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Factors associated with mental health clinicians' referrals to 12-step groups

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Abstract

As substance use and mental illness services are increasingly integrated, mental health professionals are presented with opportunities to refer greater numbers of dually-diagnosed clients to 12-step groups. This study examined the relationships among clinicians' 12-step experiences, attitudes and referral practices in 6 NYC mental health clinics. A path analysis model showed that greater interest in learning about 12-step (12-step interest) directly predicted 12-step referral practices and that 12-step interest was predicted both by clinicians' perception of the helpfulness of 12-Step groups and the severity of their patients' problems with substance abuse. Clinicians' responses to open-ended questions supported this model. Didactic and experiential education for clinicians in substance abuse and mutual aid would likely increase patient referrals to 12-step groups.

Keywords

12-step; referrals; dual-diagnosis; mental health; clinician; mutual-aid

Background

Effectiveness of 12-step mutual aid for substance use disorders

Substance abuse treatment, delivered by counselors trained as addiction specialists, and mental health treatment, provided by mental health professionals, have until recently been

conceptualized and treated separately^{1,2}. Although the co-occurring nature of substance abuse and other mental illnesses has long been appreciated by the psychiatric community, it is not until relatively recently that significant efforts have been made to integrate care¹. In the substance abuse community, 12-step fellowships have a long history. Alcoholics Anonymous (AA), the most widely prevalent mutual-aid (peer-driven) organization, was created in 1935 and its “12-steps” (and accompanying “12-traditions”) became the template for numerous other ‘Anonymous’ groups seeking to offer support and guidance for a range of addictions³. These groups share core precepts of anonymity, spirituality, and “singleness of purpose.” This last precept is based on the principle that substance abuse must remain “relentlessly in the foreground” in order to sustain attention and avoid denial⁴. Affiliation with 12-step both during and after treatment has been identified as a beneficial and cost-effective way to improve substance use outcomes, and ongoing 12-step participation has been linked both to reduced risk of relapse and better family, vocational and social functioning across age groups^{5,6,7}. The few studies that have evaluated dual-focus 12-step groups designed for persons with substance abuse and co-occurring mental illness have also reported benefits associated with 12-step participation^{8,9}.

Role of clinicians

A main conduit through which clients first reach 12-step groups is clinicians’ referrals,¹⁰ for example, half of AA members report being first referred to 12-step by a health care professional¹¹. However, few studies have sought to identify the frequency and predictors of clinicians’ 12 step referrals. Existing reports have focused on substance abuse treatment professionals, where older age, less education, and greater personal 12-step affiliation have been linked to increased referrals^{5,6,12}, but little is currently known about 12-step referrals for dually-diagnosed patients by mental health counselors. One study identified clinicians’ beliefs about their clients’ capacity for recovery as a predictor of mental health clinicians’ 12 step referrals¹³.

The quality of the clinician-client therapeutic alliance and referrals stemming from that relationship figure prominently in client participation in 12-step groups¹⁴. There also is a strong association between the “intensity” of referral (i.e., how much information is provided to clients about 12-step and how referrals are followed-up) and client outcomes¹⁵. However, some clinicians are far more likely than others to refer their clients to 12-step groups. Because the effectiveness of 12-step is strongly associated with the frequency and consistency of attendance, i.e., weekly or more often and continuously over time¹⁶, low participation and high levels of attrition can greatly reduce the benefits of what might otherwise be a cost-effective and reliable means of improving outcomes for those in recovery. Several studies have sought to identify both obstacles to and predictors of clinicians’ referrals to 12-step. For example, a 1997 survey of the directors of US Veterans Administration substance-abuse treatment programs found that personal experience with 12-step increased the likelihood of referral⁵. Clinics with greater numbers of staff in recovery tended to refer to 12-step at higher rates. Treatment orientation also was a factor in likelihood to refer; not surprisingly, 12-step oriented treatment programs were more likely to refer their clients to 12-step as a form of aftercare than those facilities that were oriented to other modalities. Factors identified as obstacles to referral to 12-step included a client’s professed atheism, having a co-occurring psychiatric disorder, and lower perceived severity of substance abuse by the client’s counselor⁶. Perceived risks associated with both the religious/spiritual aspects of 12-step and with the intensity of the experience itself emerged as significant concerns for clinicians and were associated with lower referral rates.

