Addiction self-help organizations: Research findings and policy options

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Characteristics Shared by *All* Self-Help/Mutual Aid Groups

- Members share some problem or status that results in suffering/distress
- Groups are organized and facilitated by members themselves
- Experiential knowledge is the basis of expertise
- All members are both "helpers" and "helpees"
- No fees are charged, save "pass the hat" contributions

Characteristics of *Only Some* Self-Help/Mutual Aid Groups

- A codified world view/philosophy
- A formalized program for change (e.g. 12 steps, Will Training)
- Story telling as a dominant form of discourse
- Published books, pamphlets, and/or newsletter
- Connection to a larger organization (e.g. NAMI)
- Political Advocacy

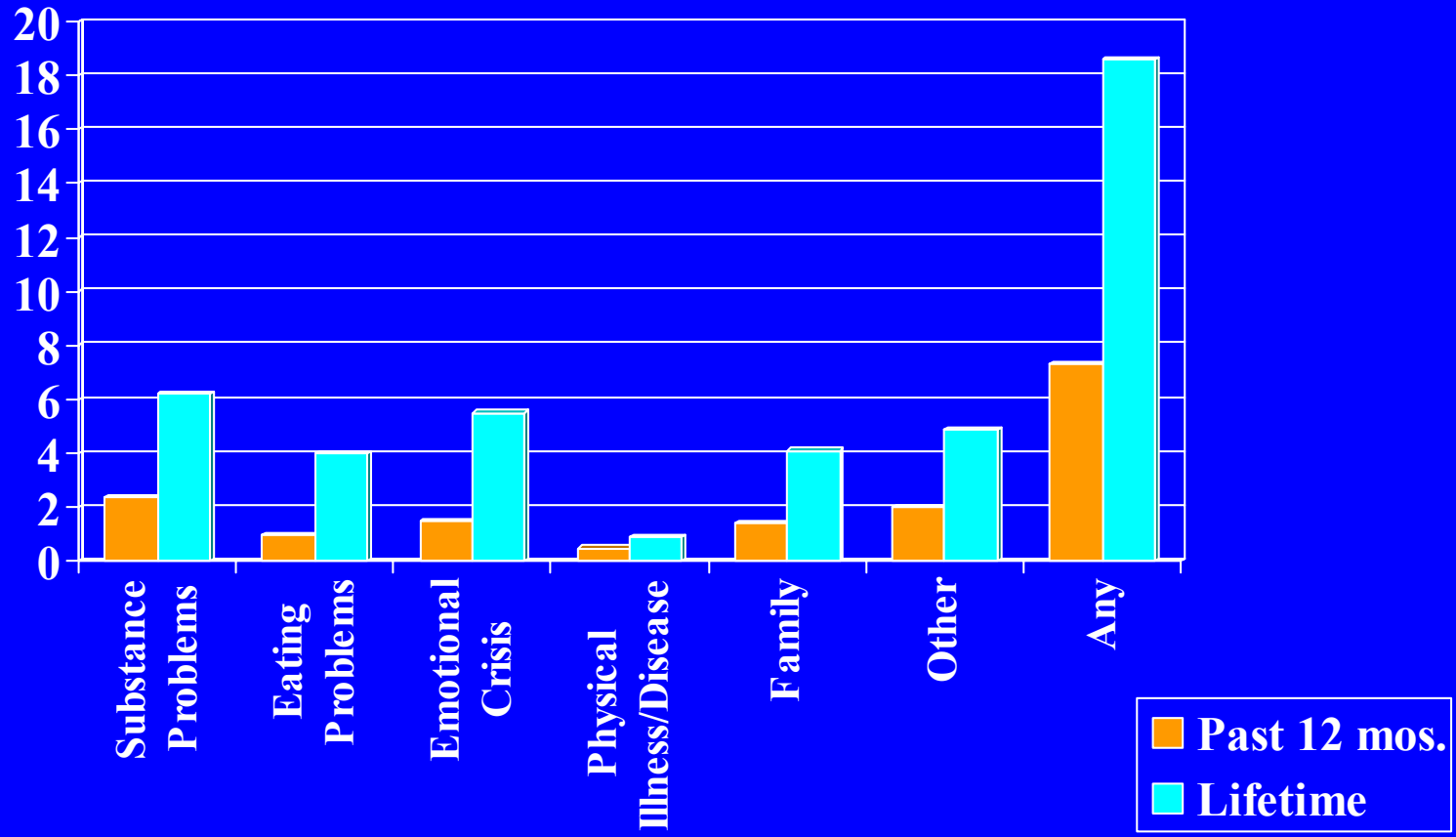
Self-help groups addressing major chronic conditions in the U.S.

