoroughly. You may stop the process at any time and I am available to answer any questions you have. Thank you for participating.

Age: (18-25) (26-35) (36-45) (46-55) (56 and up)

Gender: male/female

The Leeds Dependence Questionnaire

On this page there are questions about the importance of alcohol and/or other drugs in your life.

Thinking about your use of alcohol and other drugs during the last month that you were using them, answer each of the following questions.

1. In the last month that you were using did you find yourself thinking about when you will next be able to have another drink or take more drugs?

Never Sometimes Often Nearly always

2. In the last month that you were using was drinking or taking drugs more important than anything else you may have one during the day?

Never Sometimes Often Nearly always

3. In the last month that you were using did you feel that your need for drink or drugs was too strong to control?

Never Sometimes Often Nearly always

4. In the last month that you were using did you plan your days around getting and taking drink or drugs?

Never Sometimes Often Nearly always

5. In the last month that you were using did you drink or take drugs in a particular way in order to increase the effect it gave you?

Never Sometimes Often Nearly always

6. In the last month that you were using did you take drink or other drugs morning, afternoon and evening?

Never Sometimes Often Nearly always

7. In the last month that you were using did you feel you had to carry on drinking or taking drugs once you started?

Never Sometimes Often Nearly always

8. In the last month that you were using did you find that getting the effect you wanted more important than the particular drink or drug you use?

Never Sometimes Often Nearly always

9. In the last month that you were using did you want to take more drink or drugs when the effect started to wear off?

Never Sometimes Often Nearly always

10. In the last month that you were using did you find it difficult to cope with life without drink or drugs?

Never Sometimes Often Nearly always

General Interview Questions Begin Here

Do you consider yourself an addict/alcoholic/none of the above

Income for last year: (Unemployed) (\$5,000-\$15,000) (\$15,000-\$25,000) (\$25,000-\$35,000) (\$35,000 and up)

Do you consider yourself religious: yes/no

Do you believe in God or a higher power of some kind: yes/no

Would you mind sharing a bit about your spiritual beliefs?

Do you think that your spiritual beliefs impacted your use of drugs/alcohol in either a positive or negative way?

Do you think that your spiritual beliefs impacted your experience in attending or being mandated to 12-step fellowships?

The highest grade I completed: (High School) (Some College) (Bachelor's Degree) (Master's or other higher degree)

Age of first drug use: ____ Drugs Used: _____ Drug of Choice:

How bad do you think your drug/alcohol use was: no
problem/mild/moderate/severe/extremely severe

Did you have any hope that you could stop using?

Did you want to stop using?

How many times have you been arrested _____ How many times have you been
incarcerated _____

Would you say that your arrests were related to your use of drugs and alcohol?

Have you ever been diagnosed or treated for a mental health problem?

Do you think that your mental health problem contributed to or was related to your use of
drugs and alcohol?

Did your mental health issue impact your participation in 12-step fellowships in any way?

I know that you have been clean for a while and come to meetings regularly but have you
gone since you were court ordered or did you come on your own at a later time?

1. When you were ordered to attend 12-step meetings, how were you mandated to
attend:

- ☐ Judge
- ☐ Probation or parole officer
- ☐ A substance abuse assessment that required you to attend 12-step meetings
- ☐ Other (please explain) _____

2. Had you attended 12-step meetings prior to being mandated to attend?

- ☐ yes
- ☐ no

If you did go, what was your experience like going to meetings before you were court
ordered?

Overall, was your experience positive or negative?

- ☐ positive
- ☐ negative

- 2.b. What about your experience was positive:
- 2.c. What about your experience was negative:
3. Prior to attending a 12-step meeting, what did you expect it to be like:
- 3.a. What about your expectation was positive:
- 3.b. What about your expectation was negative:
- 3.c. Did you have any expectation that a 12-step fellowship could help you stop using or change your life?
4. Did you have any specific concerns, fears or anxieties about going to meetings?
5. If you continued going, what do you think contributed to your continued participation in 12-step meetings?
6. Please describe specifically what it was like for you to attend your first meeting after receiving your court order:
7. Did you obtain a sponsor when you were court ordered to attend meetings?
- ☐ yes
- ☐ no
- 7.a If yes, how long was it before you obtained a sponsor:
8. Did you obtain a home group when you were court ordered to attend meetings?
- ☐ yes
- ☐ no
- 8.a If yes, how long was it before you obtained a home group:
9. If you did any service in NA, what types of services did you do (please check all that apply):
- ☐ work for home group
- ☐ Hospitals and Institutions
- ☐ Area service
- ☐ Public Relations
- ☐ Other – please explain
-

9.a If yes, how long was it before you began doing service:

9.b. How often did you do service in the 12-step community?