12 Step Referrals for dually-diagnosed persons

Several US prevalence surveys have documented high rates of co-occurring mental illness (typically exceeding 50%) among those with a substance abuse disorder^{17,18,19,20,21}. Unfortunately, those with co-occurring disorders - a significant percentage of those in mental health treatment - have often not been encouraged to consider 12-step participation addiction recovery²². Coincident with policy and government efforts to integrate substance abuse and mental-health treatment, mutual-aid groups that have a more inclusive philosophy have been developed²². The great majority of research on counselor referrals has been done within substance use domains. The significance of counselor referrals takes on even greater importance among those who are dually-diagnosed, where obstacles to participation are amplified by fear of stigma, concerns about mental health symptoms, and a reticence to discuss medications and medication adherence^{23,24}. In these instances, the supportive and knowledgeable reassurance of a clinician can go a long way toward allaying anticipated challenges by helping the individual know what to expect and by addressing concerns and ambivalence. Substance use counselors have both more knowledge of and personal experience with 12-step groups than their mental health counterparts⁵. Many addiction specialists and para-professionals are motivated to enter the field because of a personal struggle with substance use and recognize firsthand the severity and impact substance abuse has had both on their own lives and on the lives of their clients. In contrast, mental health counselors are less likely to have personal familiarity with 12-step, are more likely than substance-abuse counselors to hold a professional degree, and have more ambivalence about referring mental health clients to 12-step groups^{5,12,13,25}. Given the increasingly integrated environment in which treatment is delivered, it is important to identify factors that influence the likelihood of 12-step clinician referrals for dually diagnosed patients treated in mental health settings.

Purpose of the Study

There have been few studies examining mental health counselors' attitudes and practices associated with referral to 12-step groups^{13,26,27}. The present study examines mental health counselors' attitudes about 12-step and their referral practices, and identifies factors predicting referral to 12-step groups.

Methods

Recruiting and study procedures

Clinicians were recruited in the context of a NIDA-funded study of dual-focus 12-step groups²⁸. This study includes 6 mental health facilities (clinics) in New York City that were participating in a randomized, controlled clinical trial studying the effectiveness of 12-step groups for persons who are dually diagnosed. Three sites were day-treatment programs, one residential, and two sites offered both residential and day-treatment facilities. A 15 page, 10–20 minute survey was mailed to the clinical director of each of the study sites for distribution to the clinical staff. The survey consisted of several demographic questions (age, ethnicity, education, clinical experience), several descriptive questions about the size of the clinician's case load and estimated number of substance-using clients, 80 Likert-style items representing scales (described below) concerning the clinician's attitude toward and knowledge of 12-step, clinician's perception of clients' substance use, and the frequency and intensity of clinician referrals to 12-step. The survey concluded with 4 open-ended questions inviting the respondent to share recommendations for improving both client participation in and clinic's openness to 12-step. The protocol was approved by the IRBs of NDRI, Western Michigan University, and the participating organization (where applicable). A box of surveys was sent to the clinic director at each study site and was accompanied by a letter from the NDRI principal investigator explaining the purpose of the survey. An informed

consent page was attached to each survey. The clinic director distributed surveys to the clinicians. Typically this was done during a staff meeting. Clinicians were not directly compensated for participating but the clinic was provided with up to \$200 for discretionary use, e.g., lunch for the clinicians. The project director followed up with the clinical director of each site to insure that surveys were completed and returned in a timely fashion. Completed surveys were returned to the clinic director who then sent them back to NDRI. Data were collected between April 2009 and June 2010. Survey data were entered into an Excel spreadsheet, checked for accuracy, and imported into SPSS.

Dependent variable: referral practices

To identify clinician behaviors that are consistent with referral to 12-step groups, we chose the *12-Step Referral Practices Scale (RSHP)*¹⁰. This highly reliable scale ($\alpha=.94$) consists of 20 items representing clinician practices that promote clients' participation in 12-step groups. Scale questions explore referral practices from a variety of perspectives, asking clinicians about how they initiate discussion about 12-step, address concerns, and what follow-up procedures are employed. Answer choices range from 1 (never) to 5 (always). Sample items: Thinking about your dually-diagnosed clients, how often do you give a client a meeting list? ...address client's concerns, reservations, or objections to 12-step? ...discuss the principles of 12-step? ...talk about the importance of connecting with other members? ...offer to accompany client to a meeting?

