

Published in final edited form as:

Int J Self Help Self Care. 2000 ; 1(3): 213–225.

Substance Abuse Treatment Providers' Referral to Self-Help: Review and Future Empirical Directions

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Abstract

As duration and intensity of services decline, the treatment system's success in engaging substance-using clients in self-help (SH) will increasingly influence client outcomes. Clinicians play an important role in involving clients with SH, yet little is known about how referral decisions are made or about the referral process itself. This paper reviews clinicians' attitudes toward SH and their role in referring clients to SH, and identifies types of research needed to elucidate the referral process from both clinicians' and clients' perspectives. Such research can help enhance the number and outcome of referrals to self-help groups.

Keywords

Self-help; Mutual aid; 12-step; Referral

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Self-help groups (SH groups) have recently assumed greater importance in substance abuse treatment, especially with the advent of managed care and consequent decreases in the intensity and duration of services. Empirical studies indicate that self-help (SH) can help achieve positive outcomes for clients (less substance use and improved psychosocial functioning) both during and after treatment. Research points to the important role of treatment providers in involving clients with SH groups (e.g., Humphreys, Huebsch, Finney and Moos, 1999). As services become more limited, the treatment system's success in engaging clients in SH groups will increasingly influence client outcomes. Although there is evidence that clinicians do refer many substance-abusing clients to SH groups, some clients - in particular, those with a co-occurring mental disorder - are much less likely to be referred (e.g., Humphreys, 1997). This may result in missed opportunities to provide clients with a much-needed lifelong resource for recovery. Self-help and specifically the 12-step program of recovery are often misunderstood, and indeed, lack of information and understanding have been identified as the most important factor in social workers' reluctance to refer clients to SH groups (Kurtz, Mann and Chambon, 1987). This paper briefly reviews the literature about clinicians' attitudes about SH and their role in facilitating clients' engagement in SH, and discusses two areas where empirical investigation is needed: the knowledge base and experiences from which clinicians' attitudes are derived, and the role of attitudes and beliefs about SH on referral decisions and on the referral process. Investigation of these questions can help enhance the number and outcome of referrals to self-help groups.

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³The work reported here was supported by National Institute on Drug Abuse #P30 DA11041

Growing Interest in Self-Help

Participation in SH groups is becoming more common and increasingly attractive, as Managed-care has reduced the availability and duration of formal treatment. The importance of collaboration between treatment providers and SH groups was acknowledged a decade ago with the organization of the Surgeon General's Workshop on Self-Help and Public Health (1988), designed to stimulate recommendations for how the SH movement and the formal public health system might be mutually enhanced. In 1989, the Residency Review Committee for Psychiatry began to require structured education in addiction, including 12-step and mutual aid groups. More recently, the American Psychiatric Association (1995) has addressed the role of SH groups as an adjunct to treatment in its clinical practice guidelines for substance abuse disorders, and the Practice Directorate of the American Psychological Association (1999) has included referral to 12-step SH groups ("a crucial part of any recovery program") in its recommendations concerning the role of psychologists in alcohol treatment. The APA also discussed the importance of SH as a lifelong resource for recovery after treatment.

Currently in the US, there are more visits for substance abuse and psychiatric problems to SH groups than to all addictive and mental health specialties combined (Kessler, Mickelson and Zhao, 1997). Further, such groups often engage members more intensely and for longer periods than do professional treatment programs (Humphreys, Huebsch, Finney and Moos, 1999). Indeed, in the current climate of service delivery, SH has been referred to as "the cake rather than the icing" (Humphreys et al., 1999, p.562). Clinicians are interested in SH because of the possibilities of coordinating formal treatment and SH to achieve better outcomes (e.g., Nurco, 1991); moreover, some individuals may respond to SH participation alone, perhaps after SH facilitation that includes introduction to an appropriate group (Nowinski and Baker, 1992). Increasingly, empirical evidence suggests that involvement in SH group facilitates recovery from drug and alcohol use (e.g., Devine, Brody and Wright, 1997; Emrick, Tonigan, Montgomery, Little, 1993; Humphreys, Moos & Cohen, 1997; Khantzian & Mack, 1994; McCrady & Miller, 1993; Moos, Finney, Ouimette & Suchinsky, 1999; Ogborne, 1993; Project MATCH, 1997; Rosenheck & Lida, 1997; Timko, Finney, Moos & Moos, 1997; for review, see Chappel and DuPont, 1999), as well as from mental health disorders (Galanter, 1988; Markowitz et al., 1996; New York State Office of Mental Health, 1993). Role of Clinicians in Involving Clients in Self-Help

