

Addiction self-help organizations: Research findings and policy options

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Acknowledgement of support

- Department of Veterans Affairs
- National Institute on Alcohol Abuse and Alcoholism
- The California Wellness Foundation
- The California Endowment

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

Arthritis

Visual impairment

Hearing Impairment

Ischemic Heart Disease

COPD

Diabetes Mellitus

Malignant Neoplasms

Any Life-Threatening
Chronic Illness

Example Groups

Young Et Heart

Council of Citizens with Low Vision Support Groups

Self-help for the Hard of Hearing

Mended Hearts

Asthma and Allergy Foundation Support Groups

Diabetes Anonymous

Candlelighters (Pediatric Cancer)

Reach to Recovery (Breast Cancer)

Man-to-Man (Prostate Cancer)

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

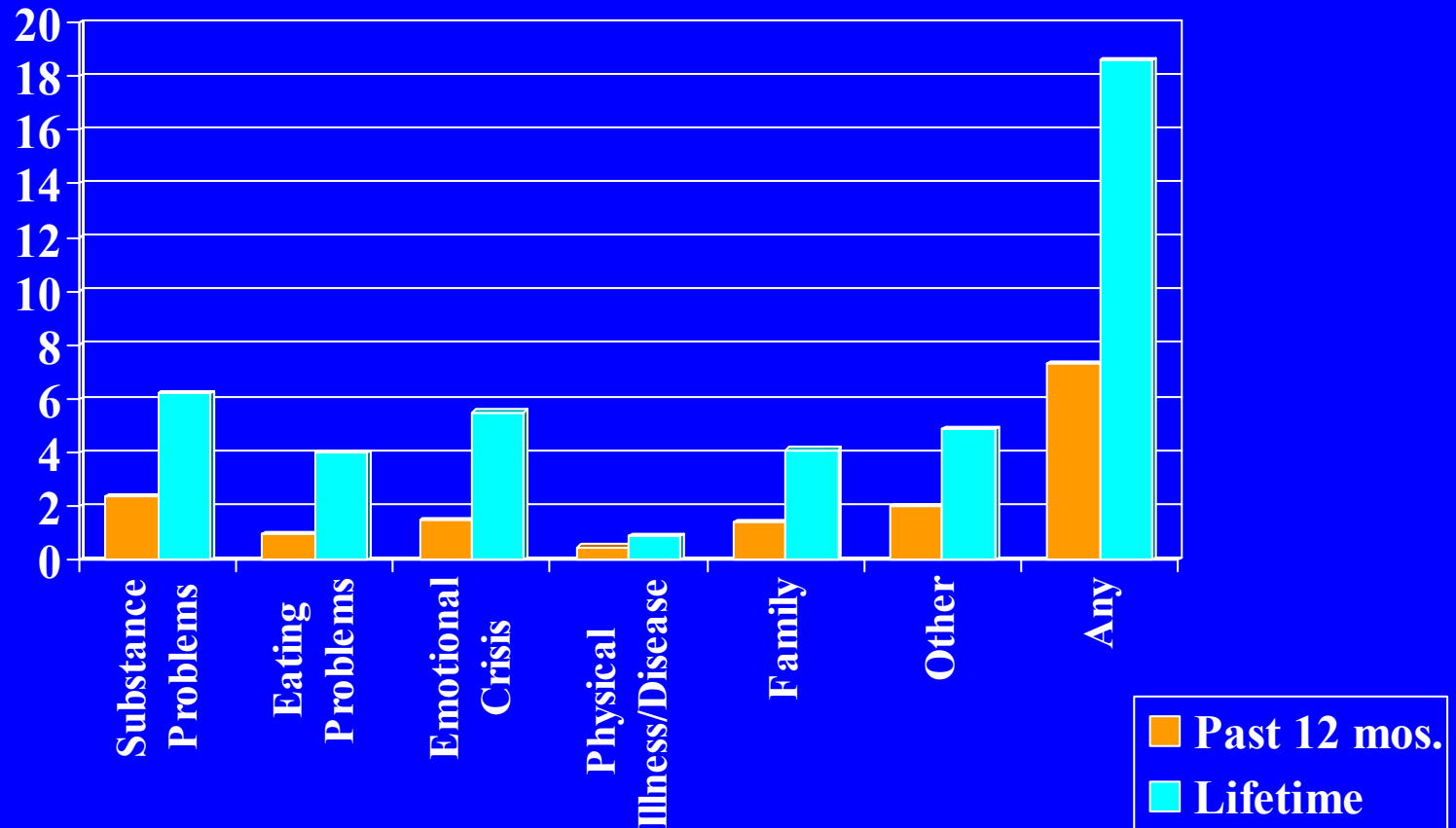
Motor Vehicles

Mothers against Drunk Driving

Illicit Use of Drugs

Narcotics Anonymous

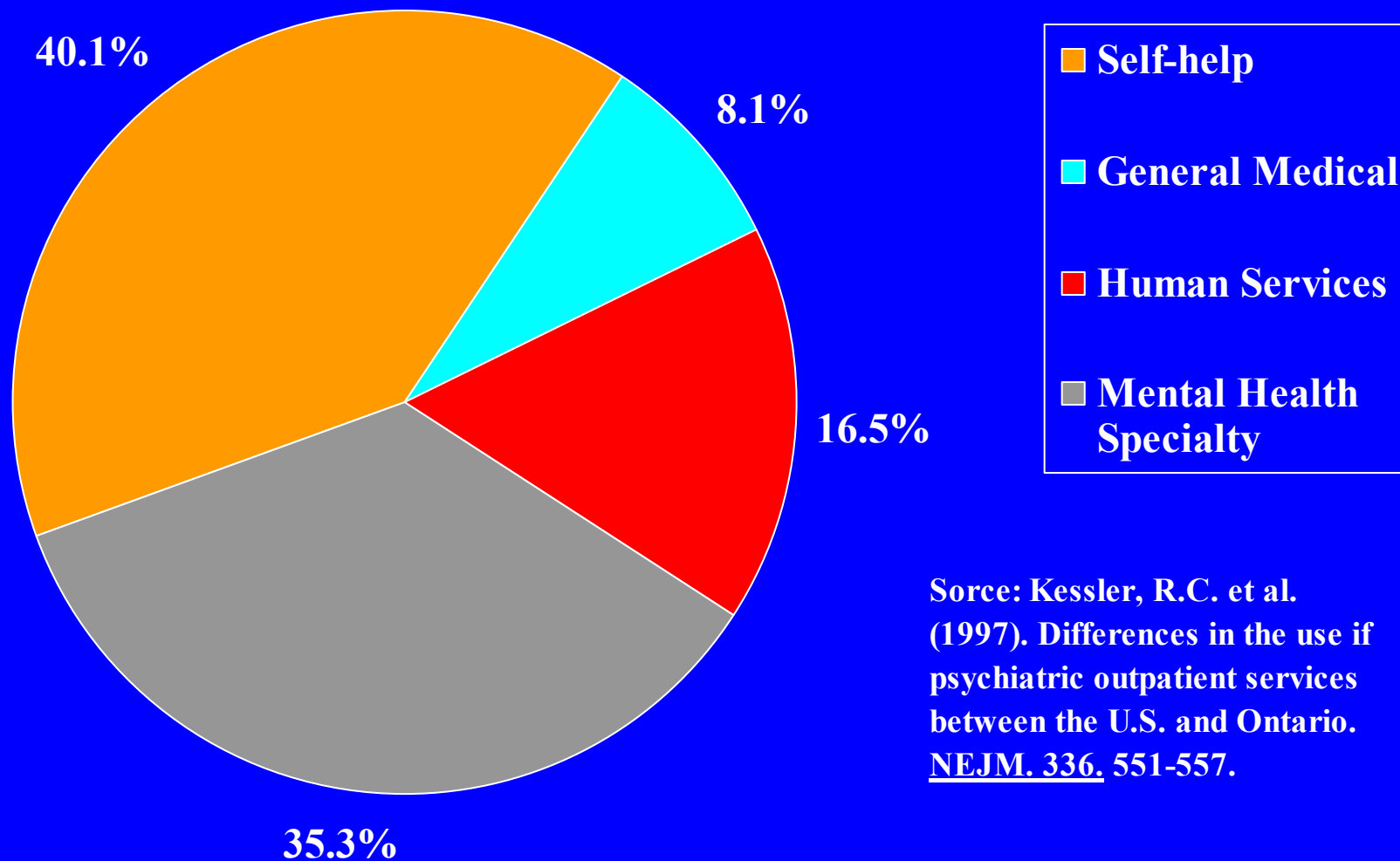
Lifetime and past 12 months participation in self-help groups, 1995



