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Structural Policy Issues on Rehabilitation and Recovery: A Case Study of Alcoholics Anonymous Centre in Kenya.

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ABSTRACT

Alcoholism is one of the chronic problems of a modern society. Many lives have been lost and thousand others ruined as a result of alcoholism. It has both social and economic implications and the effects are felt beyond the lives of individuals as it transcends across households, families and communities. Alcoholism is a risk factor for mortality and morbidity related to both intentional and unintentional injury. Addiction to alcohol can in itself be disastrous, a trap upon which individuals become enslaved and chained in such ways that escape is nearly impossible. In the recent times, Alcoholic Anonymous (AA) institutions have been the desirable alternative to help rehabilitate alcoholics and restore them to full recovery. However, just how effective Alcoholic Anonymous is remains a subject of wide speculation. The purpose of this study was to assess the efficacy of the structural policy issues on rehabilitation and recovery: A case study of Asumbi Alcoholics Anonymous Centre. . The study used an *ex-post-facto* research design. The study was conducted in Asumbi Alcoholics Anonymous Centre Asumbi Sub-County, Homa Bay, Kenya. The target population was 70 alcoholics registered at the Centre. Simple random sampling was used to select 59 respondents for the study and Purposive sampling aided the selection of the Centre manager, three administrators and the six counselors to participate in the study. The data was collected using three different questionnaires to the sampled respondents and analysis done using the Statistical Package for Social Sciences (SPSS) Version 22. Descriptive statistics (frequency tables and percentages) were used in data presentation. The findings of the study showed that modern structural and technological AA devices have appositive impact on rehabilitation and recovery of alcoholics. The AA centers need to put on proper mechanism to make a follow up to the already graduated alcoholics to avoid or reduce instances of relapse cases. There is need for support to the AA centers so that the fees charged from the clients may be reduced or abolished to enable low income an alcoholic is integrated into the centers. It is recommended that the government should support the existing AA centers and build more centers to help in rehabilitating the Alcoholics. However, it is equally suggested that further research be done on the impact of Spiritual nourishment on rehabilitation and recovery of alcoholics.

Key words: Structural Policy, Rehabilitation, Recovery, Alcoholics

INTRODUCTION

Alcoholism is often referred to as "substance abuse" or chemical dependency Bufe (1991). Alcoholics are introduced to AA and encouraged to attend AA meetings. Donnelly (1994) observed that anyone may attend open AA meetings but only those with a drinking problem may attend closed meetings or become AA members. It is through this design that secrets of AA are kept. Chartell (2008) a pioneer in methadone treatment in the United States of America (USA) for alcoholism made the following statement, "The source of strength in AA is its single- mindedness.

Alcoholics Anonymous limits what it is demanding of itself and its associates and its success lies in its limited target". A study by Tonigan and Miller (1996) in Canada shows that AA structure encourages individual members to seek recovery by working the 12-step processes. In support of this, Sussman (2010) outlined that Group meeting is the main engine structure of AA where alcoholics at all stages of recovery are assumed to share their experience, strength and hope. In contrast, according to Bufe (1991), these group meetings have promoted high relapse rate and of equal measure the indiscipline of clients. It is this structure of group meeting that has failed to encourage collective group conscience at AA centers Ye Yu and Cherpitel (2008).

However, Sussman (2010) states that a notable weakness of AA structure is that it doesn't keep attendance records at the 12-step meetings, so it is traditionally challenging to obtain specific information about 12- step membership on the progress of the clients. Another study carried by Hall (1993) in South Africa found that AA's structure doesn't have formal way of appointing group leaders. This has led to group leaders misleading the clients resulting into less or no recovery at all during group meetings. Sometimes, the leaders appointed become bad role models to the people they lead which makes it even more difficult for the alcoholics to follow the right path, the study adds.

On financial policy, Hall (1993) states that AA has affirmed and strengthened a tradition of being fully self- supporting and of not seeking, or accepting contributions from non-members. All contributions are voluntary and membership in AA involves no dues or fees (African Press International 2009). This tradition of being self- supporting according to Bhandarkar and Wilkinson (2000) has denied AA an opportunity for structural development and becoming a modern institution due to lack of enough financial support. Kelly and Stout (2009) suggests that AA's structure is loosely organized and doesn't seem to provide a clear path for maturing out of the group for those people who over time cease to require it anymore. It was necessary therefore to establish the efficacy of the AA structural policy issues based on the mentioned challenges.

According to Mulgan (2008), there are numerous questions over the effectiveness of Alcoholics Anonymous (AA) based in following its structural policies. In reality, the efficacy of AA structural policies is difficult to establish when compared to other formal treatments for alcohol abuse. Assessment is made harder by the fact that AA Centers keeps no membership records and is a loose affiliation. Eschmann and Rehm (2002) equally asserted that most recovery from alcoholism is not the result of treatment from the AA centers as only 20% of alcohol abusers are ever treated.

