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12-Step Interventions and Mutual Support Programs for Substance Use Disorders: An Overview

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Abstract

Social workers and other behavioral health professionals are likely to encounter individuals with substance use disorders in a variety of practice settings outside of specialty treatment. 12-Step mutual support programs represent readily available, no cost community-based resources for such individuals; however, practitioners are often unfamiliar with such programs. The present article provides a brief overview of 12-Step programs, the positive substance use and psychosocial outcomes associated with active 12-Step involvement, and approaches ranging from ones that can be utilized by social workers in any practice setting to those developed for specialty treatment programs to facilitate engagement in 12-Step meetings and recovery activities. The goal is to familiarize social workers with 12-Step approaches so that they are better able to make informed referrals that match clients to mutual support groups that best meet the individual's needs and maximize the likelihood of engagement and positive outcomes.

Keywords

12-Step; mutual support; self-help; recovery activities

INTRODUCTION

Substance use disorders (SUDs) are highly prevalent and negatively affect physical, psychological, social, legal, vocational, familial, educational, and other areas of life function. Because of the widespread problems associated with alcohol and drugs, and given that the majority of individuals with SUDs do not seek substance abuse treatment, social workers and other behavioral health professionals are likely to encounter individuals with SUDs in a variety of practice settings outside of specialty treatment (Caldwell, 1999; Kelly & McCrady, 2008). Recognizing this with respect to problematic alcohol use, the Institute of

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Medicine (1990) recommended broadening the base of alcohol treatment beyond specialty programs to medical, mental health, and social service agencies where the prevalence of hazardous or harmful drinking is likely to be relatively high. As health care reform is currently moving forward, an increasing amount of care for SUDs will be provided in nonspecialty settings, and social workers and other professionals will need to become more facile in identifying and intervening with individuals with alcohol and drug problems. However, given all the constraints faced by providers in nonspecialty settings and given generalist training without a specialized focus on SUDs, many professionals in such settings feel ill prepared to address SUDs. They also may feel that there are few resources available to which such clients with alcohol and drug problems can be referred and that provide a likelihood of success. Practitioners often fall back on Alcoholics Anonymous (AA) or other 12-Step self-help groups, discharging their responsibility to do something, because they are readily available and free, but lack conviction that such programs will be effective or that the client will go.

This article provides a brief overview of 12-Step programs; the positive substance use, psychosocial, quality of life, and cost-offset outcomes associated with active 12-Step involvement; and approaches ranging from ones that can be utilized by social workers in nonspecialty practice settings to those developed for specialty treatment programs to facilitate engagement in 12-Step meetings and recovery activities. The goal is to familiarize social workers and other behavioral health providers with 12-Step approaches so that they are better able to make informed referrals that match clients to mutual support groups that best meet the individual's needs and maximize the likelihood of engagement and positive outcomes (Caldwell, 1999; Humphreys, 1997; Kelly & McCrady, 2008).

EPIDEMIOLOGY OF 12-STEP PROGRAMS AND MEMBERS

There are many paths to recovery from alcohol and SUDs, and one that has been travelled by many and is associated with positive long-term outcomes is involvement in 12-Step and mutual/self-help groups (Laudet, Savage, & Mahmood, 2002; Moos & Moos, 2005, 2006). Such groups, including Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA) and a number of others (Laudet, 2008), have served as the primary, if not only, source of behavior change for many, as adjuncts to formal treatment, or as a form of continuing care and community support following treatment. These groups are highly accessible and are available at no cost in communities throughout the world, thus serving as important and readily available resources in substance abuse recovery.

In 2006 and 2007, an annual average of five million individuals age 12 or older in the United States attended a self-help group as a means of trying to deal with alcohol or drug use issues (Substance Abuse and Mental Health Services Administration, 2008). Of this number, approximately 45% attended because of alcohol only, 22% because of illicit drug use only, and 33% because of alcohol and illicit drug use. About one third of those who attended a self-help group in the past year had also been involved in some type of formal treatment over that same period. Conversely, about two thirds of those who were involved in substance abuse treatment during the past year also attended a self-help group. As of January, 2012, the AA General Service Office estimated that there were nearly 64,000 groups with 1.4 million members in the United States and Canada, and a worldwide estimate of more than 114,000 groups and 2.1 million members (Alcoholics Anonymous [AA], 2012). The membership has increased steadily over the past four decades (Kaskutas, Ye, Greenfield, Witbrodt, & Bond, 2008). Narcotics Anonymous (NA; 2010b) has similarly expanded to become an international network of support groups, with more than 58,000 weekly meetings in 131 countries. Cocaine Anonymous (CA; 2011) has grown from its origins in 1982 to more than 30,000 members and 2,000 groups internationally by 1996. In

addition, AA, NA, and CA all have Internet-based "chat" rooms and online meetings that can be found easily by doing an online search (e.g., "online NA meetings"); these online resources are viewed as ways to supplement, not replace, attending meetings in person. The only requirement for membership in 12-Step groups is a desire to stop drinking and/or using drugs. There is also a strong emphasis placed on service and helping other members get and stay clean and sober.

The 12-Step philosophy refers to a particular view of the recovery process. It emphasizes the importance of accepting addiction as a disease that can be arrested but never eliminated, enhancing individual maturity and spiritual growth, minimizing self-centeredness, and providing help to other individuals who are addicted (e.g., sharing recovery stories in group meetings, sponsoring new members; Humphreys et al., 2004). Self-help groups based on this philosophy outline 12 consecutive activities, or steps, that substance abusers should achieve during the recovery process. These steps specify that substance abusers must admit their powerlessness over alcohol and drugs, take a moral inventory of themselves, admit the nature of their wrongs, make a list of individuals whom they have harmed, and make amends to those people. Involvement in such groups is meant to provide participants with support for remaining substance free, a social network (the "fellowship") with which to affiliate, and a set of 12 guiding principles (the "steps") to be followed in the recovery process (Kaskutas, Bond, & Humphreys, 2002). The general guidelines for recovery based on this philosophy have been distilled down to what has been described as the 12-Step "six pack": don't drink or use drugs, go to meetings, ask for help, get a sponsor, join a group, and get active (Caldwell & Cutter, 1998).