Chronic Condition	Example Groups
Arthritis	Young Et Heart
Visual impairment	Council of Citizens with Low Vision Support Groups
Hearing Impairment	Self-help for the Hard of Hearing
Ischemic Heart Disease	Mended Hearts
COPD	Asthma and Allergy Foundation Support Groups
Diabetes Mellitus	Diabetes Anonymous
Malignant Neoplasms	Candlelighters (Pediatric Cancer)
	Reach to Recovery (Breast Cancer)
	Man-to-Man (Prostate Cancer)
Any Life-Threatening Chronic Illness	Make Today Count

Self-help groups addressing leading causes of mortality in the U.S.

Causes of Mortality	Example Groups
Tobacco	Nicotine Anonymous
Diet/Activity Patterns	Take Off Pounds Sensibly
Alcohol	Alcoholics Anonymous
Microbial Agents	Hepatitis B Foundation Support Groups
Toxic Agents	Parents Against Lead
Firearms	Parents of Murdered Children
Sexual Behavior	National Association of People with AIDS
Motor Vehicles	Mothers against Drunk Driving
Illicit Use of Drugs	Narcotics Anonymous

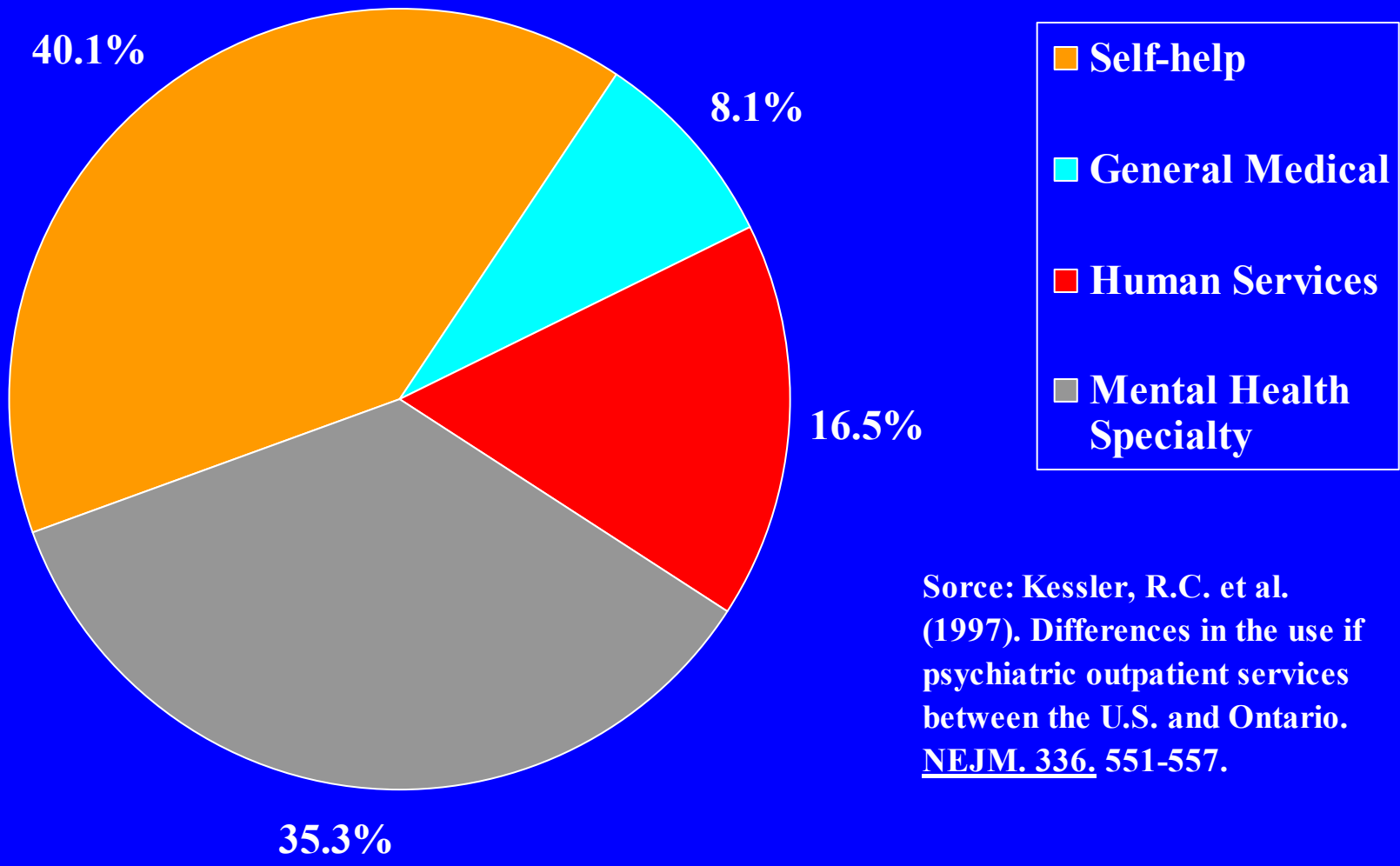
Lifetime and past 12 months participation in self-help groups, 1995



Note: Based on MIDUS survey (N=3032)

Source: Kessler, R.C. et al., 1997, Patterns and correlates of self-help group membership in the United States. Social Policy, 27, 27-46.