The literature reviewed showed a number of areas researched on the effects of alcoholism on family disintegrations, role of the 12-steps followed at the AA and very little is known on the AA policy structure and how it supports rehabilitation and recovery of alcoholics at the AA centers. This study therefore investigated the effectiveness of AA policy structures on the rehabilitation and recovery of alcoholics at Asumbi Alcoholic Anonymous.

The WHO (2004) estimates that there are about two billion people worldwide consuming beverages and 76.3 million with diagnosed alcohol use disorders. From this perspective, the global burden related to alcohol consumption both in terms of morbidity and mortality is considerable in most parts of the world. A study by International Centre for Alcohol Policies (2008) showed that the consumption of illicit or noncommercial alcohol is widespread in many countries worldwide and contributes significantly to the global burden of disease. A new study from the Centre for Public Health (2008), Liverpool John Moors University has revealed that children who are unhappy at school or home are much more likely to turn to sex and alcohol.

The Government of Kenya through the Ministry of Planning and National Development participated and endorsed the deliberations of 1990 Bucharest Population Conference. The conference underscored the importance of promoting AA centers to curb the menace of alcoholism if developing countries were to achieve industrialization by 2020. Brandsma (1980) however observed that the existing AA centers have gaps as quite a few people have benefited from them. In terms of percentages of those exposed to AA the number helped is small- about 55% remain in AA as long as a year. The AA spokes people (like the AA survey analysts) blame AA's high drop-out rate on the large number of coerced (or at least involuntary referrals). Brandsma (1980/678) is quoted saying that, "I don't actually think that retention in AA would be much higher even if all those who came to AA were volunteers", his two randomized studies in which AA treatment was assigned found AA to yield worse outcomes than other forms of treatment- or no treatment at all.

Stanton (2001) argued that receiving treatment in the AA context requires one to be labeled a drug addict. Thus, everyone who enters such a programme is saddled with a dependence diagnosis, and counselled for addiction, even if they are merely recreational users. Trice and Roman (2009) suggests that social class and personality factors definitely indicate the AA program is not effective for all alcoholics. Earlier research by Gitlow (1980) also revealed that the 12-steps processes not only fail the drug users but they can also have a negative impact when the 12-steppers "fall of the wagon", into binge use, rather, as a dieter will behave after starving himself for days or months. According to the federally sponsored National Treatment Center (2000), 93 percent of programs according to this survey endorse only abstinence.

Henry and Maxwel (1995) as quoted by Gurion (2002) observed that a 5% success rate is nothing more than the rate of spontaneous remission in alcoholics. That is, out of any given group of alcoholics, approximately 5% per year will just wise up, and quit killing themselves. They just get sick and tired of being sick and of watching their friends die. They often quit with little or no official treatment or help. Milton and Maxwel (2005) further states that when you are at AA meeting, you are in a self selecting group. That one fails to see that they go to AA meetings because they want to quit drinking. The reason that they finally quit drinking is because they strongly and

really want to quit. The commonest reason for quitting is because people just get sick and tired of being sick and want to avoid death.

There is experimental evidence that the AA doctrine of powerlessness leads to binge drinking. In a sophisticated controlled study of AA's effectiveness Brandsma (1980), court in Botswana-mandated offenders who had been sent to Alcoholic Anonymous for several months were engaging in five times as much binge drinking as another group of alcoholics who got no treatment at all, and the AA group was doing nine times as much binge drinking as another group of alcoholics who got rational behavior therapy.

A study by Daley and Marlat (1998) on alcohol treatment conducted between 1996 and 2005 that investigated the efficacy of AA based on Twelve- step processes attendance concluded that "no experimental studies unequivocally demonstrated the effectiveness of AA" in treating alcoholism. This conclusion was based on a meta- analysis of the results of eight trials involving a total of 3,417 individuals. Daley and Marlat (1998) however noted that further efficacy studies are needed and mention the presence of flaws in one included study regarding the definition of success of interventions.

David (2006) stated that there are several flaws with Alcoholic Anonymous in Kenya: First and foremost is that it is an incomplete approach to alcoholism. He however argued that there is no denying that it does have many good benefits that are helpful to some people but it is limited to select few. International Center for Alcohol Policies (2008) holds that the biggest problem with Alcoholics Anonymous is that it has a very low success rate for long term sobriety. Most alcoholics do not recover from their disease, they die. Those who do recovery using a 12-step process fight constant craving to drink and suffer with a variety of other symptoms like irritability, anxiety, tension, fatigue and depression. That has a deep impact on the quality of their lives and forces them to be dependent upon attending AA meetings the rest of their lives.