EFFECTIVENESS OF 12-STEP PROGRAMS

Although such mutual support groups are readily available, an important question is whether they are effective in achieving their goal of members becoming alcohol and drug free. Each of the three main 12-Step programs conducts periodic surveys of its members to assess demographic characteristics and to determine the length of members' abstinence. Table 1 provides information from the most recently available AA, NA, and CA membership surveys. Although viewed as not being scientifically rigorous and as based on self-selected convenience samples, the findings with respect to meeting attendance and length of abstinence are of interest. The median length of abstinence reported by AA and NA members is greater than 5 years, with roughly one third of each of the three groups having between 1 to 5 years of abstinence. Respondents reported attending, on average, two to four meetings per week. These findings, given the caveats about sample representativeness and the correlational nature of the results, suggest that longer term abstinence is achievable and sustainable among those with relatively regular meeting attendance.

The results from a number of recent empirical studies corroborate the results from these mutual support group membership surveys, supporting the clinical effectiveness of 12-Step approaches. Reviews of this literature (Humphreys, 2003; Humphreys et al., 2004; Kaskutas, 2009; Krentzman et al., 2010; Owen et al., 2003) have noted, among other positive findings, that AA and NA participation is associated with greater likelihood of abstinence, often for prolonged periods up to 16 years (Moos & Moos, 2006), improved psychosocial functioning, and greater levels of self-efficacy. Beginning 12-Step participation while in treatment, especially at group meetings held at the treatment program, and 12-Step attendance at the same time that one is enrolled in specialty treatment, are associated with better outcomes. In addition, consistent, early, and frequent attendance/involvement (e.g., three or more meetings per week) is associated with better substance use outcomes. Although even small amounts of participation may be helpful in increasing abstinence, higher "doses" may be needed to reduce the likelihood of relapse. Engaging in other 12-Step

group activities (e.g., doing service at meetings, reading 12-Step literature, doing "step work," getting a sponsor, or calling other 12-Step group members or one's sponsor) may be a better indicator of engagement and a better predictor of abstinence than merely attending meetings. In addition, increased involvement in 12-Step meetings and activities following formal treatment may serve as an important source of support and a form of continuing care that has been shown to lead to decreased utilization of mental health and substance abuse treatment services and associated costs (Humphreys & Moos, 2001, 2007).

Although the positive relationship between 12-Step involvement and clinical outcomes is compelling, it is not possible to infer a causal relationship from correlational findings. Three recent studies, using cross-lagged analyses of longitudinal data or structural equation modeling, have begun to elucidate the nature of this relationship (Connors, Tonigan, Miller, & Project MATCH Research Group, 2001; McKellar, Stewart, & Humphreys, 2003; Weiss et al., 2005). The results of these studies suggest that the reductions in substance use associated with 12-Step involvement are not attributable to potential third variable influences such as "good prognosis" participants, level of motivation, presence of comorbid psychopathology, or the severity of the individuals' alcohol or drug problem. These findings provide increasingly supportive evidence for the hypothesis that 12-Step involvement "works"; that is, increased 12-Step meeting attendance and/or involvement appear to lead to a decrease in subsequent alcohol and drug use, leading to the conclusion that the evidence supports a causal pathway between 12-Step attendance and abstinence (Kaskutas, 2009; Krentzman et al., 2010).

SPECIAL POPULATIONS—WHO MAY NEED MORE OR DIFFERENT HELP?

A question of concern is whether certain subgroups or special populations benefit as fully, or in the same way, from participation in 12-Step support groups. For example, are women, youth, ethnic minorities, and those diagnosed with substance use and psychiatric disorders, apt to derive the same benefits from 12-Step participation as White, non-dually diagnosed male adults? A related question is whether special populations benefit equally from traditional 12-Step groups versus groups that are uniquely focused on their subgroup (i.e., Spanish speaking or Native American, women-only, youth 12-Step, dually diagnosed 12-Step, or groups within a certain geographical community that may attract primarily those of a certain ethnic group).

Women

Some have speculated that women may not identify as well as men with 12-Step programs, in part because women may resist the notion of powerlessness and surrender based on their historically subservient status in society (Hillhouse & Fiorentine, 2001; Krentzman, Brower, Cranford, Bradley, & Robinson, 2012; Matheson & McCollum, 2008; Timko, 2008). Others have suggested that women may be more likely to identify with the 12-Step approach because of their tendency toward lower self-esteem, an external locus of control, and a greater willingness to admit their mistakes and to disclose negative things about themselves (Beckman, 1994; Kaskutas, 1994; Timko, 2008). Although women make up only about one third of AA members, there is evidence that they may affiliate just as strongly as men with 12-Step groups and that they may benefit just as much from attendance when it comes to drinking outcomes (Beckman, 1994; Del Boca & Mattson, 2001; Hillhouse & Fiorentine, 2001; Timko, 2008; Timko, Moos, Finney, & Connell, 2002; Witbrodt & Delucchi, 2011). Also, a number of 12-Step programs, including AA and NA, have women's-only groups that may be seen by many women as more welcoming and supportive and, thus, are more likely to be attended than mixed gender groups. Additionally, Women for Sobriety provides another mutual-support recovery resource that differs from 12-Step approaches in structure, format, and program philosophy (Kaskutas, 1994).