- ☐ 0 times a week

- ☐ 1 time a month
- ☐ 2-4 times a month
- ☐ weekly

10. Did you read 12-step literature?

- ☐ yes
- ☐ no

10.a. If yes, how often did you read literature

- ☐ 0 times a week
- ☐ 1 time a month
- ☐ 2-4 times a month
- ☐ weekly
- ☐ Daily

11. If you worked steps, how often did you work on them:

- ☐ 0 times a week
- ☐ 1 time a month
- ☐ 2-4 times a month
- ☐ weekly
- ☐ Daily

12. What is the highest step that you have worked _____

13. Why do you think people stop attending 12-step meetings:

14. What were you told about the NA program by your referral source before you went?

15. Did your referral source do anything that made you feel more open to going or more comfortable with the idea?

16. Did your referral source do anything that made you not want to go to meetings or feel uncomfortable with the idea?

17. Is there anything that your referral source could have done to better prepare you to attend meetings:

18. If you were the one referring people to meetings, do you think that something could be done to better prepare people to feel more open to going and more likely to continue going:

19. What do you think people who refer offenders to 12-step meetings should know in order to help people be ready to enter the 12-step community:

20. If you stopped going to meetings after you were court ordered, what contributed to that?
21. Did any of the following contribute to you dropping out: time, money, personalities, differences in spiritual beliefs, not working the program, work, a spouse or loved one not wanting you to attend, relapse, incarceration, transportation, not believing in the beliefs of the program, other _____
22. Did you participate in any type of mental health or substance abuse treatment while you were active or mandated to attend NA/AA?
23. Do you feel like the counselor or program that you went to understood 12-step programs and contributed to your going or not going to meetings?
23. How did going to treatment impact your experience with NA/AA.
24. How do you think that the social part of 12-step fellowships effected you?
25. Did you develop relationships in the fellowship?
26. Do you think that you wanted to go to meetings for your own reasons at any point in the time that you were mandated to attend? Would you say more about that?
27. Is there anything you have not been asked that you would like to share?
28. How has this interview process been for you?
29. Has talking about this material brought up any pain or sadness for you?
30. Do you feel like you need any support to discuss how this interview may have made you feel?
31. If at any time you do feel the need to talk with someone, here are some resources you may use.

Thanks again for your participation

Appendix G - Stage 2 Drop-out

Substance use, court involvement, and the 12-Step Community Interview Guide – Mandated but Dropped Out or Didn't Attend

Thank you for agreeing to participate in this study. The purpose of this study is to learn about people's experience with being court ordered to 12-step meetings. All of your answers are confidential and will not be shared with anyone. While answering the questions please indicate what choice best describes your experience and provide answers that explain your experience more thoroughly. You may stop the process at any time and I am available to answer any questions you have. Thank you for participating.

Age: (18-25) (26-35) (36-45) (46-55) (56 and up)

Gender: male/female

The Leeds Dependence Questionnaire

On this page there are questions about the importance of alcohol and/or other drugs in your life.

Thinking about your use of alcohol and other drugs during the last month that you were using them, answer each of the following questions.

1. In the last month that you were using did you find yourself thinking about when you will next be able to have another drink or take more drugs?

Never Sometimes Often Nearly always

2. In the last month that you were using was drinking or taking drugs more important than anything else you may have one during the day?

Never Sometimes Often Nearly always

3. In the last month that you were using did you feel that your need for drink or drugs was too strong to control?

Never Sometimes Often Nearly always

4. In the last month that you were using did you plan your days around getting and taking drink or drugs?

Never Sometimes Often Nearly always

5. In the last month that you were using did you drink or take drugs in a particular way in order to increase the effect it gave you?

Never Sometimes Often Nearly always

6. In the last month that you were using did you take drink or other drugs morning, afternoon and evening?

Never Sometimes Often Nearly always

7. In the last month that you were using did you feel you had to carry on drinking or taking drugs once you started?

Never Sometimes Often Nearly always

8. In the last month that you were using did you find that getting the effect you wanted more important than the particular drink or drug you use?