A study by Vailant (2003) observed that AA has a role for those who naturally gravitate towards it, or who-when told about AA or exposed to it think they could benefit from it. Okoth (2010) on the other hand argued that more people have quit drinking without AA than with it. In this extensive study, it is equally stated that AA has introduced a strong degree of irrationality, intolerance and hatred into the alcoholism field. According to the research carried out by Wekesa and Dora (2007) at Asumbi Alcoholic Anonymous Center, most of the people who were sent to this rehabilitation center, (55%) ended up requiring hospitalization. In addition, they actually got worse while they were in Asumbi AA, so that they ended up requiring higher rates of expensive follow- up treatment in the hospital.

Asumbi Alcoholics Anonymous Centre is the oldest rehabilitation centre in East Africa which started way back in 1978 by Turberg Brothers in Asumbi, Homa bay. It offers residential drug free treatment. At the centre, patients have to stay off all moods and mind altering drugs. Their measure of success is complete abstinence. According to the records kept at the centre, Asumbi has so far rehabilitated more than 5000 clients.

Asumbi spread its wings and opened two other centers in Nairobi-Karen in May 2005 and Ridgeways in December 2006. The main focus at Asumbi AA centre is in spiritual and personal growth as peer pressure, role modeling, self- pity, personal responsibility, reality confrontations and leveling. To achieve the above, the centre use group and individual counseling and family therapy. The residential drug-free treatment approach, the therapeutic community is based on Alcoholics Anonymous, Narcotic Anonymous programmes which has been successfully used as a treatment method and a fellowship for alcoholics/drug addicts and a well designed and after care support.

Asumbi Alcoholic Anonymous Vision

To realize self- fulfillment and social harmony for all the community members through sharing and caring for each other. According to the Original Alcoholics Anonymous Program (2009), there were three distinctly different AA programmes during the first 20-year period from 1935 through 1955. First came the original pioneer Akron AA. Christian Fellowship recovery programme founded by Bill and Bob (1935) produced a documented 75% success rate.

Second programme written by Bill and Bob (1939) embodied in the First Edition of Alcoholic Anonymous (the "Big Book") and published in the spring of 1935. Its suggested programme was grounded in the Big Book and the twelve- steps which according to Frank and Rockeffeller (1980) are too voluminous and only a few members of AA could read. Finally, during the 1940's, there was numerous offshoot programmes culminating in the essays written by Bill and Bob (1935) and twelve (12) traditions in the mid 1950's which has remained the guideline programme of the AA. Bill and Pittman (2007) holds that AA's twelve steps are a group of principles, spiritual in their nature which if practiced as a way of life, can expel the obsession to drink and enable the sufferer to become happily and usefully whole.

However, Straus (2003) found out that Bob and Bill (1935) in coming up with the 12-steps of the AA process did not recognized the details of the spiritual recovery materials to support the alcoholics in practicing the principles. Kelly and Stout (2009) further established that the primary technique of the 12-step process is the group confrontation session in which addicts are prodded to acknowledge the error of their ways, that they are powerless over their drug use, and that they must turn themselves over to a higher power. Yoder (2005) who did a similar study in Washington State University also found out that, AA programmes do not promote relapse prevention, motivational interviewing approaches and do not provide sober social support.

Frank and Rockefeller (1980) also puts it that many of the AA members have been depressed when told that they are powerless and such feelings has made them to reach for a drink to make themselves feel better. They also observed another distinct side effect of the AA programmes to be the concept behind "once an alcoholic, always an alcoholic". Many find this disheartening because they work so hard to achieve recovery and then even when they have not had a drink in years, they are still referred to as an "alcoholic". Straus (2003) agrees with this statement and outlines that this has discouraged a number of clients who graduate from AA hence relapsing.

The 12-step processes strongly espouse the notion that spiritual experiences are the means to arrest the diseases of alcoholism. According to Alcoholic Anonymous World Services (2006), the 12- steps processes followed and recited always by the clients at the AA were as follows;

1. We admitted we were powerless over alcohol that our lives had become unmanageable. I know nothing good lives in me, in my sinful nature. For I have the desire to do what is good, but I cannot carry it out (Rom. 7:18).
2. We came to believe that a power greater than ourselves could restore us to sanity. For it is God who works in you to will and to act according to His good purpose (Phil. 2:13).
3. We made a decision to turn our will and our lives over to understand Him. Therefore, I urge you, brothers, in view of God's mercy, to offer your bodies as living sacrifices, holy and pleasing to God which is your spiritual worship (Rom. 12:1).
4. We made a searching and fearless moral inventory of ourselves. Let us examine our ways and test them, and let us return to the Lord (Lam.3:40).
5. We admitted to God, to ourselves and to another human being the exact nature of our wrongs. Therefore confess your sins to each other and pray for each other so that you may be healed (James 5:16).
6. We were entirely ready to have God remove all these defects of character. Humble yourselves before the Lord, and he will lift you up (1John 1:9).
7. We humbly asked him to remove our shortcomings. If we confess our sins, he is faithful and just and will forgive us our sins and purify us from all unrighteousness (1John 1:9).
8. We made a list of all persons we had harmed, and became willing to make amends to them all. Do to others as you would have them to do to you (Luke 6:31).
9. We made direct amends to such people whenever possible except when to do so would injure them or others. Therefore, if you are offering your gift at the altar and there remember that your brother has something against you; leave your gift there in front of the altar. First go and be reconciled to your brother, then come and offer your gift (Matt. 5:23-24).
10. We continued to take personal inventory and when we were wrong promptly admitted it. So, if you think you are standing firm, be careful that you don't fall (1Cor. 10:12).
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. Let the word of Christ dwell in you richly (Col. 3:16).
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. But watch yourself, or you also may be tempted (Gal.6:1).