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



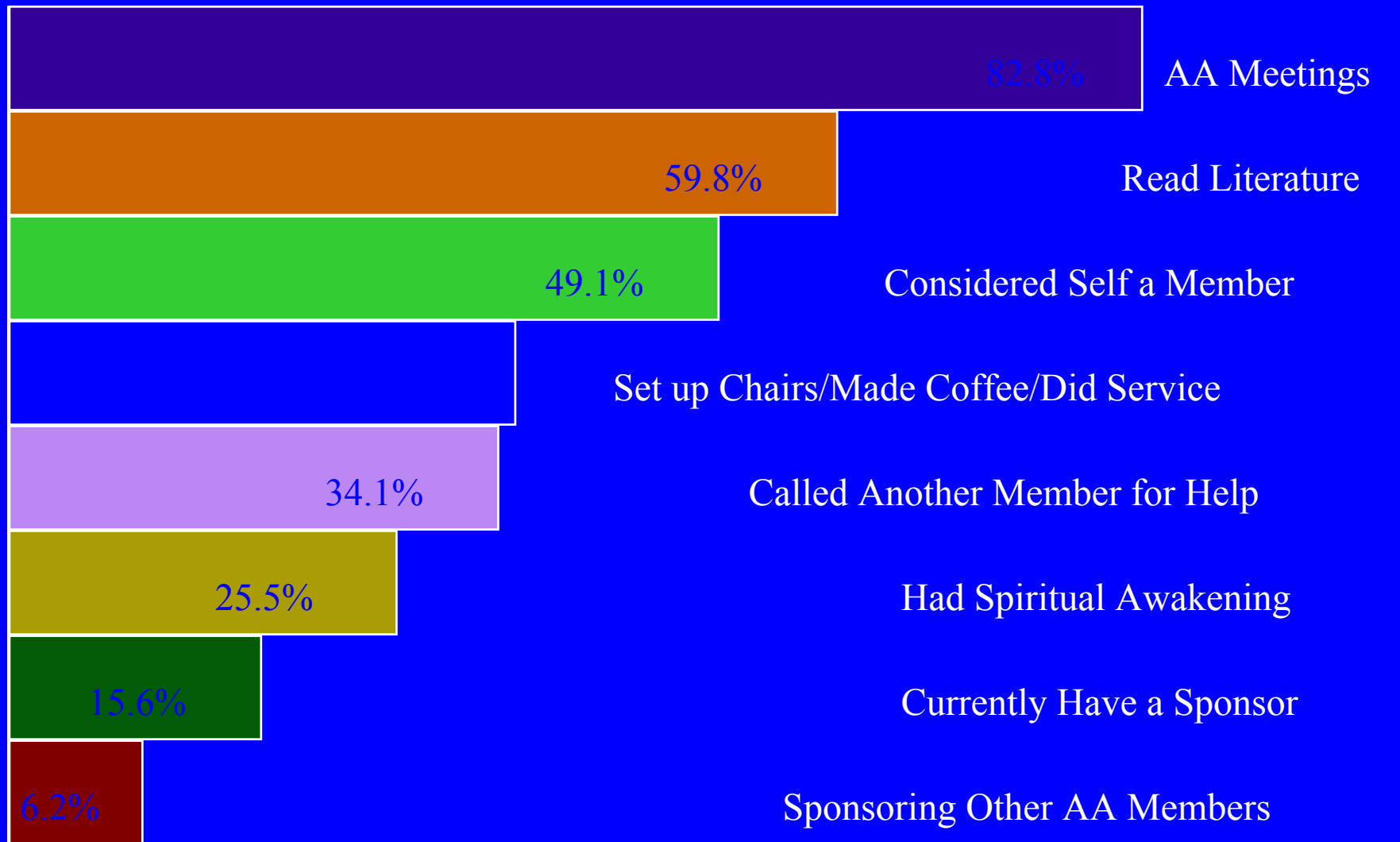
Source: Kessler, R.C. et al. (1997). Differences in the use of psychiatric outpatient services between the U.S. and Ontario. NEJM. 336. 551-557.