Youth

Although there is reason to believe that 12-Step attendance can benefit youth, only 11% and 16% of AA and NA members, respectively, are younger than age 30, and only about 2% in both groups are younger than age 21 (AA, 2008; NA, 2010a). In addition, there may be high drop-out rates for youth (Kelly, Myers, & Brown, 2002; Kelly, Myers, & Rodolico, 2008). Various factors have been proposed as to why youth may not affiliate as strongly with 12-Step programs. These include difficulty accepting the concept of never drinking or using again, inability to relate to the struggles of older adults (i.e., employment, marriage, health, and parenting issues), issues of adolescent brain development, logistical barriers to accessing 12-Step groups (e.g., transportation), lack of interest in spiritual matters, boredom with 12-Step groups, and difficulty relating to some of the "steps" of the program (Kelly et al., 2008; Kelly & Urbanoski, 2012; Sussman, 2010; Timko, 2008). In spite of possible barriers for youth, several studies have found a significant relationship between greater AA/NA participation and improved alcohol and substance use outcomes (Kelly, Dow, Yeterian, & Kahler, 2010; Kelly et al., 2002; Kelly & Urbanoski, 2012).

Ethnic Minorities

Researchers have also explored whether ethnic minorities participate in and/or benefit from traditional 12-Step groups in the same way as Whites. Some have speculated that, like women, ethnic minorities may bristle at the notion of powerlessness inherent in the 12-Step program because of past societal oppression (Timko, 2008) or that they may have trouble accepting the notion of alcoholism or drug addiction as a disease (Durant, 2005). Similar to described for women, ethnic minority groups also may view 12-Step group meetings comprising primarily majority White members as less welcoming and supportive. However, there does appear to be evidence that ethnic minorities may involve themselves to the same extent in and derive comparable benefits as Whites from 12-Step programs (Hillhouse & Fiorentine, 2001). For example, Black Americans were found to be just as likely as Whites to have attended AA as a part of their treatment and were more likely to affiliate as a member of AA, to report having had a spiritual awakening, and to have performed service in AA (Kaskutas, Weisner, Lee, & Humphreys, 1999).

Individuals with Dual Diagnoses

Individuals with concurrent psychiatric and substance use disorders (e.g., dual disorders or co-occurring disorders) often have more and greater challenges in their recovery process and poorer outcomes than individuals with only a SUD (Laudet, Magura, Vogel, & Knight, 2000). There is evidence that individuals diagnosed with substance-use and psychiatric disorders can benefit from 12-Step involvement (Bogenschutz, 2007; Bogenschutz, Geppert, & George, 2006; Laudet, Cleland et al., 2004; Laudet, Magura et al., 2004; Laudet, Magura, Vogel, & Knight, 2003; Magura, 2008; Magura, Laudet, et al., 2003; Timko & Sempel, 2004). It is possible, however, that attendance rates may be affected by diagnosis. For instance, individuals diagnosed with schizophrenia or schizoaffective disorder reported attending fewer 12-Step meetings than those with other co-occurring psychiatric diagnoses (Jordan, Davidson, Herman, & BootsMiller, 2002). It has also been suggested that specialized 12-Step support groups for the dually diagnosed, such as Double Trouble in Recovery (DTR) or Dual Recovery Anonymous, could be even more valuable for this population than traditional groups (Bogenschutz, 2005, 2007; Magura, 2008; Timko, 2008; Vogel, Knight, Laudet, & Magura, 1998). One aspect related to this is that individuals with dual disorders may feel more comfortable and safe discussing their dual recovery needs and their use of psychotropic medications as part of their ongoing treatment than would be true in traditional 12-Step groups (Bogenschutz, et al., 2006; Magura, Laudet, Mahmood, Rosenblum, & Knight, 2002; Vogel et al., 1998). Higher levels of attendance at DTR meetings by individuals with co-occurring disorders was associated with better medication

compliance, as well as with reductions in substance use and psychiatric symptoms and improved quality of life and self-efficacy (Magura, 2008; Magura et al., 2002).

HOW DO 12-STEP GROUPS WORK? MECHANISMS OF ACTION

Researchers have investigated the mechanisms of action or the "active ingredients" of 12-Step programs that contribute to their effectiveness in increasing the likelihood of abstinence and improved psychosocial function. The general categories of potential mediators that have been investigated include 12-Step specific practices, social and spiritual processes, and processes that are common across different types of therapies or behavior change (Kelly, Magill, & Stout, 2009). It appears that those factors most highly related to abstinence are social processes and common processes. A major factor appears to be the "fellowship" associated with 12-Step groups. Membership in such groups contributes to a shift in one's social network, with a reduction in the number of individuals who support drinking to an expanding network of those who support abstinence (Bond, Kaskutas, & Weisner, 2003; Groh, Jason, & Keys, 2008; Kelly, Hoeppner, Stout, & Pagano, 2012; Kelly, Stout, Magill, & Tonigan, 2011; Longabaugh, Wirtz, Zweben, & Stout, 1998). This adaptive shift in the social network is also accompanied by decreased exposure to drinking-related activities and cues that induce craving, as well as increased nondrinking activities, social abstinence self-efficacy, and rewarding social relationships (Kelly et al., 2012; Kelly, Stout, et al., 2011).

Other more common behavior change processes are also active ingredients in 12-Step self-help groups. These include the groups' encouraging bonding with other members in the fellowship, providing structure and a sense of goal directedness; the provision of behavioral norms about and role models for how to work toward abstinence; the development and engagement in non-substance-related activities that are rewarding and can take the place of substance-related activities; and the development of more effective coping skills with an associated increase in self-efficacy (Kelly et al., 2009; Moos, 2008). The changes in the individual's social network and these common behavior change processes appear to contribute more to the positive benefits of 12-Step mutual support groups than do 12-Step specific factors or spiritual mechanisms (Kelly et al., 2012).