A 1999 study of Texas correlation substance abuse treatment on AA programmes by Stanton (2001) found that those who participate in an in- prison (Twelve step) programme had the same rates as non- participants. It further states that even for employed problem drinkers who are not abusing drugs and who have no serious medical problems, an initial referral to AA alone or a choice of AA programmes, although less costly than inpatient care, involves more risk than compulsory inpatient treatment and should be accompanied by close monitoring for signs of inpatient relapse.

A further study carried by Frank and Rockeffeler (1980) also observed experimental evidence that the AA doctrine of powerlessness leads to binge drinking. In a sophisticated controlled study of AA's effectiveness, Brandsma (1980), court- mandated offenders who had been sent to Alcoholics Anonymous in Uganda several months were engaging in five times as much as binge drinking as another group of alcoholics who got rational behavior therapy.

Stanton (2001) observed that the most widely used alcoholism treatments (Twelve step) are the least effective. This is illustrated in Deborah Dawson's (1996) analysis of data from the 1992 National Longitudinal Alcohol Epidemiologic Survey. Stanton (2001) suggests that the brief intervention and motivational enhancement treatments are more successful alternatives. The current study therefore tried to establish the efficacy of AA programmes on rehabilitation and recovery of alcoholics vis a vis mentioned disparities.

According to Wilsnack and Robert (1999) Alcoholic Anonymous centers are structured contexts designed for alcoholics to discover their alcoholic selves. Such discovery is a collective group process, thus the tendency to interpret treatment solely from the point of view of the recovering alcoholic must be avoided. Tonigan and Miller (2009) further indicate that those group processes encompass attempts to shatter previous emotional and relational patterns and produce solidarity among participants. This intern will establish the grounds for authentic role taking and shared experiences. Within these processes, the center defines alcohol to the patient as a chemical that has the effect of transforming the patient into an addict.

Kelly and Brown (2000) carried out research on the effectiveness of AA process in America and observed that the only possible mathematical explanation of the AA process is that AA process kills one patient for each one that it saves, thus making the effective success balance at zero. They further notes that AA in its process of rehabilitation uses fear, guilt and lies to manipulate alcoholics. The collective process operating in these centers according to Halasyamani and Bhattacharje (1997) tells everyone who will listen to them that it has the only treatment program for alcoholism. Rather than concede that the process might have some problems, the AA true believers just shore the process on every victim they can find, using therapists, counselors, judges and parole officers as their enforcers. Alcoholics' Anonymous centers avoid any and all scientific testing processes of the effectiveness of the twelve step process.

Elly and Hardy (1999) however holds that the chances of relapse when the Twelve steps process are followed are enormously high-roughly 70% and Denzin (1998) argues that only by rearranging one's group affiliations and forming new relationships to previous drinking situations in the rehabilitation process can the alcoholic have a chance at recovery. Beck and Sandra (2003) found out that AA exists at the center of one process of redefining the meaning and patterning of group affiliations. In contrast, Beck and Sandra (2003) asserts that too many things about AA process are irrationally crazy, so irrational that the AA believers even revere the teachings of madman, Wilson (2009), who openly outlined that the AA process abandon reason, logic and human intelligence and just embrace blind faith in his religious beliefs as the answer to all of their problems.

A study by David (2006) states that AA gives newcomers a lot of bad advice and misinformation about their process of alcoholism rehabilitation and recovery. Their dogma is based on myths and superstitions about how human mind works, not facts. Giving people misinformation during rehabilitation process doesn't help clients remain sober. For example, informing clients to expect a spiritual experience makes them feel like failures when it doesn't happen, or it drives them to become delusional proclaiming that every intense emotion is a spiritual experience.

Cheryl and Charpitel (2007) holds that people get tired with the AA process, they get run down, their energy and enthusiasm gets depleted, they can become depressed after they fail many times because God still hasn't taken away all of their defects of character, moral shortcomings, or the drinking problem. Some people will just give up, and resign themselves to drinking or relapsing forever.