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

	<u>Estimated Number of Groups Worldwide</u>
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

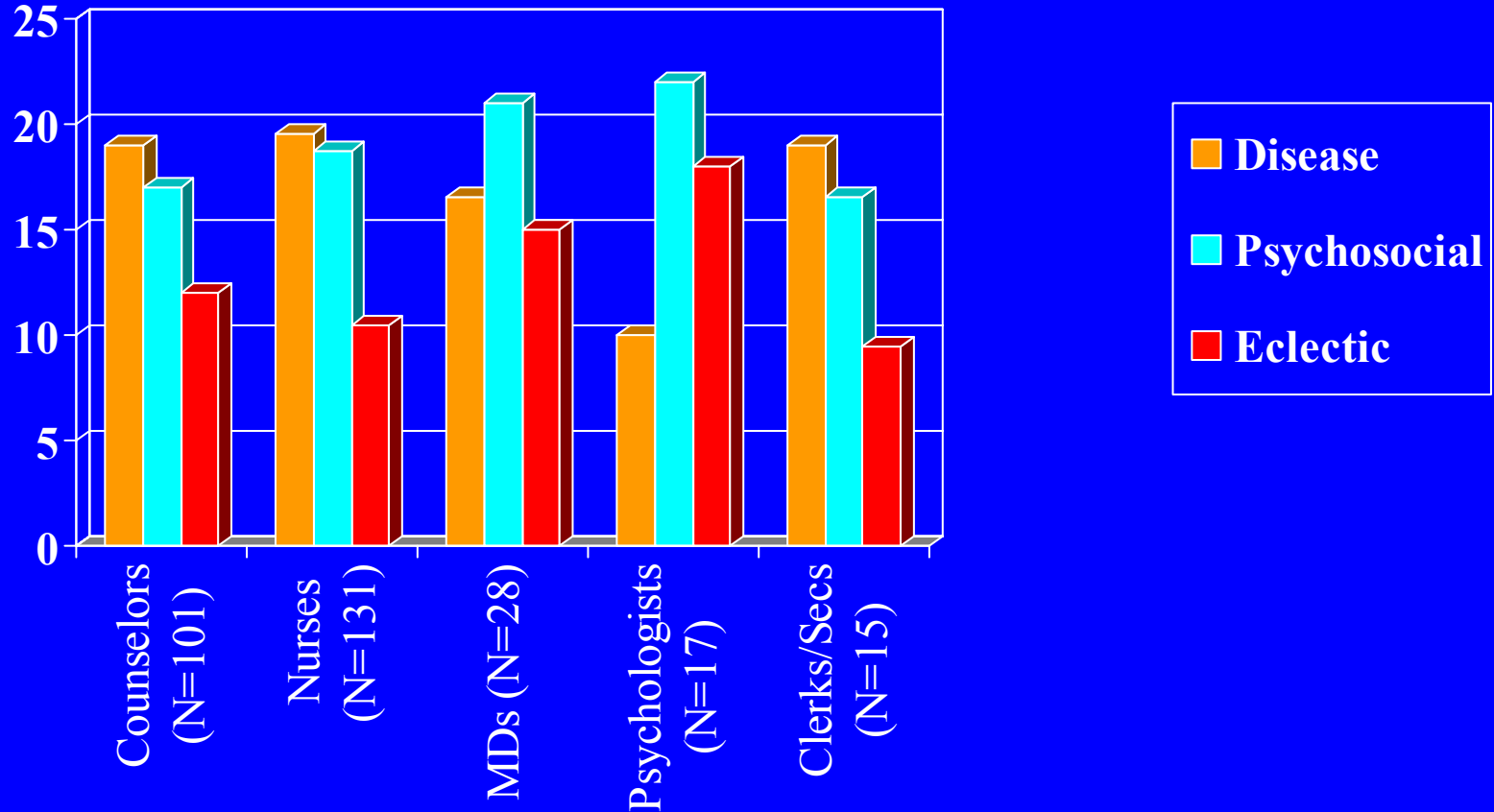
Pretreatment AA experiences of 927 alcohol treatment seekers