Proportion of help-seeking visits for psychiatric and substance abuse problems by sector, 1990



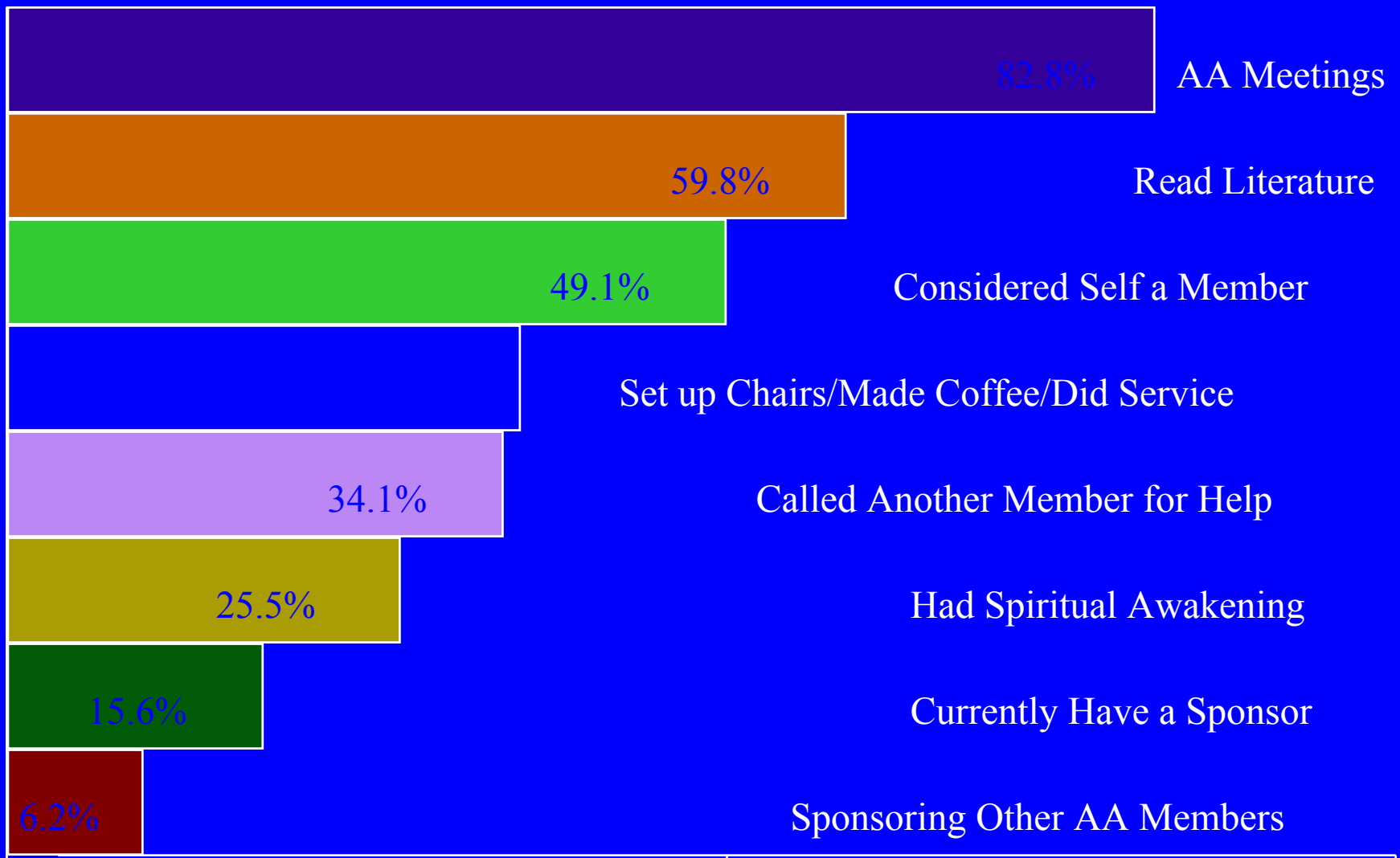
Sorce: Kessler, R.C. et al. (1997). Differences in the use if psychiatric outpatient services between the U.S. and Ontario. NEJM. 336. 551-557.

Alcohol and drug-related self-help/mutual aid organizations in the U.S.