Never Sometimes Often Nearly always

9. In the last month that you were using did you want to take more drink or drugs when the effect started to wear off?

Never Sometimes Often Nearly always

10. In the last month that you were using did you find it difficult to cope with life without drink or drugs?

Never Sometimes Often Nearly always

General Interview Questions Begin Here

Do you consider yourself an addict/alcoholic/none of the above

Income for last year: (Unemployed) (\$5,000-\$15,000) (\$15,000-\$25,000) (\$25,000-\$35,000) (\$35,000 and up)

Do you consider yourself religious: yes/no

Do you believe in God or a higher power of some kind: yes/no

Would you mind sharing a bit about your spiritual beliefs?

Do you think that your spiritual beliefs impacted your use of drugs/alcohol in either a positive or negative way?

Do you think that your spiritual beliefs impacted your experience in attending or being mandated to 12-step fellowships?

The highest grade I completed: (High School) (Some College) (Bachelor's Degree) (Master's or other higher degree)

Age of first drug use: ____ Drugs Used: _____ Drug of Choice:

How bad do you think your drug/alcohol use was: no problem/mild/moderate/severe/extremely severe

Did you have any hope that you could stop using?

Did you want to stop using?

How many times have you been arrested _____ How many times have you been incarcerated _____

Would you say that your arrests were related to your use of drugs and alcohol?

Have you ever been diagnosed or treated for a mental health problem?

Do you think that your mental health problem contributed to or was related to your use of drugs and alcohol?

Did your mental health issue impact your participation in 12-step fellowships in any way?

1. When you were ordered to attend 12-step meetings, how were you mandated to attend:

- ☐ Judge
- ☐ Probation or parole officer
- ☐ A substance abuse assessment that required you to attend 12-step meetings
- ☐ Other (please explain) _____

2. Had you attended 12-step meetings prior to being mandated to attend?

- ☐ yes
- ☐ no

If you did go, what was your experience like going to meetings before you were court ordered?

Overall, was your experience positive or negative?

- ☐ positive
- ☐ negative

2.b. What about your experience was positive:

2.c. What about your experience was negative:

3. Prior to attending a 12-step meeting, what did you expect it to be like:
- 3.a. What about your expectation was positive:
- 3.b. What about your expectation was negative:
- 3.c. Did you have any expectation that a 12-step fellowship could help you stop using or change your life?
4. Did you have any specific concerns, fears or anxieties about going to meetings?
5. If you continued going, what do you think contributed to your continued participation in 12-step meetings?
6. Please describe specifically what it was like for you to attend your first meeting after receiving your court order:
7. Did you obtain a sponsor when you were court ordered to attend meetings?
- ☐ yes
- ☐ no
- 7.a If yes, how long was it before you obtained a sponsor:
8. Did you obtain a home group when you were court ordered to attend meetings?
- ☐ yes
- ☐ no
- 8.a If yes, how long was it before you obtained a home group:
9. If you did any service in NA, what types of services did you do (please check all that apply):
- ☐ work for home group
- ☐ Hospitals and Institutions
- ☐ Area service
- ☐ Public Relations
- ☐ Other – please explain
-

9.a If yes, how long was it before you began doing service:

9.b. How often did you do service in the 12-step community?

☐ 0 times a week

☐ 1 time a month

- ☐ 2-4 times a month
- ☐ weekly

10. Did you read 12-step literature?

- ☐ yes
- ☐ no

10.a. If yes, how often did you read literature

- ☐ 0 times a week
- ☐ 1 time a month
- ☐ 2-4 times a month
- ☐ weekly
- ☐ Daily

11. If you worked steps, how often did you work on them:

- ☐ 0 times a week
- ☐ 1 time a month
- ☐ 2-4 times a month
- ☐ weekly
- ☐ Daily

12. What is the highest step that you have worked _____

13. Why do you think people stop attending 12-step meetings:

14. What were you told about the NA program by your referral source before you went?

15. Did your referral source do anything that made you feel more open to going or more comfortable with the idea?

16. Did your referral source do anything that made you not want to go to meetings or feel uncomfortable with the idea?

17. Is there anything that your referral source could have done to better prepare you to attend meetings:

18. If you were the one referring people to meetings, do you think that something could be done to better prepare people to feel more open to going and more likely to continue going:

19. What do you think people who refer offenders to 12-step meetings should know in order to help people be ready to enter the 12-step community:

20. If you stopped going to meetings after you were court ordered, what contributed to that?

21. Did any of the following contribute to you dropping out: time, money, personalities, differences in spiritual beliefs, not working the program, work, a spouse or loved one not wanting you to attend, relapse, incarceration, transportation, not believing in the beliefs of the program, other _____

22. Did you participate in any type of mental health or substance abuse treatment while you were active or mandated to attend NA/AA?

