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How safe are adolescents at AA and NA meetings? A prospective investigation with outpatient youth

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Abstract

Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) have proven to be cost-effective recovery resources for adults and also appear helpful for youth. However, anecdotal concerns about adolescents' safety at meetings have dampened enthusiasm regarding youth participation. Unfortunately, little information exists to evaluate such concerns. Outpatients ($N = 127$; 24% female) were assessed at intake, and 3, 6, and 12-months regarding perceived safety at AA/NA, experience of negative incidents, and reasons for non-attendance/discontinuation. By 12-month follow-up, 57.5% reported some AA/NA attendance with a combined lifetime exposure of 5,340 meetings. Of these, 21.9% reported at least one negative experience, which was more common among NA than AA attendees. Overall, youth reported feeling very safe at meetings and ratings did not differ by age or gender. Reasons for discontinuation or non-attendance were unrelated to safety or negative incidents. Weighing risks against documented benefits, these preliminary findings suggest referral to AA/NA should not be discouraged, but, similar to adults, youth experiences at meetings should be monitored.

Keywords

Adolescents; iatrogenic; safety; Alcoholics Anonymous (AA); Narcotics Anonymous (NA)

1. Introduction

1.1 Relapse and the use of 12-step organizations as continuing care

During the past 10 years, there has been increased attention focused on substance use disorder (SUD) interventions among adolescents (e.g., Cannabis Youth Treatment Group [Dennis et al., 2004]; Adolescent Treatment Models [Substance Abuse and Mental Health

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Services Administration, 2004]). Yet, relapse rates remain high (Dennis et al., 2004) and continuing care participation low; only about one-third of youth from either inpatient or outpatient settings engage in continuing care (Godley, Godley, Dennis, Funk & Passetti, 2007). Treatment effects tend to decay quite quickly following the withdrawal of treatment (Hunt, Barnett, & Branch, 1971; McLellan, 2002), highlighting the need for ongoing support.

Perhaps in tacit recognition of this, peer-led 12-step mutual-help groups (MHGs), such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), have emerged and proliferated during the past 75 years (Humphreys, 2004; Kelly & Yeterian, 2008). Furthermore, professional programs for both adolescents and adults have incorporated aspects of 12-step philosophy into treatment and most refer patients to AA and NA at discharge (Humphreys, 2004; Kelly, 2003; Tonigan, Toscova, & Miller, 1996; Roman & Blum, 1999).

Among adolescent-specific SUD treatment programs in the US, on average, only 9% are based solely on 12-step philosophy, but nearly half (47%) require participation in 12-step MHGs during treatment and 85% report linking their adolescent patients with AA or NA groups as a continuing care resource (Kelly, Yeterian, & Myers, 2008; Knudsen, Ducharme, Roman, & Johnson, 2008). However, while these resources appear to be seen as a valuable adjunct to professional care for adolescents, there is considerable variability across different programs and among providers within programs. Thus, despite numerous studies revealing recovery-related benefits related to adolescent AA and NA participation (Chi et al, 2009; Kelly & Myers, 2007; Sussman, 2010), anecdotal clinical concerns about adolescents' safety at these predominantly adult organizations continue to dampen enthusiasm in some programs

1.2. Therapeutic benefits of 12-step mutual-help groups and safety concerns

Results from a number of prospective, statistically controlled, naturalistic studies support the clinical utility of 12-step MHG referrals for young people, especially those with more severe substance-involvement. Youth appear to benefit from AA/NA participation at clinically meaningful levels (Chi, Kaskutas, Sterling, Campbell, & Weisner, 2009; Kennedy & Minami, 1993; Kelly et al., 2008; Kelly, Dow, Yeterian, & Kahler, 2010; Winters, Stinchfield, Latimer, & Lee, 2007). In a prior report using the current outpatient adolescent sample, we found that AA/NA participation during the first 3 months of follow-up was independently associated with an increase in percent days abstinent both concurrently and subsequently (at a 6-month follow-up), after controlling for prior professional SUD treatment, prior AA/NA participation, abstinence goal, abstinence self-efficacy, and concomitant outpatient treatment. This study also found that greater staff encouragement to attend AA/NA, as reported by the adolescents, was associated with greater frequency of attendance, but the proportion of outpatient youth attending was relatively low (Kelly et al., 2010). If clinicians, parents, or adolescents themselves believe these community groups to be unsafe, therapists and parents may be less likely to refer or encourage participation and youth will be less likely attend.