Bufe (1991) suggests that story telling process in an AA institution is away to redefine in real terms one's relationship with alcohol and involves a life review in which relationships with parents , spouses, children, friends, bosses and lovers are re-examined and reconfigured through AA talk. However Emrick and Tonigan (1993) view this story telling process as a waste of time as many clients do not tell truth of their real experiences. It was necessary therefore that the study tried to establish the efficacy of the 12-step process of rehabilitation and recovery based on the mentioned challenges.

Alcoholism is often referred to as "substance abuse" or chemical dependency Bufe (1991). Alcoholics are introduced to AA and encouraged to attend AA meetings. Donnelly (1994) observed that anyone may attend open AA meetings but only those with a drinking problem may attend closed meetings or become AA members. It is through this design that secrets of AA are kept. Chartell (2008) a pioneer in methadone treatment in the United States of America (USA) for alcoholism made the following statement, "The source of strength in AA is its single- mindedness. Alcoholics Anonymous limits what it is demanding of itself and its associates and its success lies in its limited target".

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However, Sussman (2010) states that a notable weakness of AA structure is that it doesn't keep attendance records at the 12-step meetings, so it is traditionally challenging to obtain specific information about 12- step membership on the progress of the clients. Another study carried by Hall (1993) in South Africa found that AA's structure doesn't have formal way of appointing group leaders. This has lead to group leaders misleading the clients resulting into less or no recovery at all during group meetings.

On financial policy, Hall (1993) states that AA has affirmed and strengthened a tradition of being fully self- supporting and of not seeking, or accepting contributions from non members. All contributions are voluntary and membership in AA involves no dues or fees (African Press International 2009). This tradition of being self- supporting according to Bhandarkar and Wilkinson (2000) has denied AA an opportunity for structural development and becoming a modern institution due to lack of enough financial support. Kelly and Stout (2009) suggests that AA's structure is loosely organized and doesn't seem to provide a clear path for maturing out of the group for those people who over time cease to require it anymore. It was necessary therefore to establish the efficacy of the AA structural policy issues based on the mentioned challenges.

METHODOLOGY

This study was a descriptive survey that adopted the *ex- post- facto* design. This design is the most appropriate in a study where the independent variable cannot be directly manipulated since its manipulations have already occurred (Kerlinger, 2000). Further this design is appropriate in an after the fact analysis of an outcome or the dependent variable, as well as in comparative studies (Kathuri& Pals, 1993; Mugenda & Mugenda, 2003). This study investigated the effectiveness of the AA structural policy issues on rehabilitation and recovery of alcoholics at Asumbi AA center.

Asumbi Alcoholic Anonymous center is in Rangwe Sub-County of Homa County, Kenya. Rangwe Sub-County is the largest Sub-Countyin Homa Bay County and closely boarded by Kisii South Sub-County. The area has had many cases of alcoholism most of whom are taken for rehabilitation at Asumbi AA center. In addition Asumbi AA center is one of the oldest AA centers in Kenya with the highest number of registered alcoholics which provided the appropriate place for the study. The target population was 70 alcoholics admitted at Asumbi AA center, three administrative staffs, the manager and the six counselors at Asumbi Alcoholic Anonymous Centre.

According to Krejcie and Morgan (1970), the sample size depends on the purpose of the study and the nature of the population under study. In order to determine the sample size of the alcoholics to be drawn from the 70 clients enrolled at Asumbi AA center, the study used Krejcie and Morgan (1970) table of determining sample size from a given population. For a population of seventy (70) addicts, according to the table, a sample of 59 clients was appropriate for the study. Simple random sampling was used to select 59 clients included in the study. Purposive sampling was used to select the manager, three administrators and the six counselors to participate in the study.

The instrument included an observation check list with five (5) items used to assess the availability of the facilities and the general structure of the institution. Two sets of questionnaires, one for the rehabilitation staffs with twenty (20) items and another set comprising nineteen (19) items to the sampled alcoholics to collect information on the efficacy of the structural policy issues on rehabilitation and recovery of alcoholics atAsumbi AA center. Document analysis and observation check list was also used by the researcher to collect other data related to the study.

Validity of the research instruments was done. Validity is the degree to which an instrument measures the variable it is supposed to measure Kothari (2006). To ensure content and face validity, the researcher piloted the instrument with 15 alcoholics, the manager and three counselors at the RAM Alcoholic Anonymous center in Kisii which had similar characteristics to Asumbi AA center. The research instruments were reviewed by research experts from the faculty of Educational Psychology and Science of Rongo University. The reliability of an instrument is the degree of consistency with which a research instrument measures whatever it is intended to measure Mugenda and Mugenda (2003).