The prominence of more general behavior change mechanisms found in the overall 12-Step participant population also appears to be the case with youth and individuals with dual disorders. In a manner consistent with findings of adults, youth report finding general group-therapeutic aspects of 12-Step programs as most helpful to them (e.g., "universality" or not feeling as alone with their problems, getting support from others, the installation of hope), whereas 12-Step specific factors (e.g., 12-Steps practices and principles, belief in a Higher Power, and core AA philosophy) were not rated as highly in importance (Kelly et al., 2002; Kelly et al., 2008; Kelly & Urbanoski, 2012). Mediators of the positive benefits associated with dual-focused groups for individuals with co-occurring substance use and psychiatric disorders include higher level of social support, sociability, internal locus of control, and self-efficacy (Bogenschutz, 2007; Laudet, Cleland, Magura, Vogel, & Knight, 2004; Magura, Knight, et al., 2003; Magura, Laudet, et al., 2003). However, for this population involved in DTR groups, some more specific self-help factors may also be active ingredients. These include helper therapy and reciprocal learning that were found to be related to increased abstinence (Magura, Laudet, et al., 2003) and spirituality and installation of hope that were associated with health promoting behavior but not substance use outcomes (Magura, Knight, et al., 2003).

BARRIERS TO ATTENDANCE AND ENGAGEMENT

Despite the benefit that can be derived from attending meetings and engaging in 12-Step activities, many individuals with SUDs are reluctant to do so. A number of real or perceived

barriers contribute to high attrition and low or inconsistent participation rates. Some of the prominent barriers are listed in Table 2.

Many individuals who are substance dependent view 12-Step groups as helpful resources in the recovery process, but even following treatment, many are ambivalent, fluctuate in their readiness and commitment to change, and question their need for help. These motivational factors may pose more of a barrier than aspects of 12-Step philosophy and ideology, such as spirituality, religiosity, the need to surrender, and the sense of powerlessness (Laudet & White, 2005), although the compatibility between personal and treatment belief systems and philosophies is an important predictor of engagement in 12-Step programs (Mankowski, Humphreys, & Moos, 2001). Such barriers may reduce the likelihood of initially engaging in 12-Step meetings and activities, as reflected by high rates of dropouts by those who do initiate involvement (Cloud & Kingree, 2008; Kelly & Moos, 2003). As noted by Kaskutas and colleagues, there are a number of different trajectories of involvement: some individuals with SUDs never connect with 12-Step programs, some connect briefly but then drop out, and others strongly affiliate and maintain stable and often high rates of attendance (Caldwell & Cutter, 1998; Kaskutas et al., 2005).

WHAT CAN SOCIAL WORKERS AND PROFESSIONALS DO TO HELP?

To benefit maximally from 12-Step programs it is necessary to attend meetings and engage in recovery activities, yet, as noted, meeting attendance and engagement may be limited, inconsistent, and sporadic. Social workers and other health and behavioral health providers working in substance abuse treatment programs, medical settings such as emergency departments, trauma centers, or primary care clinics, or social service agencies, all encounter populations in which SUDs are prevalent. As such, there are opportunities to attempt to inform the substance abuser about the availability and potential benefits of 12-Step programs. The 2007 AA membership survey, for example, found that 39% of members reported that they were referred to AA by a health care professional (AA, 2008). As Laudet (2003) noted, it is important to attempt to enhance the individual's motivation for change, assess his or her beliefs about and prior experiences with 12-Step self-help groups, and find a good fit or match between clients' needs and inclinations and the help and support available from such groups. In the process, there are some general principles and approaches to keep in mind and to guide the social worker or behavioral health professional in this process.

Professionals' Knowledge, Perceptions, and Attitudes

A major concern is that many behavioral health professionals working in nonspecialty settings are unfamiliar with the general philosophy (e.g., the 12 Steps and Traditions) of 12-Step-based mutual support groups in general (Stewart, 1990), about the different types of meetings and the way they are conducted (Kelly & McCrady, 2008). They are also often less aware of the positive outcomes associated with involvement in 12-Step programs. To accurately match the individual to the appropriate type of group, whether a 12-Step group or a mutual support group that is not necessarily based on 12-Step principles, it is important to become familiar with the variety of resources available (Fenster, 2006; Humphreys, 1997; Kelly & McCrady, 2008). Although clinicians have been found to view 12-Step programs as important in the recovery process, 86% of clinicians in one survey expressed extremely great interest in obtaining further training or information about 12-Step groups (Laudet, 2003). This is important, because just as the substance abusers may perceive barriers to and have negative perceptions of or attitudes toward involvement in 12-Step programs, so might some providers (Vederhus, Kristensen, Laudet, & Clausen, 2009; Vederhus, Laudet, Kristensen, & Clausen, 2010). It is also important to become aware of what resources exist in the local community. The professional and the substance abuser can find meetings and

informational resources by looking in the phone book or on the Internet under the specific group (e.g., AA, NA, CA) or "12-Step programs." It is also helpful to read materials from and about the different groups (again, readily available on the Internet) and attend some meetings that are open to the public (i.e., "open meetings") to become more familiar with the programs and specific groups to which you might be referring a client. Informed referrals are more likely to result in a better match, which, in turn, is likely to increase the possibility of client engagement (Humphreys, 1997).

Client's Readiness and Expectations

Another important component in matching the client to the appropriate 12-Step program or to some other type of mutual support group is to explore or more formally assess the individual's prior experiences with and expectations about 12-Step groups. Some have had little or no experience with 12-Step groups and may benefit from education about them. This might involve the provider sharing information derived from his or her knowledge of and visits to different self-help meetings in the area. Useful information that explains how 12-Step programs work and what one might expect by affiliating with them can be obtained from pamphlets, such as, "So You've Been Asked to Go to AA" (http://www.seattleaa.org/asked.html), "44 Questions" (http://www.recovery.linderweb.net/44questions.pdf), or "What is the Narcotics Anonymous Program" (http://www.na.org/admin/include/spaw2/uploads/pdf/litfiles/us_english/misc/What%20Is%20the%20NA%20Program.pdf), that are available through local 12-Step chapters or online.