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

100%

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 Addictive 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)	<u>Dominant Treatment Orientation</u>			<u>F (2, 386)</u>
		12 Step (n=152)	CB (n=200)	Psychodynamic (n=37)	
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	
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

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	AA	Outpatient	X²(df=1)
	(n=201)	(n=135)	(n=66)	
	%	%	%	
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 (df=199)
	mean	SD	mean	SD	mean	SD	
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)		Outpatient group (N=66)		F (df=1,199)
	Mean	<i>SD</i>	Mean	<i>SD</i>	
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**

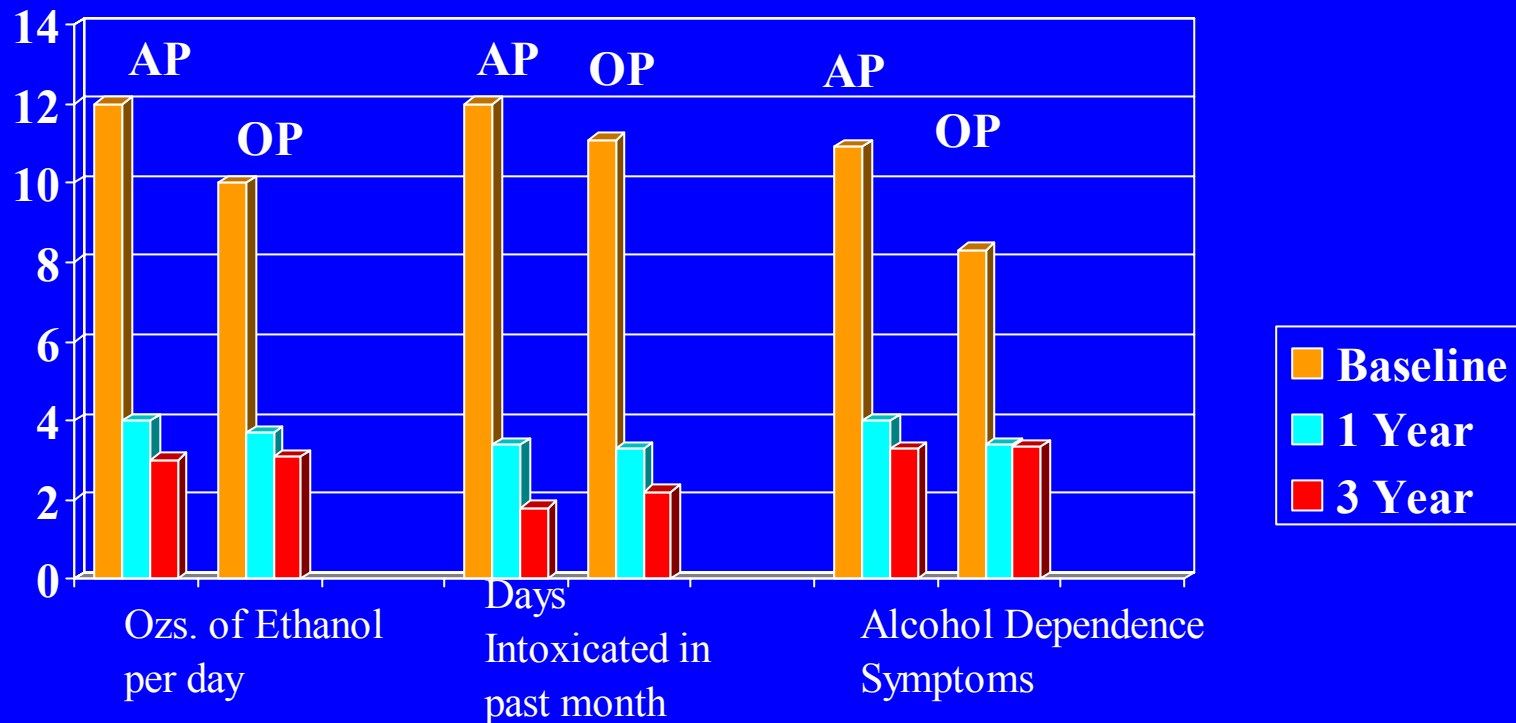
Note. *p<.05 **p<.005

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)		Outpatient group (n=66)		F (df=1,199)
	mean	SD	mean	SD	
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.