The internal consistency of the research instruments was obtained by computing Cronbach's alpha (α) using SPSS. The Cronbach's Coefficient Alpha was calculated to test the reliability of the questionnaire with specific reference to its internal consistency. Cronbach's alpha (α) of .782 was obtained. According to Mugenda and Mugenda (2003), a reliability coefficient of above +0.60 is adequate. The results therefore shows that the Cronbach's Alpha for the questionnaires were reliable enough for the study because all the questions met the threshold of the internal consistency.

The researcher got an authority letter from the District Education Officer (DEO) Homa Bay and the Homa Bay District Commissioner for endorsement to carry out the research. The researcher visited Asumbi alcoholic anonymous centre to familiarize himself with the institution. The researcher then embarked on administering the research tools to the sampled respondents. The respondents were given a specified time to respond to the questionnaires, after which they handed them to the researcher. Responding to a questionnaire by sending it back was made as easy as possible to ensure maximum response Orodho (2009). Observation checklist was used by the researcher to assess the availability of the rehabilitation facilities at the centre and their effective use towards rehabilitation and recovery.

Document analysis was also done to ascertain the history of the centre and other information related to rehabilitation and recovery of alcoholics at Asumbi AA centre. In each case, the necessary rapport was established by doing formal introduction and the subject of the research before administering the questionnaire to the respondents. The data obtained was processed using the Statistical Package for Social Sciences (SPSS) version 22.0. Descriptive statistics was used in data presentation by use of frequency tables and percentages generated to explain various attributes of the variables under study.

In scoring, the quantitative data was scored in a comparative analysis format. This involved the collection of data from different respondents who also belonged to different categories at the AA centre to identify their views. The respondent questionnaires were subjected to data inspection after which questionnaires with missing data and those with missing pages selected options were separated from those that were with complete selected options for each question. Questionnaire checking which involved eliminating unacceptable questionnaires was done. A few questionnaires which were found to be having missing data and not directly contributing to the research objectives were discarded.

To make the data compatible with SPSS program, each respondent's questionnaire was given its distinct code identity. For each of the valid respondent's questionnaires, all their chosen options were keyed in. For each variable, the following were set and fixed as in accordance with the APA format. Data entry went along with coding and transcribing process. After data entry, data cleaning process followed suits;

it was necessary to find and eliminate errors in the data. The process involved detecting impossible or incorrect values for specific variables, cases in the data which met exclusion criteria and could not be in the study, duplicate cases, missing data and outliers and skip-pattern or logic breakdowns.

Further inspection was done by choosing six questionnaires at random and then confirming from the prepared data if they were correctly keyed in. This was then used to produce the primary data matrix analysis or logical analysis and categorization which helped represent the cause and process in a tabular or graphical manner. This approach helped make easier for triangulation of the findings during the analysis stage. On the qualitative data, scoring was done using constant comparison approach (Grounded theory).

The variable in this section was influence of structural policy issues on rehabilitation and recovery of alcoholics at the AA centre. This involved simultaneous collection and analysis of data through focus group discussion. The researcher tape recorded the data collected to identify theoretical and analytical codes. A Microsoft excel database divided the responses by theme, school type and by gender. Each theme represented the findings and effectively illustrated the effects of structural issues on rehabilitation and recovery of alcoholics at AA centre.

To maintain fidelity of the open ended responses, the researcher analyzed the responses by reading the answers initially and listening to the recorded version for completeness to verify their usability in the study. Subsequent readings narrowed the focus of the responses, identified the themes and broken data into manageable units to enhance comparison and analysis.

PRESENTATIONS AND DISCUSSIONS

Items in the questionnaires sought to establish the effectiveness of the structural policy issues at the AA center. The results were expected to negate or confirm that the structural policy issues at the AA center led to rehabilitation and recovery of alcoholics at Asumbi AA center. For the clients to be admitted to the AA center, a financial policy had been put in place where all the clients were to pay some fees. According to the respondents, 100% of the clients noted to have paid some money.

The mean amount paid according to the responses was Ksh. 80,448.98 within the session at the center. Nearly all the client's 52 (88.1%) consented that the amount of fees charged at the center was exorbitantly high. This could have been the reason not many addicts were admitted at the center. This confirms the arguments by Brandsma (1980) who observed that the existing AA centers have gaps in their structuremaking only a few addicts to benefit from them. In terms of percentages of those exposed to AA the number helped is small- about 31 (52.5%) remain in AA as long as a year despite the huge amount of fees charged by the managements.

The findings further outlined that that 47 (79.7%) of the clients indicated to have paid Ksh. 90, 000, while 13.6% of them indicated to have paid Ksh. 30,000, while 13% only of the clients had paid the total amount of Ksh. 96,000, a clear indication that most of the addicts admitted at the AA were not able to raise the fees. This is contrary to the findings of Hall (1993) who noted that AA has affirmed and

strengthened a tradition of fully being self-supportive and of not seeking or accepting contributions from none members, that all contributions were voluntary and membership in AA involves no dues or fees.