Another resource is that of active AA or other recovery self-help group members who are willing to share their experience with clients who are less familiar with the programs. It has been found that a combination of a brief 5- to 15-minute physician intervention plus a 30- to 60-minute visit by a recovering alcoholic in a peer intervention was 5 times more successful than "usual care" and 3 times more successful than the brief physician intervention alone in getting patients with a drinking problem hospitalized for medical conditions to enter treatment in the 6 months following their hospital discharge; the combined physician plus peer intervention was also associated significantly with longer periods of abstinence (Blondell et al., 2001).

Many other individuals have had prior experiences with 12-Step groups but have dropped out. What do they see as the reasons for this attrition? What were the barriers that they encountered? How do these prior experiences affect their willingness to reengage, if at all? Do they view potential benefit from attending meetings again? There may be a number of factors that arise in the course of such discussions. As an example, some individuals, such as agnostics or atheists, are put off by the focus on the concept of a "Higher Power," spirituality, and perceived religiosity (Tonigan, Miller, & Schermer, 2002); others, particularly women, may have concerns with the focus on " powerlessness" (Kaskutas, 1994; Krentzman et al., 2012); whereas others, particularly those who have social phobia and/or a tendency to avoid attachments may find being in groups and the concept of joining a "fellowship" anxiety provoking (Jenkins & Tonigan, 2011; Tonigan et al., 2010). It is also important to address real barriers that make meeting attendance difficult, such as time, travel/transportation, and child care needs.

Also, as noted previously, one of the most prominent barriers to involvement is the individual's ambivalence and fluctuating readiness and commitment to give up alcohol or drug use (Laudet, 2003). It is important to listen to and address these issues and concerns in a way that reframes them in a more understandable and less threatening way (Davis & Jansen, 1998). This might also involve the use of motivational interviewing techniques to increase readiness and commitment to change, such as weighing the "pros" and "cons" of continuing versus stopping substance use and of 12-Step involvement versus

noninvolvement if one decides that stopping use is a goal (Cloud et al., 2006; Cloud & Kingree, 2008). Although helping clarify such issues, motivational interventions, if effective at increasing 12-Step engagement, appear to do so primarily for those substance abusers with limited prior experience with 12-Step groups (Kahler et al., 2004; Walitzer, Dermen, & Barrick, 2009).

There are a number of recently developed measures that can assist the practitioner in determining where the individual is in his or her readiness to engage in 12-Step groups (Cloud & Kingree, 2008). These include measures of factors such as readiness to participate in 12-Step programs, which includes the perceived severity of substance use disorder, and the perceived benefits of and barriers to 12-Step involvement (Kingree, Simpson, Thompson, McCrady, & Tonigan, 2007; Kingree et al., 2006); common attitudes and expectancies about participating in 12-Step mutual-help groups (Kahler, Kelly, Strong, Stuart, & Brown, 2006; Morgenstern, Frey, McCrady, Labouvie, & Neighbors, 1996); the potential negative aspects of 12-Step groups, including risks of participation, the limitations of such groups in relationship to different stages of readiness to change, the concepts of powerlessness and the spiritual emphasis of such groups, and the lack of professional leadership of the groups (Laudet, 2003). Additionally, there are multidimensional measures of 12-Step affiliation, which incorporates meeting attendance and engagement in recovery-related activities that can serve as indicators of participation and involvement, as well as measures of the outcomes related to 12-Step participation (Greenfield & Tonigan, 2012; Humphreys, Kaskutas, & Weisner, 1998; Kelly, Urbanoski, Hoeppner, & Slaymaker, 2011; Klein, Slaymaker, & Kelly, 2011; Tonigan, Connors, & Miller, 1996).

Program Philosophy and Counselor Practices

Many specialty substance abuse treatment programs incorporate a 12-Step philosophy. This is important, because a consistent finding in the literature is that programs that are supportive of 12-Step approaches, are based on this underlying philosophy, and have a higher proportion of staff members who themselves are affiliated with 12-Step programs as part of their own recovery process, have higher rates of 12-Step meeting attendance and engagement than do programs based on other types of treatment philosophies (Humphreys, Huebsch, Finney, & Moos, 1999; Kaskutas, 2009; Krentzman et al., 2010). In addition, the degree to which a program endorses a 12-Step orientation moderates the relationship between 12-Step involvement and subsequent outcome, with greater emphasis being associated with greater levels of improvement in substance use and psychosocial outcomes (Humphreys et al., 1999). It has also been found that concurrent involvement in specialty treatment and in 12-Step groups contributes to better outcomes than either alone (Fiorentine & Hillhouse, 2000), leading to a recommendation that if an individual is participating in specialty substance abuse treatment, this is an opportune time to initiate 12-Step involvement because it is less likely to occur on its own (Owen et al., 2003). One way to increase the likelihood of exposure to and engagement in 12-Step groups during and following treatment is to hold onsite meetings. Not only did individuals in a program with onsite 12-Step meetings have higher levels of subsequent meeting attendance and engagement, they also had more prolonged periods of substance use abstinence than those in a program without onsite meetings (Laudet, Stanick, & Sands, 2007). Such onsite meetings do not necessarily need to be restricted to substance abuse treatment programs. It is possible to make arrangements with local 12-Step organizations to hold meetings in a number of other settings in which social workers and behavioral health providers work. Again, the likelihood of involvement is greater if meetings are held at agencies in which individuals are already utilizing other services.

Another important aspect of the programmatic review is to examine counselor's behaviors in referring individuals to 12-Step meetings. In many cases, this is done in ways that do not

necessarily enhance the likelihood of accepting the 12-Step program (Caldwell, 1999). Oftentimes, even in treatment programs that label themselves as 12-Step, the "standard practice" may involve little more than providing the individual with a list and schedule of local self-help meetings and bus routes near them, and encouraging him or her to attend a meeting (Humphreys & Moos, 2007). Such a passive approach is often insufficient to get people to attend (Carroll et al., 2000; Timko & DeBenedetti, 2007; Timko, DeBenedetti, & Billow, 2006). More information on methods for getting clients to attend 12-Step meetings is presented below in the section titled "Evidence-Based 12-Step Facilitative Interventions."