One common anecdotal concern is that since the majority of 12-step groups consist of mostly adult participants with longer and more severe substance use histories (Alcoholics Anonymous [AA], 2008; Narcotics Anonymous [NA], 2008), youth may be captivated by stories of as yet untried substances, which may lead to subsequent experimentation and iatrogenic effects (Kaminer, 2005; Macgowan & Wagner, 2005). Also, the predominantly adult composition of most AA and NA groups may lead to adolescents feeling unsafe and more vulnerable to negative predatory influences. This may relate to a lack of monitoring during AA and NA meetings - a factor that has been associated with iatrogenic effects in professional treatment (Moos, 2005). To date, little, if any, empirical information is

available to support or challenge this notion, despite significant clinical and parental concerns. Furthermore, some clinicians and parents express the belief that some recovery organizations, such as AA, may be safer than others, such as NA, perhaps relating to the licit and illicit nature of the substances and associated subcultures with which each organization is primarily concerned. Also, nothing is documented regarding how gender and age may relate to safety at 12-step meetings. Specifically, it is believed by some that females may be more prone to sexual harassment among the male majority inherent in 12-step groups and that younger adolescents might be more vulnerable and at risk as they lack the social maturity and life-experience of older youth.

1.3 Study aims

To start to bridge this knowledge gap, we conducted a prospective study with outpatient youth wherein adolescent patients were asked about their 12-step attendance, perceptions of safety at meetings, and whether they had ever felt intimidated, threatened, or sexually harassed at a meeting. Youth were also asked to report reasons for not attending 12-step meetings at all or for discontinuing 12-step attendance, as well as reasons for liking or disliking meetings. These open-ended questions were evaluated to determine whether any reasons were related to safety concerns or negative experiences. Finally, parents of teens were asked about their perceptions of adolescents' safety at AA/NA meetings and whether they had ever attended 12-step meetings, and clinic staff in addition to their perceptions of adolescents' safety, were asked about adolescent barriers to AA or NA meeting attendance, which were evaluated with regard to safety.

2. Method

2.1 Participants and procedure

Participants were adolescents who presented for treatment at a private outpatient SUD treatment facility in the Northeastern U.S. between August, 2006 and May, 2009 and agreed to enroll in a one-year naturalistic follow-up study of outpatient treatment effectiveness. Individuals were eligible if they (a) were within their first month of treatment at this facility, (b) were between the ages of 14 and 19 at the time of study entry, (c) had a parent/guardian consent to participation (if under 18), and (d) were English-speaking. Exclusion criteria were (a) active psychosis or (b) having an organic brain/cognitive disorder affecting comprehension of the study and its risks and benefits. Of the 160 adolescents who were eligible to participate in the study, 95% ($n = 152$) agreed to be contacted by study staff and 127 (79.4%) were enrolled. Follow-up rates were 91% at 3-months, 84% at 6-months, and 87% at 12-months.

The final sample was 75.6% male, 86.6% White, and 16.7 years old ($SD = 1.2$) at the time of study entry. At baseline, most participants were living at home with at least one parent (93.7%), enrolled in school (75.6%), not employed (56.8%), and justice system involved (50.4%). Marijuana was the most commonly reported drug of choice at baseline (70.9%), followed by alcohol (11.8%), heroin/narcotics (11.1%) and cocaine/amphetamines (3.2%). The vast majority (93.7%) met lifetime DSM-IV criteria for a substance use disorder, with marijuana dependence being the most common (57.5%). Approximately 61% of the sample met DSM-IV criteria for at least one past-year Axis I condition other than SUD, with the most common being conduct disorder (41.3%).

2.2 Measures

Adolescent AA/NA attendance, safety ratings, negative incidents, and reasons for nonattendance or dropout—The Timeline Follow-Back (TLFB; Sobell&Sobell, 1992) was used to record the frequency of AA/NA attendance in the past 90 days at

baseline, 3 months, and 6 months and in the past 180 days at 12 months.. At each timepoint, participants who had ever attended AA or NA were asked to rate how safe they felt at AA or NA (separately) on a scale of 1 (*not at all safe*) to 10 (*completely safe*). Youth also were asked a single question as to whether they had ever experienced an incident at an AA or NA meeting (separately) where they had felt intimidated, threatened, or sexually harassed (coded 0 = no; 1 = yes). Using an open-ended question format, participants who had not attended AA or NA were asked to state reasons why they had not attended and participants who had attended AA or NA and then stopped were asked why they stopped going. In addition, youth were asked open-ended questions as to what they liked and disliked about AA and NA meetings. Because youth could give more than one reason to each of these open-ended questions, the total number of reasons exceeds the sample size.