	Estimated Number of Groups Worldwide
Alcoholics Anonymous	95,000
Al-Anon	32,000
Narcotics Anonymous	21,000
Cocaine Anonymous	2,000
Adult Children of Alcoholics	1,500
Secular Organization for Society	1,200
Marijuana Anonymous	1,000
Rational Recovery	800
Women for Sobriety	350
SMART Recovery	200
Moderation Management	50

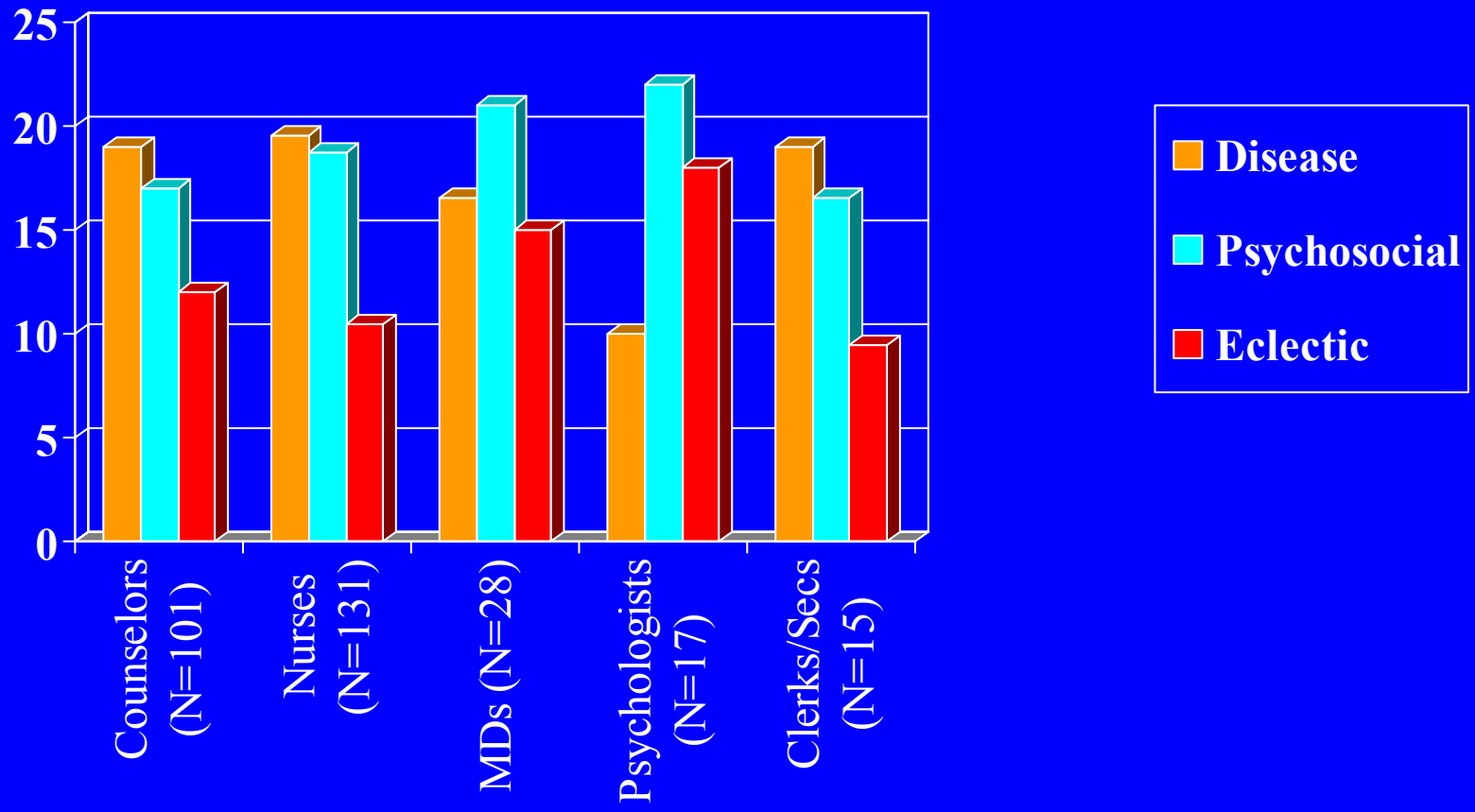
Source: White and Madara (1998). Self-help sourcebook. Denville, NJ: American Self-help clearinghouse

Pretreatment AA experiences of 927 alcohol treatment seekers



Source: Humphreys, K. et al. (1998). The relationship of pre-treatment Alcoholics Anonymous affiliati on with problem severity, social resources and treatment history. Drug and Alcohol Dependence, 49, 123-131.

Endorsement of Disease, Psychosocial, and Eclectic Models of Addiction by VA Treatment Staff (n= 327)



Source: Humphreys, K., Greenbaum, M.A., Noke, J.M., Finney, J.W. (1996). Reliability , validity and normative data for a short version of the understanding of Alcoholism Scale. Psychology of Addicitive Behaviors, 10, 38-44.

Rates of referral of substance abuse patients to *12-step* self-help/mutual aid organizations in VA substance abuse treatment system, 1994

	Total (n=389)	Dominant Treatment Orientation 12 Step (n=152)	CB (n=200)	Psychodynamic (n=37)	
	%	%	%	%	F (2, 386)
Alcoholic Anonymous	79.4	86.8	77.1	62.2	15.80**
Cocaine Anonymous	24.3	25.6	23.6	22.2	0.26
Narcotics Anonymous	44.9	47.0	43.3	45.4	0.51
Adult Children of Alcoholics	10.6	13.8	8.7	8.4	4.81*
Al-Anon	12.7	15.3	11.5	9.2	1.97

Note. *p<.01 **p<.005

Source: Humphreys, K. (1997). Clinicians' referral and matching of substance patients to self-help groups after treatment. Psychiatric Services, 48,, 1445-1449.