23. Do you feel like the counselor or program that you went to understood 12-step programs and contributed to your going or not going to meetings?

23. How did going to treatment impact your experience with NA/AA.

24. How do you think that the social part of 12-step fellowships effected you?

25. Did you develop relationships in the fellowship?

26. Do you think that you wanted to go to meetings for your own reasons at any point in the time that you were mandated to attend? Would you say more about that?

27. Is there anything you have not been asked that you would like to share?

28. How has this interview process been for you?

29. Has talking about this material brought up any pain or sadness for you?

30. Do you feel like you need any support to discuss how this interview may have made you feel?

31. If at any time you do feel the need to talk with someone, here are some resources you may use.

Thanks again for your participation

Appendix H – Recruitment Scripts

Script Jail Personnel

Have you ever been court ordered to attend narcotics anonymous (If yes than read script)? There is a student from The University of North Carolina who is going to be doing a study in the jail related to people's past experience with being court ordered to 12-step support groups. The goal of the study is to help people like judges and probation officers make better decisions about who should be referred to 12-step groups and to give them some tools on how to do it in a way that increases the chance that people will actually go. There is no benefit to participating and you will not be paid but your participation could help a lot of people down the road. Your role would include a 1 ½ hour interview and the jail administration has signed an agreement indicating that they will not review any information gathered during your interview. Please understand that despite the jail's agreement not to access information there is the unlikely possibility that your information could be reviewed. Consequently, please do not share any information about any behavior that could affect you legally or as an inmate of BCDF. Specifically, do not discuss any behavior or actions on your part that could lead to criminal charges or complicate your current legal charges in any way. This study is only interested in your experience with having been mandated to Narcotics Anonymous.

Are you interested in speaking with the researcher to see if you want to participate? If yes: "Great, I will let the researcher know. The researcher will not interview everyone who expresses interest but I will let you know one way or the other."

Script for 12-Step Community members who may know appropriate and eligible participants

You know Tom B? Tom is doing research as a part of his doctoral work at UNC and he would like to interview people who have been court ordered to 12-step meetings in the past and stayed clean at least a year. The goal of the study is to help people like judges and probation officers make better decisions about who should be referred to 12-step groups and to give them some tools on how to do it in a way that increases the chance that people will actually go. There is no benefit to participating and you will not be paid for your participation. Your role would include a 1 ½ hour interview and what you share will be protected from access to people outside of the research project. Please understand that despite precautions taken to safeguard your information, there is the unlikely possibility that your information could be reviewed. If you participate, please do not share information about any behavior that could affect you legally. Specifically, do not discuss any behavior or actions on your part that could lead to criminal charges or complicate any current legal charges you may currently face. This study is only interested in your experience with having been mandated to Narcotics Anonymous.

The interview will be taped if you are ok with that and later transcribed so that people are not able to connect your answers with you. Tom has a research assistant who is conducting the interviews and will never directly know who participated and will not listen to the tapes before they are transcribed.

Do you want to talk to the research assistant to learn more? If yes, the individual will be given contact info for the assistant.

Although the primary researcher will approach the majority of potential subjects based on his knowledge of the fellowship, members of the community may be provided with the above script. The research assistant will contact anyone who does express interest and review the entire consent form verbatim and answer any question they may have. If they are still interested, the research assistant will schedule a time with them to do the interview and proceed.

Script 12-Step Community Referrals Approached Directly by Researcher

I don't know if you know but I am working on a doctorate at UNC and am doing research as a part of that process. I am looking for people who have been court ordered to 12-step meetings in the past and stayed clean at least a year to participate and wanted to see if you have any interest. The goal of the study is to help people like judges and probation officers make better decisions about who should be referred to 12-step groups and to give them some tools on how to do it in a way that increases the chance that people will actually go. There is no benefit to participating and you will not be paid for your participation. Your role would include a 1 ½ hour interview and what you share will be protected from access to people outside of the research project. Please understand that despite precautions taken to safeguard your information, there is the unlikely possibility that your information could be reviewed. If you participate please do not share information about any behavior that could affect you legally. Specifically, do not discuss any behavior or actions on your part that could lead to criminal charges or complicate any current legal charges you may currently face. This study is only interested in your experience with having been mandated to Narcotics Anonymous.