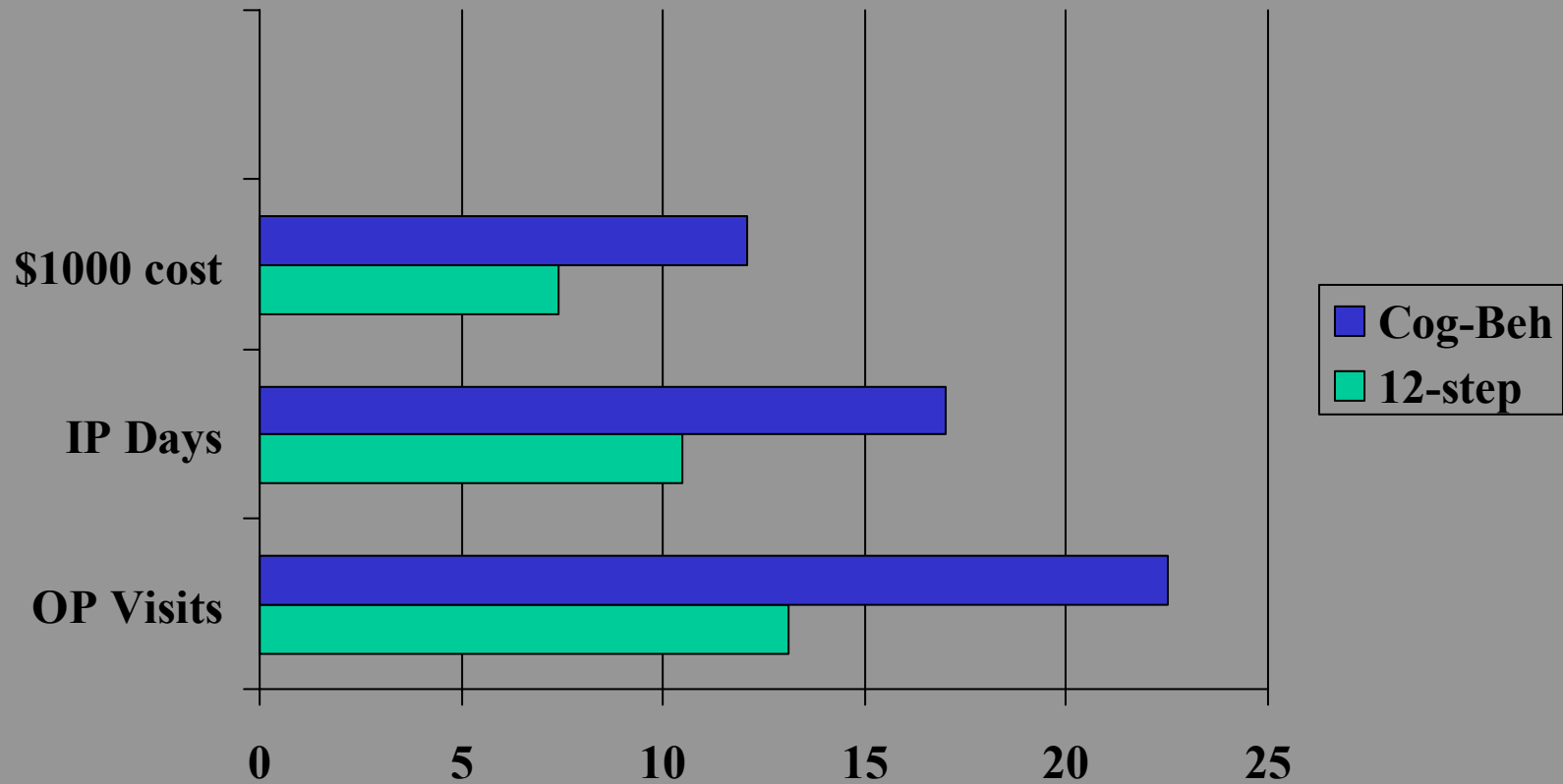
Replication of findings in Department of Veterans Affairs Sample