Common Alcoholics Anonymous Beliefs

1. Alcoholism is a disease with mental, physical, and spiritual components
2. Alcoholics are characterologically different than non-alcoholics, and no one is "somewhat" alcoholic
3. Alcoholism is rooted in the moral character of the alcoholic, in particular his/her self-centeredness
4. One cannot control alcoholism, but one's Higher Power can
5. Alcoholism is progressive and irreversible, and can only be arrested through total abstinence

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Hospitalization and Alcoholics Anonymous (AA) versus AA alone: Cost and benefits

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Sample: 156 alcohol-abusing blue-collar workers

Design: Random assignment to compulsory inpatient treatment plus AA or AA attendance only

Results: Both groups showed substantial improvement on all measures.

No difference between groups on 12 job-related outcomes.

Hospitalized group had better outcomes on 8 of 19 substance abuse-related outcomes.

Total alcohol-related health care costs over 2 years averaged $1200 (10%) higher in the initially hospitalized group.

Source: Walsh, D.C., et al. (1991). A randomized trial of treatment options for alcohol-abusing workers. New England Journal of Medicine, 325, 775-782.

Outcomes and Health Care Cost Offset of Alcoholics Anonymous

Principal Investigator: Keith Humphreys, Ph.D.

Co-Investigator: Rudolf Moos, Ph.D.

Research Design

- Participants recruited at detoxification units and alcoholism information and referral services in the San Francisco Bay Area
- Inclusion criteria: Contact due to a personal alcohol problem
- Exclusion criteria: Prior formal treatment for alcohol problems
- Collateral data on drinking behavior collected where possible
- Follow-ups conducted at 1, 3 and 8 years

Baseline demographic characteristics of 201 alcoholic individuals who initially chose AA or outpatient treatment

Characteristic	Total sample (n=201)	AA (n=135)	Outpatient (n=66)	
	%	%	%	X^2(df=1)
Caucasian Race	86.6	88.9	81.8	1.91
Female	49.3	54.1	39.4	3.82
Married	25.9	23.7	30.3	1.01
Employed	52.2	48.1	60.6	2.75
	Mean	Mean	Mean	t (df=199)
Age (years)	35.3	34.7	36.4	-1.22
Income (in $1,000s)	19.5	17.0	24.6	-3.08*
Education (in years)	13.6	13.2	14.4	-3.80*

Note. *p<.05

Baseline clinical characteristics of alcoholic individuals who initially chose AA or outpatient treatment

Clinical Characteristic	Total sample (n=201)		AA (n=135)		Outpatient (n=66)		t
	mean	SD	mean	SD	mean	SD	(df=199)
Ethanol Consumption (oz.)	11.5	*9.1*	12.3	*8.9*	10.0	*9.4*	1.65
Days intoxicated in past month	11.7	*10.2*	11/9	*10.3*	11.4	*10.1*	.33
Alcohol Dependence Scale score	10.1	*8.4*	10.9	*8.4*	8.6	*8.4*	1.83
Adverse Consequences Scale score	9.8	*7.4*	10.6	*7.1*	8.2	*7.6*	2.25*
Depression scale score	19.8	*8.7*	20.2	*8.9*	18.8	*8.3*	.84

*p<.05

3-year Utilization by alcoholic individuals who initially chose AA or professional outpatient treatment

Treatment type and year	AA group (N=135) Mean	*SD*	Outpatient group (N=66) Mean	*SD*	F (df=1,199)
Outpatient treatment (N visits)					
Year 1	5.8	*16.9*	31.7	*36.9*	
Years 2 and 3	.7	*5.6*	1.9	*8.9*	
Total	6.5	*18.8*	33.6	*36.6*	48.21**
Alcoholics Anonymous (N visits)					
Year 1	74.1	*84.5*	12.8	*28.3*	
Years 2 and 3	13.9	*57.4*	27.1	*100.0*	
Total	88.0	*104.7*	40.0	*108.2*	9.15**