The Department of Veterans Affairs (DVA)—Center on Substance Abuse Treatment (CSAT) Workgroup on Substance Abuse Self-Help Organizations (Humphreys et al., 2004) pointed out that many people mistakenly believe that all substance abuse treatment programs in the United States are based on the 12-Step philosophy and that all clinicians in them are already promoting self-help groups. However, the Workgroup indicated that this belief is not supported by research. There are few "pure" 12-Step treatment programs or practitioners. Rather, most are likely to incorporate an eclectic perspective, blending 12-Step, cognitive-behavioral, and other philosophies and techniques. Even practitioners who describe themselves as "12-Step oriented" typically consider only a subset of 12-Step processes important for clients. Thus, even having a program with a 12-Step treatment philosophy, and counselors that encourage 12-Step involvement, may not be sufficient to increase 12-Step involvement and activities; that is, a systematic, manually guided 12-Step facilitative intervention and "treatment as usual" are not equivalent. One of the recommendations of the DVA-CSAT Workgroup (Humphreys et al., 2004) is that community-based treatment programs, even those that label and represent themselves as "12-Step oriented," should evaluate whether their current program practices actively support involvement in 12-Step self-help groups. Further, they also should examine the methods employed by their counselors in this regard. Typically, they noted, when counselors do attempt to support 12-Step self-help group involvement in treatment, they rarely use empirically supported methods. When clinicians use empirically validated techniques to support mutual help group involvement, it is far more likely to occur (Humphreys, 1999). This has led to recommendations to utilize evidence-based, empirically supported interventions to facilitate 12-Step involvement (Donovan & Floyd, 2008; Humphreys, 1999; Humphreys et al., 2004), including among health care and behavioral health providers who work outside of specialty substance abuse treatment programs but who have want to link patients in their settings to community-based 12-Step programs (Kelly & McCrady, 2008).

Evidence-Based 12-Step Facilitative Interventions

A number of interventions have demonstrated efficacy in facilitating attendance at 12-Step meetings and engagement in 12-Step recovery activities. "TS [Twelve Step] facilitative treatment content designed to orient, facilitate, and acculturate clients into TS recovery practices are effective at increasing measures of affiliation during the first year following treatment" (Cloud & Kingree, 2008, p. 285). These approaches differ with respect to the extent to which they emphasize getting people to attend meetings, with the assumption that they will learn about 12-Step philosophy and tenets by "doing," versus trying to get substance abusers to better understand the components of 12-Step programs, with the assumption that having a better understanding and acceptance of these principles will lead to greater engagement. Both approaches have merit and are important resources, potentially being appropriate and effective with different subgroups of individuals. It has been noted that interventions that focus on and are effective in increasing attendance may be insufficient to ensure active or continued involvement and that early attrition may be due in part to individuals' inability to embrace or utilize other aspects of the 12-Step program. In such cases, approaches that focus more on 12-Step practices and tenets and less on meeting

attendance may be needed (Caldwell & Cutter, 1998). Table 3 provides an overview of the focus and key features of the four 12-Step facilitation reviewed below.

Systematic encouragement and community access—The former of these approaches is built on the notion of a "buddy system." One of the potential barriers to attending meetings is not knowing anyone who is there. Alcoholics Anonymous has developed a program called "Bridging the Gap" in which members of community-based AA groups will come to institutions such as correctional facilities or residential programs, meet with the substance abusers, and take them to a meeting in the community (AA, 1991). In addition, the 12-Step member can answer questions, introduce the individual to other members, and serve as a source of "moral support" and as a "transitional object" as the client enters into a new social environment about which he or she is uncertain and ambivalent. It has been suggested that more directive facilitative interventions such as this may be more effective in engaging such individuals than motivational enhancement approaches (Walitzer et al., 2009). It has been a common practice in many treatment programs and medical settings to use AA or NA members who serve as volunteers in a "buddy system" or as temporary sponsors (Blondell et al., 2001; Chappel & DuPont, 1999; Collins & Barth, 1979). Individuals who have initiated and engaged in 12-Step activities through the efforts of such volunteers have credited the peer intervention as being the most important factor that motivated them to seek help for their SUD. When people recovering from alcoholism and drug use provide help to an individual who is abusing substances, they are furthering their own 12-Step work, which is of benefit to them (Zemore, Kaskutas, & Ammon, 2004); further, such interventions are relatively simple, practical, involve little or no costs, and pose little patient risk (Blondell et al., 2001).

This approach has also been formalized into a relatively brief intervention that could be implemented in a number of settings. It was called "systematic encouragement and community access" and involved a counselor calling a community 12-Step volunteer. The volunteer in turn would talk to the person about the meeting, offer to provide a ride to the meeting, and later call to remind the person about the meeting and encourage attendance (Sisson & Mallams, 1981). Subsequently, an individually administered three-session intensive referral procedure has been developed which more fully standardizes this process (Timko et al., 2006). The initial session, which lasts between 45 to 60 minutes, provides information about 12-Step approaches, explores concerns and expectancies the person may have, and facilitates the linkage between client and community volunteer. Two brief (e.g., 15- to 20-minute) sessions follow up to see whether the person has attended a meeting and, if so reinforces attendance and continued involvement, and if not, explores barriers and once again links the client to a community volunteer for another attempt to get the person to a meeting. Individuals who abused substances who were involved in the intensive referral/ buddy system intervention, compared to those receiving standard referral, demonstrated increased 12-Step attendance and affiliation as well as reduced substance use during the year following the intervention (Timko & DeBenedetti, 2007; Timko et al., 2006).