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

Comparison Groups

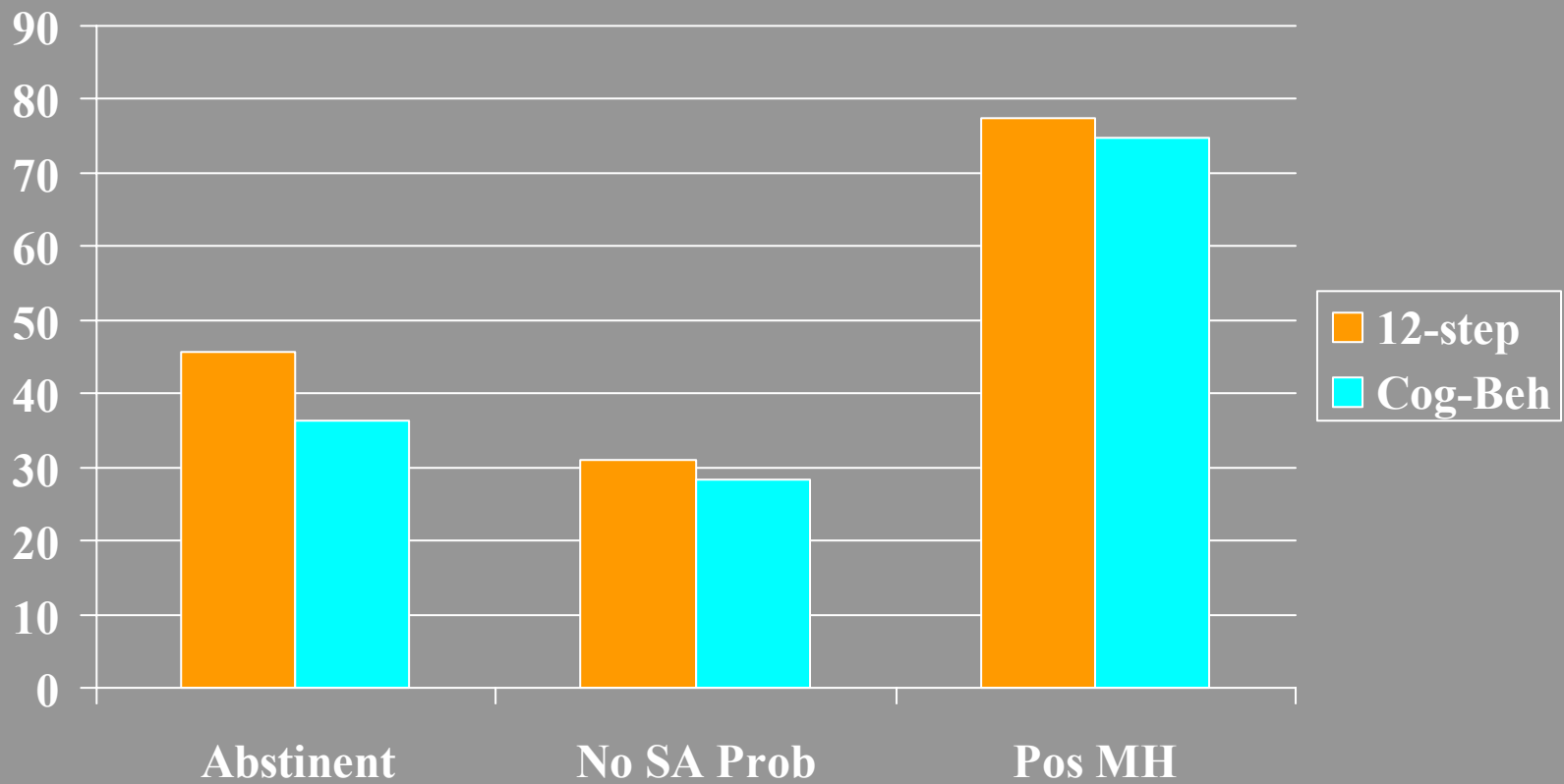
- **887 Admissions each were recruited from the 12-step and cognitive-behavioral treatment condition**
- **At intake, groups did not differ on substance abuse problems, psychiatric problems, demographic variables, prior health care utilization, or prior involvement in self-help groups**

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

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

Design: Patients 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%

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.