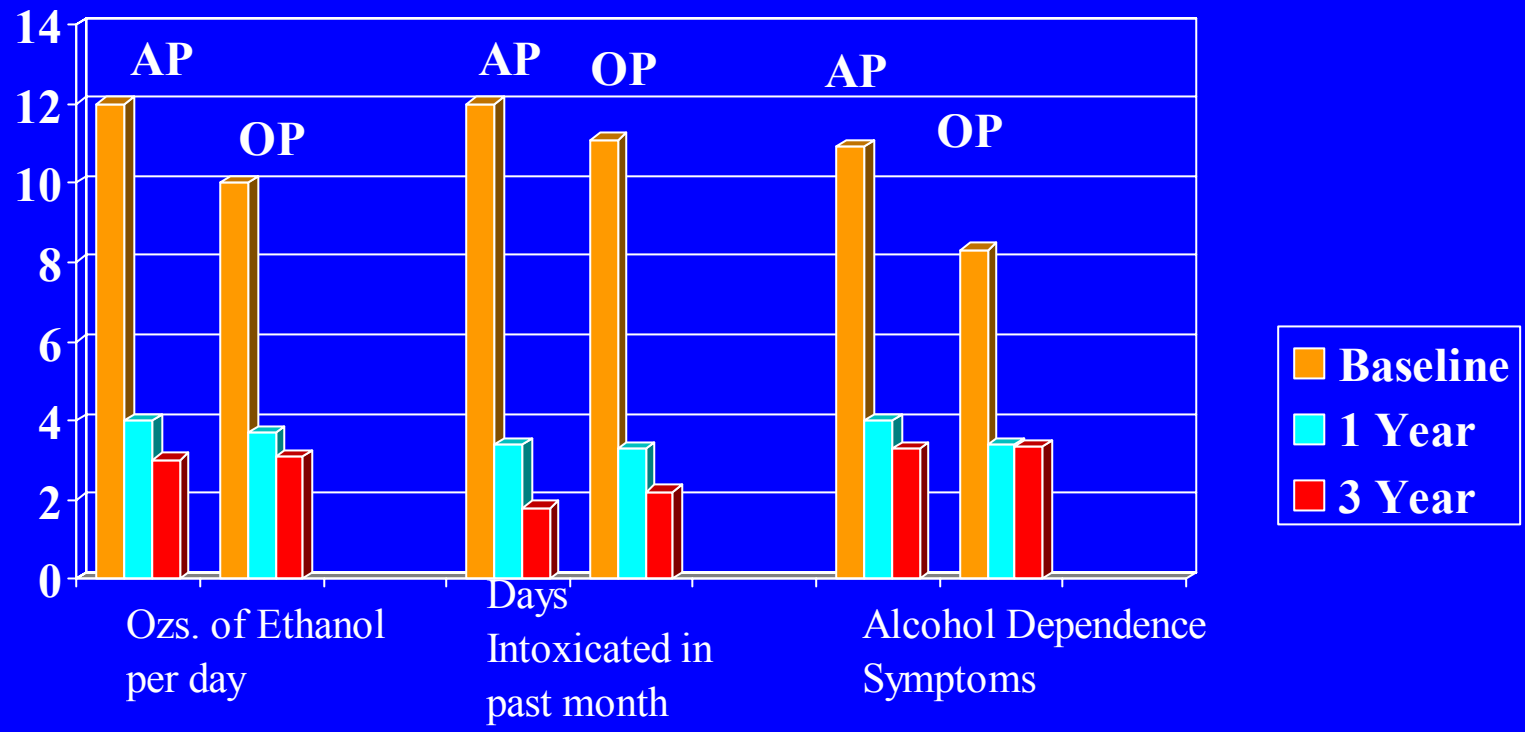
Note. *p<.05 **p<.005

Use of AA and professional alcoholism treatment over three years by alcoholic individuals who initially chose Alcoholics Anonymous or professional outpatient treatment

Treatment type and year	AA group (n=135) mean	SD	Outpatient group (n=66) mean	SD	F (df=1,199)
Detoxification (N days)					
Year 1	.4	*2.5*	.2	*1.2*	
Years 2 and 3	.2	*1.1*	.2	*1.4*	
Total	.7	*2.8*	.4	*1.8*	.52
Inpatient/Residential treatment (N days)					
Year 1	4.7	*21.4*	6.7	*28.7*	
Years 2 and 3	11.6	*45.9*	13.1	*62.0*	
Total	16.2	*50.5*	19.8	*74.4*	.16
Per person costs					
Year 1	$1,115	*$2,386*	$3,129	*$4,355*	
Years 2 and 3	$1,136	*$4,062*	$948	*$2,852*	
Total	$2,251	*$5,075*	$4,077	*$5, 371*	5.52*

Note *p<.05

Alcohol-related outcomes of individuals initially selecting AA or outpatient treatment (OP)



Source: Humphreys, K., Moos, R.H. (1995). Reduced substance abuse related health-care costs among voluntary participants in Alcoholics Anonymous. Psychiatric Services, 47, 709-713.