Independent variables

Sociodemographics—Respondents were asked age, gender, ethnicity, job title, years of experience in current position, years of experience in the field, years of experience in clinic, and highest academic degree awarded.

Substance Abuse Severity Scale (SASS)—Constructed by the investigators, this five question scale ($\alpha=.88$) asks clinicians to assess the impact drug/alcohol abuse has on clients' lives. Sample question: Of your clients who are currently abusing drugs or alcohol, how often does their substance abuse create significant difficulty in providing treatment to them? Five answer choices range from "never" to "every time."

Mental Health Confidence Scale (MHCS)²⁹—This 17-item scale ($\alpha=.95$) examines clinicians' beliefs about the self-efficacy of clients diagnosed with mental health disorders. Questions include "How many of your clients can get support when they need it? ...can face a bad day? ... can make friends?" Answer choices range from "none to almost all."

Clinician Optimism Scale (COS)³⁰—Ten item scale ($\alpha=.72$) examines clinicians' beliefs about their clients' capacity for improved social engagement, recovery, and self-sufficiency. Five choice scale ranges from "none" to "almost all," and includes questions such as "How many of your clients will be able to function very well in the community? ... will find work that enables to be self-sufficient? ...will have more trouble managing their lives than non-dual diagnosed clients?"

Helpfulness of 12-Step Scale (HTS)⁶—Seven item scale ($\alpha=.78$) is designed to evaluate clinicians' perceptions about the importance and efficacy of 12-step groups. Questions are posed in a zero ("not at all," or "harmful") to ten ("extremely," or "very helpful") format. Questions included "In your professional judgment how helpful/harmful are 12-step/self-help groups for dually-diagnosed individuals," and "How important a role do you believe 12-step groups can play in a person's recovery process?"

Interest in 12-Step—Single question item: “How interested would you be in obtaining further information/training about 12-step groups?”

Personal and Professional 12-Step Involvement—“Have you ever attended a 12-step meeting for personal reasons?” “Have you attended a 12-step meeting as part of your professional responsibilities?”

Statistical analyses

Descriptive analyses were undertaken to investigate demographics, attitudes associated with client recovery, beliefs about 12-step participation, experience with and interest in 12-step groups. Bivariate analyses (correlation, chi-square) were used to select variables that predicted the primary dependent variable, referral practices (RSHP). Finally, regression analyses were conducted in order to construct a path-analytic model that predicted referral practices. Responses to the open ended questions were not coded, but were used to provide a qualitative context for understanding level of counselors' 12-step referral practices.

Results

Descriptives

The sample consisted of 105 clinicians. Average number of respondents per site was 17.5 (SD 7.48). Sociodemographics for the clinician sample are reported in Table 1. Respondents, all of whom had clinical experience with clients in the past year, were mostly female (64%), 49.6 (SD13.24) years of age and had 19.0 (SD11.06) years of clinical experience. Ninety-five percent had a caseload at the time of the survey; 76% ran groups. Sixty-eight percent were White, 18% Asian, 7% Black, and 2% Hispanic and 5% other. Job titles were: social worker (36%), psychologist (22%), psychiatrist (16%), nurse (11%), student/intern (8%), and administrator (5%). More than half of the respondents (56%) had a master's degree, 17% MD, 12% Ph.D., and 11% and 4% BA and high school diploma respectively. Sixty-seven percent reported having alcohol or drug abusing clients on their caseload, 43% had attended 12-step meetings for personal and 39% for professional reasons at some point in their life

Table 2 shows descriptive statistics on the clinicians' attitudes and practices about their clients and about 12-step. Clinicians reported that substance abuse “often” caused their clients significant difficulties such as poor medication adherence and preventing them from recovering from their mental illness (SASS mean=3.57, SD=.74, range 1–5). Clinicians indicated that “some to most” of their dually-diagnosed patients had the capacity to deal successfully with a range of mental health challenges including making friends, setting goals, and advocating for themselves (MHC=3.34, SD=.69, range 1–5) and expressed moderate confidence in their dually-diagnosed clients' capacity for improvement (COS=3.15, SD=.60, range 1–5). Clinicians expressed interest in learning more about 12-step groups (12-step interest=3.56, SD=1.14, range 1–5). But in spite of holding generally favorable views toward 12-step (HTS=7.36, SD=1.41, range 0–10), only “rarely to sometimes” embraced practices associated with referrals (RSHP=2.84, SD=.81, range 1–5).