Treatment providers can contribute to the Institute of Medicine's (1990) goal of broadening the base of treatment for alcohol (and substance) use problems within the community in which they work (Caldwell, 1999). As discussed earlier, the importance of collaboration between service providers and SH has been acknowledged by several professional organizations. The American Psychiatric Association (1995), generally favorable to SH as an adjunct to treatment, noted that "referral is appropriate at all stages in the treatment process, even for patients who may still be substance users" (p. 11). It cautioned, however, that individuals who are on psychoactive medications should be referred to groups where the use of medication is recognized and supported as useful, rather than seen as a form of substance abuse. Survey data collected shortly before the APA guidelines were issued found clinicians' referral patterns generally consistent with APA guidelines: the majority of substance-abusing clients were referred to AA (79%) or NA (45%-Humphreys, 1997). Dually-diagnosed clients, atheists, those with a less severe substance abuse problem, the homeless, unemployed, those over 65, and the dually-addicted were less likely to be referred to SH groups.

Although the importance of referring clients to SH groups has been widely recognized (e.g., Cross, Morgan, Mooney, Martin & Rafter, 1984; Timko, Moos, Finney, Moos & Kaplowitz, 1999; Vaillant, 1983), research on the effect of referrals on SH involvement is scarce. A small pilot study compared "simple referral" (i.e., clinician's suggestion that client attend SH groups and giving client a meeting list) with "intensive referral" whereby clinician and client arranged

for an experienced 12-step member to accompany the client to a group meeting (Sisson and Mallam, 1981). While all clients in the intensive group became members of the SH group, none in the "simple referral" condition did, suggesting that not only whether, but also how, clinicians refer clients to SH may enhance clients' subsequent engagement. Another study indirectly documented the importance of clinicians' role in engaging clients in SH groups. Investigating how treatment programs' theoretical orientation influences clients' participation in -- and benefit derived from--SH, Humphreys and colleagues (1999) found that clients in 12-step and eclectic programs (combined 12-step and cognitive-behavioral) had higher rates of subsequent SH participation than did clients in the cognitive-behavioral treatment programs. Moreover, program orientation moderated the effectiveness of SH participation: As the degree of programs' "12-stepness" increased, the positive relationship between SH participation and outcome (substance use and psychosocial) became stronger.

The Social Model Program (SMP) provides an example of how substance abuse treatment orientation can contribute to clients' affiliation with self-help groups. Started and staffed entirely by recovering individuals, SMPs are based on the 12 traditions of AA, emphasizing democratic group processes with shared and rotated leadership and minimal hierarchy (for description of SMP, see Borkman, Kaskutas, and Barrows, 1996 and Borkman, Kaskutas, Room, Bryan, & Barrows, 1998). Unlike traditional treatment services which are typically short-term, SMPs are long-term residential programs offering a continuum of care from detoxification through primary recovery, secondary supportive recovery and sustaining lifelong recovery after residents have left the program. Based on the premise that sobriety is supported by a sober environment, it places a strong emphasis on linking clients with recovery resources, especially 12-step fellowships, both at the program and in the community. While no outcome data on SMP clients' post-treatment self-help affiliation appear to be available, one study has documented SMPs' ability to link it residents with community-based recovery resources (Barrows, 1998). Assessing the community orientation of two SMPs and a more traditional 10-days medical model program, the author found that SMPs exposed their clients to a number of different SH meetings both at the program and in the community over several months. Further, SMP residents attended meetings in the community and community residents attended meetings at the SMP, thus creating a sort of "recovery community" that may form a bridge from treatment to life-long recovery when residents leave the program. In contrast, the traditional short-term program had minimal links to the community and exposed clients exclusively to self-help meetings held at the program and closed to community residents. In the current service delivery climate, SMPs, based on long-term non-medically-oriented stays, represent an ideal rather than a realistic goal. However, their emphasis on linking clients with community recovery resources, in particular 12-step self-help groups, and their ability to do so, can and should be regarded as a model for other forms of substance abuse treatment delivery. When the treatment system provides clients with education and information about SH groups and exposure to such groups, clients "may find community-based SH groups a logical, comfortable extension of what they have learned in treatment" (Humphreys, Huebsch, Finney and Moos, 1999, p.562).