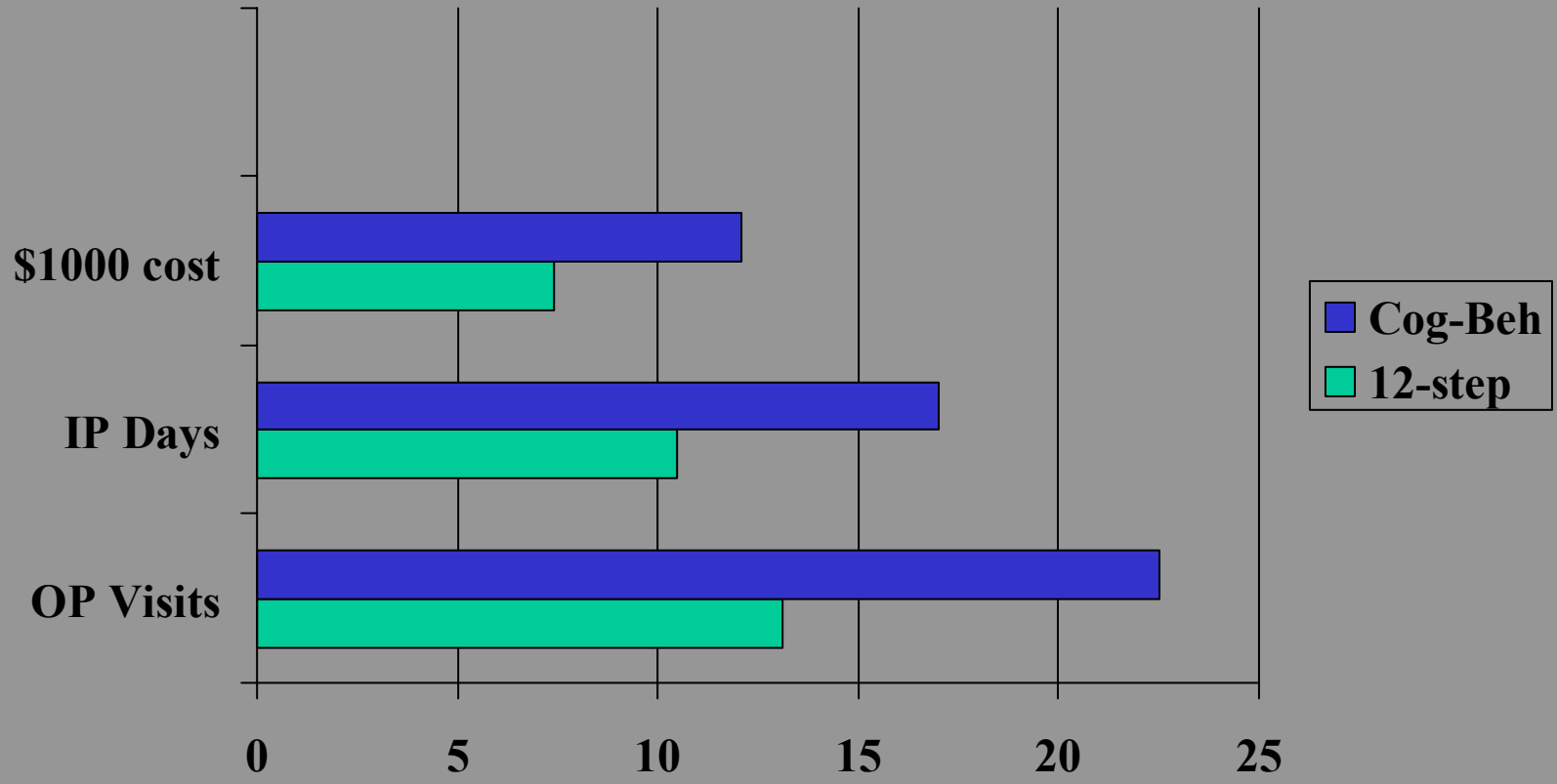
Replication of findings in Department of Veterans Affairs Sample

Source: This study appeared in Alcoholism: Clinical and Experimental Research around May, 2001