We will tape the interview if you are ok with that and later transcribe it so that people are not able to connect your answers with you. I don't want anyone to feel pressured to do it and I don't want anyone to feel uncomfortable about me hearing their information so I will not personally conduct the interviews and I will not listen to any of the tapes before they are transcribed. If you are interested here is the number of the research assistant. You can call them if you choose to learn more about the study and make a choice about whether or not you want to take part in the study. I want you to totally hear me that if you want to do it that's fine and if you don't that is fine too.

Appendix I - Consent Form

Mandated Treatment, 12-Step Support Groups, and Criminal Recidivism

Policy Implications and Perspective

You are being asked to take part in a research study designed to identify the factors that contribute to people following up with mandated referrals to 12-step support groups.

Your participation in this study is voluntary. You may refuse to join, or you may withdraw your consent to be in the study at any time, for any reason, without penalty. If you choose not to participate, we will not contact you again. No person or entity will be informed of your participation or lack of participation for any reason.

Research studies are designed to obtain new knowledge. This new information may help people in the future. You may not receive any direct benefit from being in the research study and there may be risks as a result of your participation in the research study.

Details about this study are discussed below. It is important to understand what this study is about so you can decide if you want to take part in it. You will be given a copy of this consent form. You should ask the researchers named in this brochure, or their staff members, any questions you have about this study at any time.

What is the purpose this study?

The purpose of the study is to gain the information needed to create tools for judges, probation officers, and treatment providers to make referrals to the 12-step community in a manner that improves the likelihood of the individual staying involved in the support group. Research has shown that offenders who are referred to 12-step fellowships commit fewer future crimes and are less likely to relapse on drugs, including alcohol, if they stay involved in 12-step meetings.

How long will your part in this study last?

It will take between 1-2 hours for you to be interviewed.

How many people will take part in this study?

About 40 adult males will participate in this study. Some participants will have been ordered to attend in the past but are currently incarcerated. Other participants include those who are active in the 12-step community following a mandate and at least one year of abstinence from drugs and alcohol.

What will happen if you take part in the study?

Those who take part in this study will be asked to discuss their experience and opinions about what increases and/or decreases the likelihood of an individual maintaining involvement in 12-step meetings after a court mandated referral. There are no right (or wrong) answers to the questions that will be asked. All information will be collected and the data will be entered into a secure database. All identifying information will be removed and your information will be shared with no one at any time.

Those individuals who are interviewed will be asked a series of questions designed to understand better their experience with the topic. Your responses will be audio taped if permission is given and the tapes will be transcribed and the tapes will then be stored securely. If you are currently incarcerated, the BCDC has signed a written agreement that they will not access or review any material collected during your interview. If you are an inmate please understand that despite the jail's agreement not to access information there is the unlikely possibility that your information could be reviewed. Consequently, please do not share any information about any behavior that could affect you legally or as an inmate of BCDC. Specifically, do not discuss any behavior or actions on your part that could lead to criminal charges or complicate your current legal charges in any way. This study is only interested in your experience with having been mandated to Narcotics Anonymous.

You may choose to respond or not respond to any question at any point during your participation in the study. Your name will be assigned a code and all that will appear on any document is your code. The sheet linking names to codes will be stored in a password protected computer file.

All study participants may review any notes or documentation produced during the interview. Participants are entitled to receive a finished copy of the research when it is complete. If you would like a copy, please inform the interviewer and they will assure that you receive a copy.

If you are an inmate of the Buncombe County Detention Facility, your sentence or incarceration experience will not change if you do or do not participate in this study.

What are the possible benefits from being in this study?

Overall, research like this benefits others by gaining new knowledge. You may or may not benefit from this study—however you may benefit if the discussion helps you to better understand how you and others think about the referral process to 12-step meetings. Buncombe County itself will benefit from the presentation of the outcome of this research and it is the research team's hope that policies and procedures will be implemented that improve the treatment of substance abusers committing criminal acts.

What are the possible risks or discomforts involved from being in this study?

We do not anticipate any risks or discomfort to you from being in this study. We think you will be at ease answering the questions we will ask. Some individuals may share experiences or memories that may cause discomfort and we are available to help you process any of those feelings or help you link with someone who can help you. Again, please be mindful not to share information that may impact you legally in any way.

How will your privacy be protected?