A four-session group-based intensive referral approach has been developed and tested for individuals with co-occurring psychiatric and substance use disorders (Timko, Sutkowi, Cronkite, Makin-Byrd, & Moos, 2011), in which a member of a dual disorders self-help group serves as a volunteer to help inform the participants about dual-disorder groups and to link the individual to community-based self-help groups. Compared to the usual referral practice in the clinics, those in the intensive referral group intervention attended more substance-focused and dual-disorders-focused self-help meetings and had less drug use and better psychiatric outcomes at a 6-month follow-up.

Making AA Easier—An intervention that falls midway along the continuum between "doing" (e.g., getting the individual to meetings) and "understanding" is Making A.A. Easier (MAAEZ; Kaskutas & Oberste, 2002; Kaskutas, Subbaraman, Witbrodt, & Zemore, 2009). MAAEZ is a relatively brief, structured, manual guided intervention. It consists of six 90-minute group sessions led by a counselor who is in recovery and has extensive personal experience with 12-Step meetings. A primary goal of MAAEZ is to familiarize individuals with the "culture" of 12-Step meetings and help them anticipate and learn ways to deal with some of the issues in 12-Step meetings and programs that often lead them to reject future participation. It does not attempt to teach people about 12-Step philosophy and concepts, feeling that once at meetings and affiliated with the program this information will be provided by other members or one's sponsor. Rather, through the groups MAAEZ attempts to identify potential barriers to engagement and minimize resistance. The introductory session focuses on the benefits of attending 12-Step meetings and how to choose meetings. Subsequent sessions focus on and attempt to explain the individualized notion of "spirituality" versus religion; myths about 12-Step programs, different types of meetings, and the rituals involved in them and expected behavior at meetings; the role and function of a sponsor, how to choose a sponsor, with role-playing of asking a group member to serve as a temporary sponsor; and relapse risk factors, the "people, places, and things" that should be avoided to reduce the risk of relapse. The final session involves those who have completed the first five sessions sharing with newcomers who are in their first group; this allows program completers serving in a "helpers" role to the new participants.

Individuals who participated in the MAAEZ intervention, compared to individuals in the same programs who did not receive this intervention, were significantly more likely to be abstinent from alcohol and drugs at a 1-year follow-up assessment, and the likelihood of abstinence increased as a function of the number of MAAEZ group sessions completed (Kaskutas et al., 2009). Unlike motivational enhancement approaches which appeared to benefit those with little prior 12-Step experience (Kahler et al., 2004), MAAEZ appears to be more helpful with individuals who have had more prior experience with 12-Step programs. It also seemed to be more effective for individuals with severe psychiatric problems and those who were atheist or agnostic.

12-Step Facilitation Therapy—An approach that falls more toward the "understanding the concepts" end of the continuum of interventions is 12-Step Facilitation Therapy (TSF; Nowinski, 2000; Nowinski & Baker, 1998; Nowinski, Baker, & Carroll, 1992). As originally designed, TSF was a 12- to 15-session, individually administered, manually guided intervention based on the core cognitive, emotional, behavioral, and spiritual principles of 12-Step programs, with a focus on facilitating early recovery. Although developed originally as individual counseling, TSF also has been adapted for use in a group therapy format (Brown, Seraganian, Tremblay, & Annis, 2002a, 2002b). The emphasis, in the individual and group approaches, is on the first three of the 12 Steps. The intervention has two primary goals: (a) acceptance that one has a chronic, progressive illness, over which one has lost control, and that complete abstinence is the necessary goal and (b) there is hope for recovery through acceptance of one's loss of control, by having faith in a Higher Power that can be of help to the individual whose willpower has been overcome by addiction, and by acknowledging that 12-Step fellowship has been instrumental in the recovery of millions of people and provides the best opportunity for achieving and maintaining abstinence.

The intervention consists of five core sessions that all participants receive. These include an initial introductory session that includes a substance use and 12-Step history and provides an orientation to 12-Step concepts and philosophy; content sessions focusing on the concepts of acceptance and surrender; a session on getting active, which focuses on attending meetings, becoming actively involved, participating while at meetings by speaking or doing service

work, getting phone numbers of members whom they would feel comfortable calling if they feel an urge to drink or a need for support, and how to get a sponsor. In addition, there are a number of elective sessions that can be chosen based on the individuals' needs and interests. These include sessions dealing with genograms (e.g., looking at patterns of addiction within one's family tree); enabling in relationships; people, places, and things that serve as relapse triggers; dealing with negative emotions (hungry, angry, lonely, tired or HALT), which are also associated with a high risk for relapse; taking a moral inventory; and developing a sober life style. The fifth core session is at the end of the intervention and involves a review and planning for continued involvement.

Project MATCH (Matching Alcohol Treatment to Client Heterogeneity) compared TSF to motivational enhancement therapy and cognitive-behavioral therapy in a large multisite trial. It was found that patients treated in TSF attended more 12-Step meetings, had reductions in drinking comparable to patients in the other treatment conditions, and had higher levels of overall abstinence than found in the other two treatments (Project MATCH Research Group, 1997, 1998; Tonigan, Connors, & Miller, 2003). The TSF manual originally developed for the use with alcohol use disorders has been adapted for use with individuals with drug use disorders (Baker, 1998) and has been shown to increase 12-Step participation among individuals with co-occurring alcohol and cocaine dependence (Carroll et al., 2000; Carroll, Nich, Ball, McCance, & Rounsavile, 1998). Twelve-Step facilitation therapy delivered in a group format had substance use outcomes comparable to more well-established, empirically supported relapse prevention groups; further, treatment matching effects were found for gender, substance abuse patterns, and psychiatric severity that favored treatment in the TSF group over the relapse prevention group (Brown et al., 2002a, 2002b).