Parent Safety Ratings—Parents of participants were asked at treatment intake to complete a questionnaire regarding their opinions of AA/NA, regardless of whether their child had ever attended AA/NA. Parents rated how safe they felt their adolescent is or would be at AA/NA meetings on a scale of 1 (*not at all safe*) to 10 (*very safe*; assessed as a single variable) and whether they themselves had ever attended a 12-step meeting.

Staff Safety Ratings—Staff at the outpatient treatment facility were asked to complete a questionnaire regarding their opinions of AA/NA. Staff rated how safe they believe adolescents are at AA/NA meetings on a scale of 1 (*not at all safe*) to 10 (*very safe*) and were given the opportunity to make note of any important barriers to adolescent involvement in AA/NA in an open-ended question. Staff also provided information on how long they had worked in the addiction field, which was examined in relation to perceptions of safety.

3. Results

3.1 Adolescents' AA and NA participation and related safety ratings

The percent of youth reporting any lifetime exposure to 12-step meetings by the end of the 12-month follow-up was 57.5%. Table 1 shows attendance at each time point, the average number of meetings attended in total and by fellowship type (i.e., AA or NA), and perceptions of safety. Between a quarter and one third of youth outpatients reported attending either AA or NA in any given follow-up period, with participants reporting attending between 1 and 3 meetings per week. As shown, the proportion attending at intake, 3-, 6-, and 12-month follow-ups were 27.6%, 27.7%, 23.7%, and 27.9%, respectively. Average frequency of attendance showed an increasing trend over time, except for attendance at NA from 6-month to 12-month follow-up. Youth perceptions of safety were uniformly high among participants and across time, although perceived safety of NA was generally rated lower than AA. At baseline and 3-month follow-up, there was a trend for NA to be perceived as less safe as compared to AA ($t(21) = 1.94, p = 0.06, t(22) = 1.88, p = 0.07$, respectively). However, the difference in safety ratings between NA and AA attendees was not significant at the 6- or 12-month follow-ups ($t(25) = 0.69, p = 0.50, t(36) = 0.77, p = 0.47$, respectively).

To test whether attendance and safety ratings were related to age or gender, we computed point biserial and Spearman correlations, respectively. There was a statistical trend for older youth at intake ($p = .065$) and at the 3-month follow-up ($p = .094$) to attend more 12-step meetings, but this trend was not apparent at the 6- or 12-month follow-ups. There was no relation between age and perceived safety ($ps > .11$). Gender was not related to attendance or ratings of perceived safety at any timepoint ($ps > .10$). Furthermore, there was no difference in safety ratings between those youth who reported attending AA/NA at multiple study

timepoints ($n = 38$, $M = 8.77$, $SD = 1.65$) and those who reported attending AA/NA at only one timepoint ($n = 22$, $M = 8.35$, $SD = 2.26$), $t(58) = -0.84$, $p = .41$.

3.2 Reported prevalence of negative incidents at AA or NA

Of those youth reporting at least some lifetime exposure to 12-step meetings (57.5%; $N = 73$), 21.9% reported at least one incidence of feeling intimidated, threatened, or sexually harassed at a meeting.

More NA attendees reported incidents (17.8%) compared to AA attendees (11.0%; $\chi^2 = 12.3$, $p < .001$). There was no significant relationship detected between gender and reporting of negative incidents at 12-step meetings, with females being no more likely than males to report negative incidents at any time point ($ps > .14$). Age was marginally related to reporting an incident, with younger adolescents somewhat more likely than older adolescents to report a negative incident, but only at the 3-month follow-up point ($p = .076$).

We also tested whether those who reported a negative incident at AA or NA at study intake or across the follow-up period were more likely to perceive 12-step MHG meetings as less safe. No differences were observed between youth reporting an incident as compared to those who did not at baseline, 6-, or 12-months ($ps > .15$). However, there was a difference at 3-month follow-up, with those reporting an incident ($M = 6.19$; $SD = 2.5$) reporting a significantly lower safety rating than those youth who did not ($M = 9.04$; $SD = 1.7$; $t(7) = 3.12$, $p = .01$).

3.3 Adolescents' reported reasons for not attending AA or NA or ceasing 12-step attendance

Participants with no 12-step attendance at any time point were asked to give reasons for not attending. Out of a total of 254 responses (generated from 75 individuals at intake, 57 at 3-month, 48 at 6-month, and 39 at 12-month), none of the reasons for not attending were related to concerns about safety. Similarly, of the 259 reasons for disliking AA/NA (generated by 52 individuals at intake, 59 at 3-month, 57 at 6-month, and 69 at 12-month), and the 152 reasons reported for discontinuing attendance (generated from 26 individuals at intake, 33 at 3-month, 34 at 6-month, and 46 at 12-month) only one reported reason was related to harassment: "People coming drunk and harassing others." No other responses were related to safety concerns or incidences of feeling threatened, intimidated or sexually harassed. Of the 296 reasons for liking AA or NA (generated by 52 individuals at intake, 59 at 3-month, 57 at 6-month, and 69 at 12-month), two participants mentioned AA/NA being "a safe place to talk" and "feeling safe."