Every effort will be taken to protect your identity as a participant in this study. Your full name will not appear on any transcripts developed from the recorded interviews. The list of those in the group and your contact information at all times will be stored securely. All audio files will be kept in locked cabinets throughout the study. If you are an inmate, the Buncombe County Detention Center Major and the Sheriff have signed an agreement not to listen to or access any information obtained during the interview process.. Please be mindful that the researchers is required to report any information you share indicating that there is a **current** risk of harm to yourself or another. The researchers is also required to provide information in the event that a court orders the release of information

Will you receive compensation of any kind for participating in this study?

You will not be compensated for participating in this study.

Will it cost you anything to be in this study?

The only costs to you are your time, any travel costs you have in getting to the meeting place, or having to find child care while you take part in this study.

What if you have questions about this study?

You have the right to ask and have answered any questions you may have about this research. If you have questions, or concerns, you should contact Tom Britton at 828-280-1784 (tpbritto@email.unc.edu) or Dr. Peggy Leatt at 919-966-9122 (leatt@email.unc.edu). They are the leaders of this project and will be happy to answer your questions.

What if you have questions about your rights as a research participant?

All research on human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights as a research subject you may contact, anonymously if you wish, the Institutional Review Board at 919-966-3113 or by email to IRB_subjects@unc.edu. If you contact the IRB, please refer to study 10-1735.

Participant's Agreement:

I have read the information provided above.

I have asked all the questions I have at this time.

Yes____ No ____

The researcher would like to audiotape the interview to help in correctly reporting your answers. The taping is completely optional and if you agree please check yes and if not please check no.

Yes____ No ____

By signing this consent form, I give permission to the University of North Carolina at Chapel Hill to use my information in this research project. All consents shall be stored in a locked filing cabinet throughout the study and will be destroyed 12 months after the research is complete.

(optional)

Signature of participant Date

(optional)

Printed name of participant

Signature of person obtaining consent Date

Printed name of person obtaining consent

Appendix J - Codebook

Category	Code	Key Words	Related Sub-Category	Code
Fear	F	anxiety, social, uncomfortable, not a part of, shy, hate, die, prepare, look at me and related	Motivator	FM
			Inhibitor	FI
Motivation	M	desire, interest, didn't want to, I had to, waste of time, forced, mandated, court ordered, absconded, authority, sentence, trying and time	Motivator	MM
			Inhibitor	MI
False Confidence	FC	control, I got this and addict	Motivator	MFC
			Inhibitor	MFC
Judged	J	judged, ashamed, holy roller, better than and embarrassed	Motivator	MJ
			Inhibitor	MJ
Trigger	T	drugs and trigger	Motivator	MT
			Inhibitor	MT
Hope	H	desire, hope, encourage, counselor, peers, change, hopeless and other people succeeding	Motivator	MH
			Inhibitor	MH
Belonging	B	understood, people like me, social, friendly, family and addict	Motivator	MB
			Inhibitor	MB
Help	HP	success, clean, helpful and inspiring	Motivator	MHP
			Inhibitor	MHP
Step Work	SW	Sponsorship, steps, worked, literature, book	Understanding	USW
			No Understanding	NUSW
Orientation	O	Orientation, meeting list, contacts, phone numbers, go to a meeting,	Motivator	MO
			Inhibitor	MO
Relapsed	R	Used, relapsed, got high	n/a	n/a

Appendix K – Key Information Points

- (1) What were the most important variables that made people continue going to NA?
- (2) What were the most important variables that made people stop going to NA?
- (3) How do people's family and network react that increase or decrease attendance at NA?
- (4) How was the idea of attending NA first introduced to individuals who continued or dropped out of NA?
- (5) What role do positive or negative expectancies of 12-step play in drop-out or retention?
- (6) How do emotions impact retention or drop out from NA?
- (7) Did the type of crime, sentence, or type of mandate impact retention?
- (8) How did the composition of the group impact retention?
- (9) Does the level of hope about recovering from addiction impact retention?
- (10) Does shame play a role in retention?
- (11) How comfortable are helping professionals and officers of the court with 12-step fellowships and does level of comfort impact successful referrals?
- (12) Does fear play a role in retention?
- (13) How educated are officers of the court and helping professionals in 12-step fellowships and does the level of education increase successful referrals?
- (14) Does mental illness play a role in retention?
- (15) What specific variables do people attribute level of comfort to?
- (16) Does the personality of one's probation officer and/or counselor impact retention?
- (17) Does the positive or negative association and expectancy of one's PO or counselor impact retention?
- (18) Does drug of choice impact retention?

- (19) How do people feel when they have to get attendance sheets signed and does
that impact retention?

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