Comparison Groups

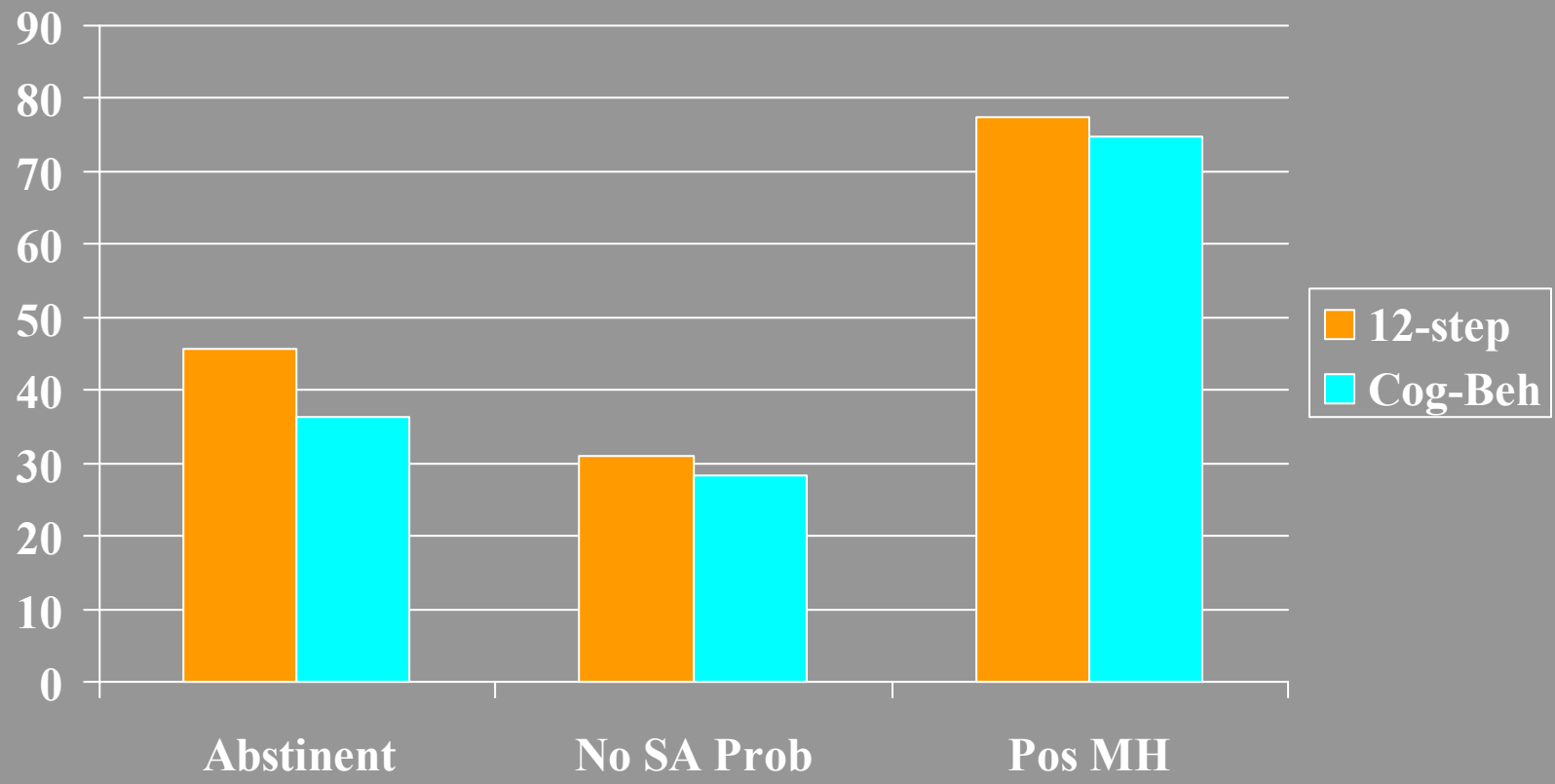
- 887 Admissions each were recruited from the 12-step and cognitive-behavioral treatment condition
- At intake, groups did not differ on substance abuse problems, psychiatric problems, demographic variables, prior health care utilization, or prior involvement in self-help groups

1-Year Treatment Costs, Inpatient days and outpatient visits



Note: All differences significant at p <.001

1-Year Clinical Outcomes (%)



Note: Abstinence higher in 12-step, $p < .001$

Self-help groups can be an effective component of aftercare for drug-dependent patients

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Sample: Drug-dependent individuals just completing primary treatment (N = 168)

Design: Parents randomly assigned to standard aftercare or enhanced aftercare that included self-help groups (RTSH; Recovery training and self-help)

Results: Abstinence from opioid use at 6-month follow-up for RTSH group: 34%
Abstinence from opioid use at 6-month follow-up for control group: 20%

Source: McAuliffe, W.E. (1990). A randomized controlled trial of recovery training and self-help for opioid addicts in New England and Hong Kong. Journal of Psychoactive Drugs, 22, 197-209.

12 Step Facilitation Therapy Findings in Project Match

- 1726 alcohol dependent patients were randomized to 12-step facilitation, cognitive-behavioral or motivational enhancement therapy
- Patients in all three conditions showed substantial and sustained reduction in quantity and frequency of alcohol consumption
- No main effects for type of therapy were evident by 15 month follow-up
- Among patients with low psychiatric problems, 12 step facilitation therapy was more effective at increasing percent of days abstinent

Source: Project Match Research Group (1997). Matching alcoholism treatments to client heterogeneity. Journal of Studies on Alcohol, 58, 7-29.

How can referrals to self-help groups be more effective?

Sample: 20 alcohol outpatients

Design: Outpatients randomly assigned to standard 12-step self-help group referral (list of meetings and therapist encouragement to attend) or intensive referral (in-session phone call to active 12-step group member)

Results: Attendance rate for individuals after intensive referral: 100%
Attendance rate after receiving standard referral: 0%

Source: Sisson, P.W., & Mallams, J.H. (1981). The use of systematic encouragement and community access procedures to increase attendance at Alcoholics Anonymous meetings. American Journal of Drug and Alcohol Abuse, 8, 371-376.