3.4 Parents' safety ratings

Parents' ratings of safety for their child's attendance at AA or NA meetings was generally high ($M = 7.6$, $SD = 2.2$), and somewhat lower than youth safety ratings ($M = 8.6$, $SD = 2.0$), although not significantly so ($p > .05$). There was no significant relationship observed between parents' safety ratings and their child's safety rating or between parent's safety ratings and their child's report of negative incidents at any follow-up time point. The percentage of youth participants whose parents reported ever attending a 12-step meeting was almost one third (32.3%). At baseline, adolescents' safety ratings were significantly and negatively related to parents' AA/NA attendance ($r = -.29$, $p = .04$), such that adolescents tended to give a higher safety rating if their parents reported never having been to an AA or NA meeting. There were no significant relationships between parents' AA/NA attendance and either their adolescents' safety ratings at any other time point or reported negative incidents at any time point ($ps > .22$).

3.5 Treatment facility staff ratings of safety and related barriers

Clinical staff ($N = 7$; 88% of those surveyed; M years of experience in the field = 20; $SD = 9.6$) rated safety of their adolescent patients' attendance at 12-step meetings as generally high ($M = 7.9$, $SD = 1.8$). Additionally, no staff at this outpatient facility mentioned safety concerns as being a potential barrier to 12-step attendance among youth.

4. Discussion

This is the first study to directly address concerns about youth safety at community 12-step meetings. By the 12-month follow-up, almost 58% ($n=73$) reported at least some AA/NA attendance with a combined lifetime exposure of 5,340 meetings. From these, 21.9% ($n=16$) reported at least one negative meeting experience, which was more common among NA than AA attendees. Overall, youth reported feeling very safe at meetings and safety ratings did not differ by age or gender, although compared to AA, there was a trend for NA to be rated as less safe. Reasons for discontinuation or non-attendance were unrelated to safety or negative incidents.

Overall, approximately one in five youth AA and NA attendees reported feeling intimidated, threatened, or sexually harassed at some point during their lifetime AA or NA meeting exposure, with NA attendees reporting these incidents proportionately more than AA attendees. Of the total amount of AA/NA meeting exposure in our sample (5,340 meetings), however, such negative experiences may be rare. For instance, the 16 youth (21.9%) who reported a negative incident (from the 73 exposed to an AA/NA meeting), accounted for 38% (2,020) of attended meetings. In addition, despite some reports of negative incidents, this did not appear to deter youth from attending. Furthermore, from several hundred reported reasons for not attending or discontinuing community 12-step meeting attendance, none were related to safety concerns. Parents and clinical staff, in general, also perceived adolescents' attendance at AA and NA meetings to be safe and staff did not mention safety as a barrier to AA or NA attendance. Compared to older youth, there was a trend for younger adolescents to attend fewer meetings during and early following treatment, and also to report feeling intimidated, harassed or threatened, albeit only at the 3-month follow-up. Although future research should confirm the robustness of such findings, this may reflect tendencies for less substance-involved younger adolescents to find AA and NA groups somewhat more intimidating and less relevant. Consequently, they choose to attend less or their parents decide that attendance may not be necessary.

Results suggest that young people generally feel safe at 12-step mutual-help recovery meetings, but a significant minority do report some negative incidents, which may be more common for NA than AA attendees. It is unclear as to why exactly NA may be associated with more negative experiences than AA. It may relate to the illicit nature of the substances of focus in NA that may correlate with more antisocial characteristics or possible gang-related histories among its members. Given the potential for a more clinically relevant match with NA rather than AA for many young people whose primary substance is not alcohol, future research should examine this in more detail.

Our findings suggest that although concerns about safety may have a legitimate basis, they may be overstated. After all, it is also critical to consider the alternatives to AA or NA. Given these young people have to be somewhere, the question arises as to whether being alone, or in another social or physical environment (e.g., with former friends, on the street, or in parks) constitutes higher or comparable risk while bestowing a similar level of potential recovery benefit as that which might be conferred by attending AA or NA. In order to minimize risk and maximize attendance and any related therapeutic benefit, clinicians could assess safety for youth attending 12-step meetings and inquire about the exact nature

of any reported incidents to help determine whether the perceived risks constitute opportunities for personal recovery growth, or whether the nature of the risks indicate evasive action should be taken. Such reports will need to be weighed regarding risks and benefits within a broader recovery context.