Due to the huge fees pegged on the members, it was observed that 25% of the clients found at the center were those that had been detained for luck of fees despite them having gone through the programmes successfully. In fact most of the clients interviewed, 89% noted that the fees paid at the center was too high that they felt that only few clients got the opportunity to access the AA services. About 7 (11.9%) of the clients who had been detained at the center acknowledged that they could not raise the fees however long they were detained at the center, a fact that denotes their humble background.

Based on the presence and effective use of the structural policy issues at the center, the objective further aimed at determining this efficacy by establishing the response of clients on recommending others to the center. Out of the clients interviewed, 43 (72.9%) of the clients would quite often recommend friends to the AA centers. This they attested to by accepting that AA center had organized and good structural policies to rehabilitate the alcoholics. The other 18.6% would fairly often recommend, while 13.6% would often recommend a friend to be rehabilitated at an AA center. The concept of Anonymity was strongly emphasized as a policy observed at the center. This policy was observed to be the foundational principle of the fellowship of Alcoholics Anonymous, whereas the concept of confidentiality is the foundational principle of clinical practice. However, 28 (47.5%) of the clients noted that there was no clear time-table of events at the center and many of them were not even aware of the chronology of daily routine and events at the center. This was noted to have brought confusion and conflict of events at the center.

As observed earlier by (Bill & Pittman, 2007), the concept of Anonymity has limited application in a way that it's concerned with the person's identity (the full name or face) as members of AA might discuss, at own discretion, his or her affiliation with AA at the level below public media. On the clients perception on the anonymity, an overwhelming majority 54 (91.5%) of the clients agreed that the center strictly observed concept of anonymity. Strangers were not allowed at the center without thorough scrutiny and adherence to the AA rules and regulations while within the center. However, the concept of confidentiality, according to the AA manager and counselors had unlimited application in a way that it did not allow the disclosure of any addict's information, even whether they are or were addicts of the counselor, at any level and in any situation.

The findings of the study established that a significant majority 49 (83.1%) of the clients were in agreement that anonymity was a policy at the AA that required that the information of other members were never disclosed, even within the fellowship. The main purpose of practicing both anonymity and confidentiality as a policy at the AA center according to the manager was to protect the reputation of addicts while in the process of rehabilitation and recovery at the AA, so they would not be afraid or feel betrayed in the whole process.

The study further noted that 46 (78%) of the clients agreed that the practice should never protect the fellowship of AA, as a whole, as well as the counseling profession, from abuse by some individuals for the purpose of personal gain, publicity, or some other selfish reasons. Thus all the counselors noted that

the policy was very paramount in giving the client confidence to undergo through the AA process successfully as their identity was protected and remained anonymous.

In coming up with appropriate policies to rehabilitate the alcoholics, the reasons for alcohol intake were sought by the management. The researcher also asked to know from the clients why they engaged themselves into binge drinking before they were referred to the AA center. According to the respondents, most clients 54 (91.5%) engaged in alcohol abuse so as to add pleasure to their meal, or get-together, to escape from problems, to feel more adult, as an act of rebellion, for experimentation, to escape pressures, problems or relieving stress and frustrations among other reasons. In 20% of the youths admitted at the AA attributed their reasons of becoming addicts to frustrations at home, schools, peer influence and lack of employments opportunities. However, the main reasons for alcohol consumptions according to the respondents were noted as recreation (33.9%), passing time (27.1%) and averting family problems (25%) as indicated in Table 1

Table 1
Reasons for alcohol intake by the clients

	Frequency	**Percentage**
Reasons for taking alcohol		
Recreation	20	33.9
Passing time	16	27.1
To avert family problems	15	25.4
None committal	8	13.6
Total	**59**	**100%**

The study established that before joining the AA center, 81.4% of the clients did not have control over alcohol. Only 11 (18.6 %) of the clients had applied some traditional control to their alcohol intake. It was actually established that the few who tried to control their intake were those who initially were drinking below five bottles per day though no success on control was realized as seen in Table 2.

Table 2
Number of bottles drunk by clients and their alcohol control

Number of bottles of alcohol the clients were drinking per day before joining this AA center	**Did you have control over alcohol consumption before coming to this AA center**		**Total**
	Yes	**No**	
Below 5	66.7% (4)	33.3% (2)	10.50% (6)
Above 5	9.1% (2)	90.9% (20)	37.29% (22)
Between 5- 10	62.5% (5)	37.5% (3)	13.56% (8)
Over 10	0% (0)	100% (19)	32.20% (19)
None committal			6.80%(4)

The 25% of those who tried to control the intake mentioned methods like taking neem tea after drinking, changing brands of alcohol and using traditional medicine. It was established that 54% of the clients had problem of withdrawal and were stressed up in the process of rehabilitation and recovery at the AA center. However, after rehabilitation and recovery, the clients gained social maturity, self-esteem and control although some still had peer pressure.