Stimulant Abuser Groups to Engage in 12-Step—Stimulant Abuser Groups to Engage in 12-Step (STAGE-12) represents an attempt to combine and blend the focus on "doing" and "understanding" by combining the intensive referral procedure with the content from the TSF manual developed for use with drug abusers (Baker, Daley, Donovan, & Floyd, 2007; Daley, Baker, Donovan, Hodgkins, & Perl, 2011). It was developed with the goal of facilitating cocaine and methamphetamine abusers to attend and engage in 12-Step meetings and activities (Donovan & Wells, 2007). It consists of three individual and five group sessions. The first individual session incorporates the linkage of the stimulant user with an outside 12-Step volunteer to help explain the meetings and treatment philosophy as well as attend a meeting together. The second and third sessions, coming midway and at the end of the active treatment phase, review progress, reinforce and support continued involvement of those who have attended meetings, and problem solve barriers and attempt another link to a volunteer for those who have not attended meetings. The five groups, which involve rolling admission following the initial individual session, include a focus on acceptance (Step 1); people, places, and things; surrender (Steps 2 and 3); getting active; and managing emotions.

The results of STAGE-12 with regard to stimulant use outcomes are mixed (Donovan et al., 2013). During the 8-week intervention period, stimulant abusers who received STAGE-12 as part of their specialty intensive outpatient treatment, compared to those who received intensive outpatient treatment without STAGE-12, were significantly more likely to be abstinent from stimulants. However, if not abstinent during this period, those in STAGE-12 were likely to have had more days of stimulant use. The Stage-12 group showed a significant reduction in their drug use severity and perceived need for treatment from the start of treatment to a 3-month follow-up whereas those in treatment as usual did not. Furthermore, individuals in STAGE-12 had more days of 12-Step meeting attendance, more days of doing service at meetings, and engaged in more 12-Step recovery activities. This latter finding is of particular note because engagement in 12-Step recovery activities appears

to be a mediator of change and subsequent abstinence associated with 12-Step mutual support groups (Subbaraman, Kaskutas, & Zemore, 2011).

SUMMARY

Twelve-step programs serve as readily available, easily accessible, and no cost resources for individuals with substance use disorders. There is clear evidence from a variety of sources that early involvement, in the form of meeting attendance and engagement in recovery activities, is associated with better substance use and psychosocial outcomes as well as reduced health care costs. Despite these benefits, attendance and engagement is often low and inconsistent, with relatively high rates of attrition. Social workers, health care providers, and behavioral health professionals can increase the likelihood of linking substance abusers, in specialty and nonspecialty settings, to 12-Step programs by the methods and style they use in their referral process. Professionals are encouraged to become more familiar with 12-Step programs in general and in their specific locales, to be aware of the positive outcomes associated with active involvement in such programs, attempt to match client needs to specific mutual support groups, to incorporate the use of community-based 12-Step volunteers to serve as “bridges” into such groups, and utilize empirically supported 12-Step facilitative approaches that are adapted to the unique features of their practice settings.

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TABLE 1

Demographic Information, Average Meeting Attendance, and Years of Reported Abstinence from Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA) Membership Surveys

	AA 2007 Survey N > 8,000	**NA 2009 Survey N = 11,723**	**CA 1996 Survey N > 1,000**
Gender			
Female	33%	42%	32%
Male	67%	58%	68%
Age			
≤30 years	13.6%	16%	11% (≤24 years)
31–50 years	45%	56%	78% (25–44 years)
51+ years	41.4%	28%	11% (45+ years)
Ethnicity			
White	85.1%	73%	55%
Black	5.7%	10%	27%
Hispanic	4.8%	10%	4%
Other	4.4%	7%	14%
Marital Status		N/A	N/A
Married	35%		
Single	34%		
Divorced/separated/widowed	31%		
Average number of meetings attended per week	2.4	4	3.5
Years of abstinence			
< 1 year	31%	12%	55%
1–5 years	34%	33%	31%
> 5 years	45%	55%	14%

Sources. Alcoholics Anonymous (2008), Narcotics Anonymous (2010a), Cocaine Anonymous (2011).

TABLE 2

Prominent Factors That May Represent Barriers to 12-Step Involvement

- Fluctuations in readiness and commitment to change
- High degree of spirituality or perceived religiosity, especially for individuals who are atheist or agnostic
- The need to surrender
- The sense of powerlessness
- Lack of compatibility between personal and treatment belief systems and philosophies
- Lack of comfort or perceived support in the group, due to membership in a special population (e.g., women, ethnic minorities, youth, dual disorders, sexual orientation)
- Social phobia or social anxiety

TABLE 3

Focus and Key Features of Four Evidence-Based 12-Step Facilitation Interventions

12-Step Intervention Features	Systematic Encouragement and Community Access (SECA)	Making AA Easier (MAAEZ)	Twelve-Step Facilitation Therapy (TSF)	Stimulant Abuser Groups to Engage in 12-Step (STAGE-12)
Primary focus	To increase 12-Step engagement by linking the individual to 12-Step group through use of a 12-Step volunteer	To increase likelihood of 12-Step engagement by reducing real or perceived barriers and addressing expectations	To increase likelihood of 12-Step engagement by increasing knowledge and understanding of 12-Step principles and steps	To increase likelihood of 12-Step engagement by linking the individual to 12-Step group through use of a 12-Step volunteer and increasing knowledge and understanding of 12-Step principles and steps
Goal	Facilitation of participation in Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or Cocaine Anonymous (CA)	Facilitation of participation in AA, NA, or CA	Understanding and integration of the 12-Step concepts of acceptance and surrender	Facilitation of participation in AA, NA, or CA *plus* understanding and integration of the 12-Step concepts of acceptance and surrender
Intervention delivery	3 individual sessions	6 group sessions	5 “core” and 6 “elective” individual or group sessions	3 individual and 5 group sessions