Inferential analyses

Table 3 presents the associations among perceptions in client functioning (SASS, MHCS, COS), attitudes toward 12-step (HTS, 12-step interest), and referral practices (RSHP). Two domains emerged as significant ($p < .05$) zero-order predictors of 12-step referral practices, both yielding positive associations: greater interest in learning more about 12-step ($r = .36$) and perception of the helpfulness of 12-Step ($r = .21$). In the path model (Figure 1), referral practices was predicted by greater 12-step interest ($\beta = .36$; $p < .01$); 12-step interest was

predicted by clinicians' perception of the helpfulness of 12-Step groups ($\beta=.50$; $p<.01$) and the severity of their clients' problems with substance abuse ($\beta=.29$; $p<.01$).

Qualitative Analysis

Clinicians were asked four open ended questions: "What are the ways clients might benefit by participating in 12-step groups?", "What problems do you think they might encounter if they did participate?", "What could you do to encourage these clients to participate in 12-step?", and "What can this clinic do to encourage clients to participate in 12-step groups?" Their responses largely echoed and amplified the responses to the Likert scale questions. Benefits cited by clinicians included the sense of community, opportunity for education about mental illness and support for medication adherence; respondents associated non-participation with greater potential for relapse. In response to the first question, benefits of participation, one clinician wrote, "participation in the meetings decreases isolation, decreases shame, develops support networks, breaks through denial, [helps them] accept their illness, and gives them the support to hold onto a job." Not all clinicians were sanguine about 12-step benefits. In response to the question about potential problems and risks with participation, several indicated that they had "issues with religious orientation," and that they had concerns about "wrong advice offered by non-professionals;" another opined that "low cognitive ability would hamper clients' abilities to understand concepts." Of particular interest was the leitmotif (cited by 10 clinicians) that 12-step participation acts as a trigger: "Hearing war stories can trigger them; one person monopolizes the group... meeting active users, then going astray." Beliefs that 12-step might reawaken and trigger substance use behaviors in vulnerable clients is consonant with similar findings in which clinicians expressed concern that suicide screenings could induce suicidal ideation in clients not previously disposed to such thoughts³¹. The question about what the clinic could do to increase participation elicited a call for guaranteeing that the meetings take place "no matter what." One clinician lamented that meetings were inconsistently held around holiday times when they are needed most. The question exploring ways in which clinics can encourage participation in 12-step was answered with a resounding call for more education, both for staff and for clients, and is exemplified by the clinician who declared, "We should all attend a few meetings, dismiss objections, and discuss reservations. Once a substance abuse diagnosis is confirmed, I would encourage, remind, insist, and applaud their attendance at every visit." This sentiment is consistent with the key results of the survey: Clinicians who perceive both that their clients' substance use causes them serious problems and that 12-step is helpful are more likely to be interested in learning more about 12-step and to engage in practices that promote it.

Discussion

The role of clinician referrals to 12-step has been previously examined in substance-use contexts. Integrated care improves access for consumers and more efficiently allocates health care resources for providers. As economic, political, and social realities continue to catalyze the integration of mental health and substance use services, identifying the factors that predict mental health referrals to 12-step fellowships becomes increasingly urgent. Because there are both educational and experiential differences between mental health and substance use counselors, and because mental health services have been historically delivered separately from substance use treatment, we sought to better understand what characterized the referral-to-12-step process specifically among mental health counselors. In the present study a response to a single item, "How interested would you be in obtaining further information/training about 12-step groups?" was associated with referrals to 12-step groups. The relationship between interest and referrals was predicted both by the clinicians' perceived helpfulness of 12-step (HTS) and by an appreciation of the difficulties substance

abuse caused their clients (SASS). Mental health clinicians held generally favorable views toward 12-step, but it is of clinical relevance that they expressed reservations associated with both the religious aspect and potential “dependence” on 12-step, which is consistent with earlier findings among substance use counselors^{6,27}. In contrast to earlier findings obtained in substance use or dual-diagnosis settings, for the mental health clinicians neither personal 12-step involvement⁵, confidence in clients’ capacity for recovery¹³, nor age or educational attainment⁶ were associated with 12-step referrals. Differences in findings may be due to differences in participants’ specialties and training (mental health vs. substance abuse), in the clients they serve (dual vs. single disorders), and the nature of clinicians’ previous 12-step involvement. One reason single-focus 12-step groups receive ongoing referrals is that the majority of single-focus substance abuse counselors, (typically 85–90%)³² referring clients have personal experience with these groups, which is not the case with the clinicians in the present study, only 43% of whom had participated in 12-step for personal reasons.