The counselors in making their observations attested that control and recovery was easier for those who were drinking fewer bottles per day than those who drank more. In fact, the research revealed that majority of the client's 48% who took longer time at the center and still find themselves relapsing even after the normal rehabilitation period at the were those that had been deeply involved into alcoholism before being referred to the AA. Conclusion was therefore made that the management needed to design workable policies that would ensure that those who had been deeply involved into alcohol abuse were added more time at the center to ensure proper rehabilitation and recovery before they are released out of the AA.

SUMMARY OF FINDINGS

This study made an assessment of the efficacy of alcoholics anonymous on rehabilitation and recovery of alcoholics with special reference to Asumbi AA center in Homa Bay District. The objectives of this study were:-

i) To establish the efficacy of the AA programmes on rehabilitation and recovery of alcoholics at Asumbi AA center
ii) To establish the influence of the 12-steps AA process in rehabilitation and recovery of alcoholics at Asumbi AA center
iii) To establish the efficacy of the structural policy issues at the AA on rehabilitation and recovery of alcoholics at Asumbi AA center

This study was conducted in Asumbi AA center in Homa Bay District, Homa Bay County, Kenya. Simple random sampling procedure was employed in selection of the 59 clients used in the study. Statistical analysis was employed to draw inferences according to stated questions. Based on the analysis and subsequent interpretation of the results, the study came up with the following conclusions in relation to the stated objectives:-

i) Most of the counsellors at the center do not have adequate training to handle the clients appropriately
ii) The amount of money (fees) paid by the clients at the center is too high and this has led to many clients overstaying at the center or discouraging admission of many clients
iii) Following the 12- step process by the clients significantly enhanced rehabilitation and recovery of alcoholics at the AA centers
iv) Alcoholics anonymous programmes had been well implemented at the center
v) Most of the structural set ups at the center were old and out dated

CONCLUSIONS

The following conclusions were made on the basis of the findings:-

Group counseling programmes had positive effect in rehabilitation and recovery of alcoholics at Asumbi AA centre and the 12-steps process had been taken seriously by the AA management in rehabilitation and recovery of alcoholics at the AA centre. It was noted that proper following of the 12-steps process at the AA leads to rehabilitation and recovery of alcoholics and therefore modern structural and technological AA devices has appositive impact on rehabilitation and recovery of alcoholics. Adequate implementation and following of the AA programmes leads to rehabilitation and recovery of alcoholics. Due to the relaxed policy applied at the Centre, most of the counselors at the center do not have adequate training to handle the clients appropriately. This could be as a result of low pay that the center offers to the staffs which could not attract qualified personnel at the Centre. The policy on fees made at the Centre by the clients is equally too high and this has led to many clients overstaying at the center due to unpaid fees or discouraging admission of many clients due to exorbitant fees charged.

RECOMMENDATIONS

Modern structural and technological AA devices have positive impact on rehabilitation and recovery of alcoholics. There is need therefore for the government to support the existing AA centers and build more centers to help in rehabilitating the alcoholics. It should be made a policy that all the AA counselors be employed by the government to avoid compromising the quality of their training and services offered at the AA centers due to unqualified personnel. There is need for support to the AA centers through the government and none-governmental organizations so that the fees charged from the clients may be reduced or abolished to enable low income alcoholics be integrated into the centers. The AA management needs to design workable policies that would ensure that those who had been deeply involved into alcohol abuse were added more time at the center to ensure proper rehabilitation and recovery before they are released out of the center.

Group counseling was observed to be a critical forum for disclosure and feedback and significant number of clients (16) were neutral on making decision on the application of Group counseling as a program at the centre. A part from the 12-steps process, 83.3% of the staff noted they do have other programmes to follow at this centre; AA traditions, Life skill classes, one on one counseling sessions, Spiritual sessions and Co-curriculum activities with the clients, Relapse prevention skills, after care and Group counseling where the clients share their experiences

In rating the effectiveness of the AA programmes at the centre, 71.7% of the clients strongly agreed that the centre had group counseling programmes. The research revealed that during the group counseling sessions, clients developed a support network through each other, they no longer felt isolated by their condition and they progressively gained greater sense of normality. Through the groups, a significant number of clients noted that they find a forum of peer support, gaining strength as they shared their feelings and experiences with others who were facing the same obstacles as themselves. Some clients' confessed to have gained strength in seeing the resourcefulness of those in the situation, while others renew their feelings of self- worth through assisting others.

Guidance and Counseling lessons on rehabilitation and recovery of alcoholics should be included in the Kenya Secondary Schools' curriculum so that the youths get adequate knowledge on the effects of alcoholism.

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