4.1 Limitations

There are some important limitations which should be noted in this study. First, the primary aims of the main investigation were not to explicitly address safety concerns of adolescents attending 12-step meetings. As such, the questions posed were not as detailed as they ultimately need to be. For example, youth were asked how “safe” they felt at AA or NA, but the notion of safety can be interpreted in many different ways. For example, someone trying to stay abstinent from substances may interpret “safety” as being offered drugs at an NA meeting, whereas someone else might perceive it to pertain to physical safety. This was not explicitly differentiated in this study. Further studies should define and ask about safety concerns on a variety of different levels.

Furthermore, regarding reports of negative incidents, we do not know exactly what made these young people feel unsafe or the extent to which negative incidents posed *actual* safety risks. For instance, a large meeting size or a sponsor’s years of sobriety may make any newcomer feel “intimidated,” regardless of age. In this study intimidation was combined in the *same* question as sexual harassment and feeling threatened. Consequently, we do not know the actual prevalence of each of these very different types of experiences. Future studies should focus on differentiating these types of incidents, as well as the extent to which these pose an actual threat. Also, since safety concerns or incidents have not been reported among adults, we do not know how these figures compare to adult AA/NA-exposed samples, making it impossible to know the extent to which these results are specifically related to adolescents’ developmental status or other factors. Finally, the sample size was somewhat small and thus trends toward statistical significance must be interpreted with caution as our study has limited statistical power.

4.2. Conclusions and Future Directions

Referral to AA and NA community mutual-help groups appears to be a common clinical practice among adolescent SUD treatment providers nationally (Knudsen et al., 2008). Increasing empirical evidence suggests such referrals may have clinical utility, as AA and NA may provide a cost-effective and easily accessible way to help sustain recovery (Kelly et al., 2008). Yet, anecdotal concerns pertaining to adolescents’ safety at meetings have remained. Findings here suggest exposure to 12-step meetings is common among outpatient youth, that outpatient youth report feeling very safe at these groups overall, but that some report negative experiences. While we cannot ascertain how frequently these youth experienced negative events, it would seem that as a function of total 12-step meeting exposure, this may be quite rare. Furthermore, from several hundred reported reasons given for disliking, discontinuing, or not attending AA or NA only one was related to safety.

Iatrogenic or side effects from any psychosocial or pharmacological treatment must be weighed within the context of overall potential benefit (Kaminer, 2005; Macgowan & Wagner, 2005; Moos, 2005). While it is important that more detailed research is conducted in this regard, placing these findings in the context of the empirical evidence regarding the ability of AA and NA to enhance and extend treatment benefits for young people at no cost, our study suggests youth should not be discouraged from attending AA or NA groups due to potential safety concerns. Rather, similar to adult patients clinicians should continue to monitor adolescents’ 12-step experiences and assess the specific nature of any reported concerns in order to address them appropriately and with maximum therapeutic benefit.

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Table 1

Percent attending, average attendance, and safety ratings

	Baseline			3-month follow up			6-month follow up			12-month follow up		
	Total	AA	NA	Total	AA	NA	Total	AA	NA	Total	AA	NA
% attending (N)	27.6 (35)	26.8 (34)	9.4 (12)	27.7 (33)	25.0 (28)	5.2 (5)	23.7 (27)	20.6 (22)	8.4 (9)	27.9 (31)	27.9 (31)	10.8 (12)
M % (SD) days attended	22.5 (27.0)	15.9 (19.6)	23.8 (36.7)	19.2 (24.7)	24.4 (22.1)	26.7 (41.4)	27.1 (22.9)	21.2 (14.8)	29.1 (34.2)	34.4 (30.9)	29.3 (29.7)	14.1 (20.5)
Median days attended	8.9	8.3	4.4	8.9	14.4	14.4	27.2	20.0	21.1	27.8	16.1	8.8
Safety ratings	8.7 (2.3)	9.0 (1.8)	7.5 (3.1)	8.6 (2.0)	8.8 (2.1)	7.5 (2.6)	8.5 (2.1)	8.5 (2.1)	8.0 (3.0)	8.3 (2.4)	8.5 (2.3)	8.0 (3.0)

% attending = at least one meeting; M % days AA/NA attended = among those attended in the past 90 days at baseline, 3- and 6-month follow-up and 180 days at 12-month follow-up. Safety ratings = 1 ‘not at all safe’ to 10 ‘completely safe’.