In addition to providing clients with information about and exposure to SH groups, treatment programs and clinicians can promote stable SH affiliation among ambivalent clients if they "address the barriers to the effective use of specific tenets and identify and nurture those areas where clients have affinity with [SH groups]" (Caldwell and Cutter, 1998). To those ends, treatment providers should discuss clients' past experience with SH participation, identify and correct inaccurate beliefs, and build on areas where clients' experiences and belief systems are compatible with basic tenets of the 12-step recovery program to facilitate the initiation of affiliation with SH groups. Clinicians can also help decrease client drop out of SH groups after they begin attending. The drop-out rate from self-help groups is estimated to be high, particularly in the first few months; for instance, AA estimates that 50% of alcoholics drop out

in the first 3 months (AA, 1989). Caldwell (1999) has discussed possible reasons why participants drop out, including lack of readiness and inability to embrace important aspects of the program. The latter may be due, in part, to the approach taken by clinicians when introducing SH, such as failing to provide clients with minimal understanding or preparation (Johnson and Chappel, 1994), or adopting a rigid approach to the program (e.g., attendance requirements) without considering individual clients' needs and inclinations. Caldwell (1999; Caldwell & Cutter, 1998) proposed that clinicians work in collaboration with clients to match clients' needs with the tools and support available within SH programs.

Clearly, clinicians can educate clients about available recovery resources including those in the community, such as SH group meetings, that clients may use both during and after treatment. The foregoing empirical evidence, pointing to the important role of clinicians in engaging clients in SH, assumes that clinicians have the tools necessary to educate clients adequately. Their ability to do so, however, rests largely on their attitudes and beliefs toward SH.

Clinicians' Attitudes toward Self-Help

Empirical evidence, mostly from the mental health field, indicates that most clinicians hold positive attitudes toward SH (Kurtz, 1990; also see Kurtz, 1997). However, why they give SH groups high effectiveness ratings, they tend to hold views that may limit their collaboration with SH organizations. In a study of 748 outpatient mental health facilities making and receiving referrals to SH groups, SH effectiveness ratings tended to be high and respondents believed that the groups could play an important role in the mental health system. However, only 31% rated as "high" the probability that their agency would be interested in exploring the integration of SH into its services (Levy, 1978). Social workers' positive view of mutual aid groups but low rate of collaboration with or referral to such organizations was also documented by Kurtz and colleagues in their survey of 120 mental health social workers (Kurtz, Mann and Chambon, 1987). A more recent investigation yielded similar results. Mental health clinicians working in community mental health centers and psychiatric hospital (N = 831) gave SH high effectiveness ratings but rated that professional services as more useful for clients than SH (Salzer, McFadden and Rappaport, 1994). A survey of professionals and SH members found that many positive interactions were described but that there were tensions and obstacles to successful collaboration, including negative attitudes, competition, ideological conflicts and role ambiguity (Stewart, Banks, Crossman & Poel, 1995).

Clearly, SH programs -- especially the Anonymous groups based on the 12-step program-- are widely misunderstood and misinterpreted. This is largely because the 12-step program contradicts contemporary dominant western cultural norms of self-reliance and widespread secularism and, instead, is based on spiritual principles emphasizing powerlessness and the reliance on a higher power (Davis and Jansen, 1998). Further, the concept of powerlessness is both the foundation of recovery and a stumbling block for many clinicians (Davis & Jansen, 1998). Arguably, SH groups and professional treatment are different in kind rather than degree (Borkman et al., 1998) because of their different assumptions. Thus, examining SH groups under the heading of 'treatment' is misguided and cannot lead to a fair assessment of self-help (e.g., Rappaport 1993); rather, it limits our understanding of the process and creates misunderstandings (Davis and Jansen, 1998). It should be noted that twelve-step fellowships, basing their public relations policy on attraction rather than promotion (Tradition Eleven, AA, 1952) do not advertise, recruit, respond to criticism or address widely held misunderstandings about their program of recovery or about the fellowships. That stance, itself at odds with cultural norms of standing up for oneself when attacked, may be wrongly interpreted as an inability to correct misunderstandings or worse, as an admission that they are in fact true. This reinforces

the need for identifying and dispelling misunderstandings clinicians may hold about the 12-step program of recovery (see discussion next section).