Limitations

When interpreting the results of this survey, certain limitations must be kept in mind. Some respondents were aware that this survey was associated with the ongoing DTR groups at their clinics, which could have resulted in biasing their responses. Although clinical directors confirmed that all clinical staff had completed the surveys, not all questions were answered, reducing statistical power. The dependent variable, referral practices, is self-reported, and like any such measure might not accurately reflect actual referral practices. The sample, drawn from New York City mental health clinics, may or may not reflect the experiences, attitudes and practices of the broader community of mental health clinicians, limiting the generalizability of the findings. Although the open-ended questions’ intent was to spur respondents to discuss the broader spectrum of barriers to referral, this study did not specifically explore some important domains such as a client being a member of a sexual minority or methadone maintenance patient, factors that might influence clinicians’ referral practices. These are areas for future investigation.

Implications

That clinicians from different backgrounds are influenced by different factors when it comes to referring their clients to 12 Step becomes particularly salient in the current health care environment. Pending constitutional challenge and the current presidential election year, if fully implemented, the Affordable Care Act (‘Health Care Reform’) would simultaneously (a) integrate services (bringing both providers and consumers of mental health and substance abuse services together) and (b) encourage greater numbers of people to accept services for substance abuse, even if they sought services for other problems such as psychiatric symptoms. Providing a strong educational initiative for mental health providers may help ensure that consumers are referred to needed services such as 12-step fellowships consistently and reliably.

The study suggests that while both a generally positive attitude about 12-step and a recognition of the severity of substance abuse issues influence clinicians’ decisions to refer to 12-step, the most direct predictor of clinician referral is 12-step interest. Future efforts to spur referrals to 12-step among mental health clinicians must therefore include strong educational initiatives that focus on the: 1) efficacy, value, and ongoing support afforded by 12-step fellowships; 2) nature and prevalence of dual-diagnosis; 3) severity of substance abuse and its impact upon the client’s quality of life; and 4) challenges and opportunities associated with providing 12-step support for the dually diagnosed. As these educational goals are achieved, providing mental health clinicians greater opportunities to work with substance-abusing clients would both generate their interest in, and increase their readiness

to refer their clients to 12-step. In a health care system that increasingly integrates substance abuse and mental health services, this would likely lead to increased referrals to 12-step for mental health patients with co-occurring substance abuse, a group that has had limited opportunity to benefit from this modality.

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Figure 1. Path Model: Factors that predict 12-step interest and 12-step referral practices
All coefficients are $p < .05$.

Table 1

Sociodemographics of Clinician Sample (N=105)

Mean age	49.6 (SD 13.2)
Mean years clinical experience	19.0 (SD 11.1)
Female	64%
White	68%
Asian	18%
Black	7%
Hispanic	2%
Has drug or alcohol abusing clients	67%
Has attended 12-step for personal reasons	43%
Has attended 12-step for professional reasons	39%

Table 2

Scales

Variable	Mean	(SD)	Scale Range
Substance abuse severity (SASS)	3.57	0.74	1–5
Mental health confidence (MHCS)	3.34	0.69	1–5
Clinician optimism (COS)	3.15	0.6	1–5
Helpfulness of 12-Step (HTS)	7.36	1.41	0–10
Interest in 12-Step (one item)	3.56	1.14	1–5
12-Step referral practices (RSHP)	2.84	0.81	1–5

Table 3

Correlation Coefficients

Variable	1	2	3	4	5	6	7	8	9
1. Years of treatment experience	----	-.40**	-0.06	-0.07	-.27*	0.01	0.03	0.05	0.1
2. Female		----	-0.01	0.09	.34**	0.06	0.04	0.06	0.05
3. Patients' substance abuse severity (SASS)			----	-.39**	-.50**	.25*	.40**	-0.14	0.21
4. Mental health confidence (MHCS)				----	.33**	-0.04	-0.17	0.05	-0.01
5. Clinician optimism (COS)					----	-0.09	-0.16	0.15	-0.11
6. Helpfulness of 12-step (HTS)						----	.55**	0.19	.21*
7. 12-step interest							----	0.1	.36**
8. Have you ever attended a 12-step meeting?								----	0.09
9. 12-step referral practices									----

*

p .05;

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p .01