Clinicians' attitudes towards SH bear not only on their referral decisions but also on treatment programs' openness to holding group meetings on their premises. Field observations conducted for an ongoing study of the effectiveness of SH for the dually-diagnosed (author citation) provide some insights into clinicians' misunderstandings about SH. The study includes the documentation of dual-recovery SH groups (Double Trouble in Recovery – DTR) being started in the treatment setting. We have observed that many professionals know of the benefits of participation in 12-step recovery groups and are eager to encourage client affiliation with SH fellowships including holding DTR group meetings onsite. In some agencies, clinicians, knowing that SH groups are traditionally autonomous from treatment organizations, practice the “hands-off” attitude whereby they agree to a group being started on the premises but provide no support or guidance. They believe that a group of individuals who share a common problem and meet with no professional present *de facto* becomes a self-help group, not knowing that group members may have had no prior exposure to SH groups and need guidance. At the other end of the spectrum, there are clinicians who view SH groups as part of treatment and feel that staff should attend group meetings and take notes, not understanding that doing so would compromise the confidentiality and anonymity of SH group proceedings. They too are usually well-intentioned and feel that documenting the deeply personal self-disclosure that occurs in SH meetings (and perhaps more so than in counseling sessions with clinicians) can help clients by pointing to specific issues they are struggling with. Overall, clinicians' attitudes about SH, favorable but cautious, may rest in part on misconception or limited knowledge.

Need for Research on Clinicians' Beliefs and Knowledge-Base about Self-Help

Behavior -- and intention to behave -- are based on attitudes which, in turn, are based on personal beliefs (Fishbein, 1979). Beliefs rest largely on what is learned and experienced. For clinicians to educate clients about SH, they need to know and understand the SH processes. Despite the acknowledged importance and effectiveness of SH in the recovery process, clinicians' knowledge of SH appears to be limited and more training seems needed for clinicians to better understand SH (e.g., Caldwell, 1999; Caldwell & Cutter, 1998; Davis & Jansen, 1998; Humphreys et al., 1999; Wollert, 1999). Reviews of both professional social work journals (Davis and Jansen, 1998) and graduate university curricula in social work (Wollert, 1999) point to the absence of information about SH. Lack of awareness, information and understanding has been identified as the “most important factor in social workers' reluctance to refer clients to SH groups” (Kurtz & Chambon, 1987). For example, in one study mentioned earlier found that only half (56%) of a sample of 120 social worker linked clients to the four most available mental health groups (Kurtz, Mann & Chambon, 1987). The most common reason for not linking clients of SH was lack of awareness of either the groups' existence or their programs.

Most clinicians learned about SH through the media, other clinicians, and clients (Todres, 1982). Of the 16 recommendations from the Surgeon General's Workshop (1988) discussed earlier, the incorporation of information and experiential knowledge about the concepts and benefits of SH in the training and practices of clinicians was given the highest priority. The need for training in SH was also articulated by a sample of graduate students in clinical psychology and social work who were surveyed about their understanding and attitudes toward SH: 97% agreed or strongly agreed that they needed more training on that topic (Meissen, Mason & Gleason, 1991). Training and information about SH are crucial because of the cultural misconceptions about the 12-step program of recovery discussed earlier; “social workers may need more information about 12-steps to determine their own interpretation and meaning of the controversies surrounding the program” (Davis and Jansen, 1998, p. 170).

Despite limited knowledge about SH, clinicians routinely make referral decisions. The knowledge gap may result in "missed opportunities for bridging people to [SH groups]" (Caldwell and Cutter, 1998, p. 227). Most of the "matching rules" clinicians use (Humphreys, 1997) lack empirical support. For example, Humphreys found that clients with a comorbid psychiatric disorder were less likely to be referred to SH, reflecting the belief among clinicians that the dually-diagnosed cannot productively engage in self-help groups. However, several studies found that dually-diagnosed individuals can become engaged in and benefit from participating in 12-step groups (Jerrell and Ridgely, 1995; Kurtz, Garvin, Hill, Pollio, McPherson, & Powell, 1995; Noordsy et al., 1996; Ouimette, Finney, and Moos, 1997; Powell, Kurtz, Garvin, & Hill, 1996). [Powell and colleagues (1996) have argued that commonly used referral strategies, often relying on a single procedure (e.g., giving client a meeting list or introducing him/her to an AA contact person), are of limited benefits to dually-diagnosed individuals; the authors proposed a model of AA utilization for dually-diagnosed individuals based on a health beliefs framework. The need for clinicians to be aware of and knowledgeable about SH groups as an important recovery resource may be even more acute when clients' recovery needs go beyond a single disorder.] Abstinence-based treatment with AA or NA has been found to work as well for unemployed, African-American, and unmarried addicts as for more affluent and educated clients (Miller and Verinis, 1995); and referrals to 12-step groups have been found effective for increasing attendance -- irrespective of clients' religious background (Winzelberg and Humphreys, 1999) -- again countering prevalent clinicians' beliefs identified by Humphreys. In addition to misguided beliefs about who can and cannot benefit from SH, clinicians are also concerned about the "dangers" and limitations of SH. Other misconceptions about 12-step programs include the belief that 12-step groups are a religion or cult, that SH groups lack professionalism, that their effectiveness lacks empirical support, that members become overly dependent on the group, that members (especially those who are dually-diagnosed) get bad advice from other group members, and that the usefulness of these groups is limited in time (i.e., only needed in early recovery) or in scope (i.e., deals with only one substance while clients have multiple issues) - see Chappel and DuPont, 1999 for discussion. These beliefs are generally unfounded.

Overall, it appears that clinicians' decisions about referral are often based on limited or inaccurate knowledge about the benefits of SH. Thus questions arise: What do clinicians know about SH and where do they learn it? Is such knowledge adequate to form educated opinions, to make referral decisions, and to address clients' ambivalence and misconceptions about SH groups so as maximize engagement in SH? The first step in answering these questions is to determine clinicians' beliefs about SH, their source and accuracy of these beliefs, the attitudes they generate about SH, and their impact on referral decisions.

Need for Research about the Process of Referral to Self-Help

The association between referral to SH and subsequent engagement in SH has been empirically demonstrated (e.g., Humphreys et al., 1999), as is true for the importance of "intensity" of referral (Sisson and Mallam, 1981, discussed earlier). Thus, research suggests that clinicians' role in facilitating engagement in SH relies not only on whether they refer clients to SH but also on how they proceed. Although there is evidence that clinicians refer many clients to SH groups (Humphreys, 1997), there has been no empirical investigation of what the process entails or what the rules clinicians use are based on.

Humphreys (1997) has noted the need to gain an in-depth understanding of clinicians' rules for matching clients to SH. Relevant research questions include: Is self-help participation discussed with new clients as part of an initial assessment? Are specific experiences, concerns and misgivings identified and addressed? If so, how? How well equipped are clinicians to address misinformed clients who may say: "I went once, I didn't like the leader," "that group

is all heroin addicts, I use crack," "I don't want to hear about God," or "I know someone who went for years, he started preaching all the time"? After a referral is made, is there a follow-up session to discuss what happened and to address clients' possible questions and concerns? Further, the impact of clinicians' characteristics (such as ethnic background, age, gender, education, personal experience with self-help, and recovery status) on likelihood to refer and on how referrals are made needs to be investigated.

Need to compare Clients and Clinicians' Perceptions of the Referral Process

In addition to documenting the referral process as described by clinicians, it is important to examine clients' experience of being referred (or not referred) because what clients "hear" clinicians say about SH partly determines the outcome of a referral (i.e., whether or not a client attends a group and becomes involved). As noted earlier, many clients may be ambivalent about SH -- particularly early on, when they are ambivalent about entering recovery. What they have experienced previously or heard from peers may color their views of SH even before clinicians broach the subject. Further, clients and even long-time group members often hold erroneous beliefs about SH groups (Chappel and DuPont, 1999) including many of the misguided beliefs held by clinicians (discussed earlier). In a recent pilot study, prospective members' ambivalence toward SH groups was recently evident during four focus groups with out-of-treatment substance abusers (S. Magura, personal communication, August 1999). Concerns and objections about SH groups were raised by participants regardless of prior group attendance: confidentiality (from staff when groups are held at the program), anonymity and privacy ("[other members] can take some of your issues and use it against you, I have a lot of deep issues, it's better one on one"), inability to identify with other members ("no two people have the same problems"), and negative opinions of group leaders ("they think they know everything; they know nothing").

Thus, how clients perceive clinicians' referral in the context of their prior experiences and beliefs needs to be studied to understand how the referral process can best lead to successful client engagement in SH.

Conclusions and Future Directions

Given Humphreys' (1999) findings that substance abuse treatment can enhance the effectiveness of SH, it is appropriate to ask: "How can client engagement in SH be maximized by reducing existing barriers, such as missed opportunities to refer and client's ambivalence toward participation?" Answers will come from studies of the referral process, including the basis for clinicians' decision to refer and clients' perspectives about self-help. Specifically, the source of clinicians' knowledge and "matching rules" must be investigated, as well as the professional/client dialogue about SH addressing clients' concerns and ambivalence about group affiliation. Such information will help identify the need for training if misconceptions and/or limited knowledge are uncovered, and thus, contribute necessary information to SH training in academic curricula. Finally, and most importantly, it will provide knowledge that can contribute to enhancing the number and outcome of referrals to self-help groups.

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