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Consumer Evaluation of Dual Focus Mutual Aid

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Abstract

Double Trouble in Recovery (DTR) is a “dual focus,” 12 step-based mutual aid program tailored to assist recovery from co-occurring substance use and psychiatric disorders.

Objective—To determine consumers’ perceptions of DTR’s usefulness for their recoveries and the relationships between perceived DTR usefulness and self-help processes, self-efficacy to cope with problems in recovery, and changes in behaviors conducive to dual recovery.

Methods—Consumers attending DTR groups, located within a psychiatric day-treatment program, completed anonymous surveys 8 months (N=19) and 20 months (N=61) after DTR was implemented.

Results—DTR participants rated DTR favorably and length of DTR attendance was significantly associated with increased self-efficacy for recovery and positive changes in recovery-oriented behaviors. Perceived DTR usefulness was significantly associated with greater engagement in three specific self-help processes and increased self-efficacy for recovery; notably, these associations were independent of consumers’ overall satisfaction with the treatment program.

Conclusion—This study is the first to document consumers’ perceived usefulness of DTR in relation to indicators of recovery. Overall, the study provides additional evidence for the benefits of implementing consumer-led dual focus groups in treatment programs.

Keywords

dual diagnosis; co-occurring disorders; self-help; mutual aid; 12 step program; substance use; mental illness; outpatient treatment; psychiatric co-morbidity; recovery

Introduction

More than five million adults in the U.S. have a co-occurring substance use disorder and serious mental illness, according to the National Survey of Drug Use and Health (Substance Abuse and Mental Health Services Administration, 2005). This is one of the most stigmatized and underserved populations in all of mental health care. One-half of this population (two million) received neither substance use treatment nor mental health care during the past year, and specialty treatment for co-morbid disorders is only starting to become available (SAMHSA, 2005). Co-occurring disorders are more severe and chronic

than single disorders (Hagnell & Grasbeck, 1990; Hirschfeld, Hasin, Keller, Endicott, & Wunder, 1990; Kessler, 1995; Murphy, 1990) and tend to predict of negative treatment outcomes (Ritsher, McKellar, Finney, Otilingam, & Moos, 2002; Gonzalez and Rosenheck, 2002; McLellan, Luborsky, Woody, O'Brien, & Druley, 1983; Rounsaville, Kosten, Weissman, & Kelber, 1986), although not in all studies (for a review, see Bogenschutz Geppert, & George, 2006).

Mutual aid refers to people helping each other address a shared problem in living, usually in a group context, without mediation by professional treatment or service providers. However, members of mutual aid groups may and often do simultaneously receive professional treatment and services. Twelve step groups are a form of mutual aid, characterized by the use of the 12 Steps to recovery as originally articulated by the founders of Alcoholics Anonymous [AA] (1952). A growing body of evidence indicates that 12-step groups are helpful in maintaining abstinence from substances of abuse (e.g., Devine Brody, & Wright, 1997; Fiorentine & Hillhouse, 2000; Humphrey, Mankowski, Moos, & Finney, 1999; McCrady & Miller, 1993; Timko, Moos, Finney, & Lesar, 2000). There is less research on mutual aid or 12-step groups for persons in mental health recovery, but this also has been positive. For example, a national survey of over 2000 participants in peer-led mood disorder support groups indicated that the longer people attended, the less likely they were to have stopped medication against medical advice and to be hospitalized (Sheffield, 2003). Carpinello, Knight, Markowitz, & Pease. (2000) found significant associations between mutual aid affiliation and self-efficacy for mental health recovery, which has been identified as crucial in the recovery process (Hays and Buckle, 1992; Markowitz, 2001; Corrigan et al., 2005; Hansson, 2006).

Some studies have indicated that traditional “single focus” 12-step groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) have been underutilized by individuals with dual diagnoses (Jordan, Davidson, Herman, & BootsMiller, 2002; Noordsy, Schwab, Fox, & Drake, 1996; Zaslav, 1993; Minkoff, 1989; Minkoff and Drake, 1991), although the evidence is mixed (Bogenschutz et al., 2006). Studies have also shown that clinicians are less likely to refer persons with dual diagnoses than those with a single diagnosis to traditional mutual aid groups (Humphreys, 1997; Villano et al., 2005; Laudet, 2000), and that AA contact persons believe that specialized groups for dually-diagnosed individuals would be more helpful than AA (Meissen, Powell, Wituk, Girrens, & Arteaga, 1999) It is unclear whether dually-diagnosed patients benefit as much from traditional 12 step groups as substance use – only patients (Bogenschutz et al., 2006).

Previous research has indicated that participation in a dual focus 12-step group, Double Trouble in Recovery (DTR), is associated with positive changes for persons with co-occurring disorders (Magura, Laudet, Mahmood, Rosenblum, & Knight, 2002; Laudet et al., 2004). DTR is a mutual aid program adapted from the 12 steps of AA, specially designed to meet the needs of persons dually diagnosed with a mental illness and substance use disorder. DTR encourages members to discuss their addictions, mental illnesses, psychotropic medications, and experiences with formal treatment, without the shame or stigma they might encounter in traditional “single focus” 12-step groups such as AA or NA (Vogel, Knight, Laudet, & Magura, 1998). DTR was started in New York State in 1989 and currently has over 200 groups meeting in the U.S., with most currently in New York, Georgia, Colorado, New Mexico and Florida. Groups meet in community-based organizations, psychosocial clubs, supported housing; inpatient psychiatric hospital units, and outpatient treatment programs for mental health, substance abuse and dual-diagnosis.

Past research on the effectiveness of DTR among mainly long-term members demonstrated that DTR affiliation was associated with increased abstinence from drugs/alcohol (Laudet et

al., 2004), better psychiatric medication adherence (Magura et al., 2002), and improved coping and quality of life (Magura, Cleland, Vogel, Knight, & Laudet, 2007). Specific self-help processes in DTR groups - helping others and mutual learning - were associated with a higher rate of abstinence (Magura et al., 2003). Dually diagnosed persons with higher psychiatric symptom severity were more likely than others to attend DTR consistently, demonstrating that DTR is accessible for the most severely impaired (Magura et al., 2003).

The purpose of the present study was to determine the responses of patients with a dual diagnosis to voluntary DTR groups that were initiated within an outpatient psychiatric treatment program. We sought to explore members' involvement in the DTR groups and associations among DTR attendance, self-help processes (which measure hypothesized mechanisms of action in mutual aid), confidence to cope with problems arising in recovery (self-efficacy), and changes in behaviors conducive to dual recovery. We also sought to understand members' views about how DTR helps with their recoveries and what might facilitate DTR attendance. We hypothesized that longer duration of DTR attendance would be associated with engaging in self-help processes, increased self-efficacy for mental health recovery, and improvements in recovery-oriented behaviors. The present study also extends previous research by reporting on consumers' perceived usefulness of DTR in relation to indicators of recovery. In addition, this study focuses on relatively new DTR members - almost all with less than one year of participation - rather than the primarily long-term members previously studied.

Methods

Setting

The setting is a psychiatric continuing day treatment program (CDTP) that is operated by a medical college in an inner city area in New York City; most patients are insured by Medicaid. Patients typically attend the group-based CDTP program 3–5 days per week, participate in one to four groups per day, and typically spend 2–6 hours in the program each day. Patients are offered breakfast and lunch on days they participate in the program. The CDTP provides mental health services both for persons with single psychiatric disorders and those dually diagnosed with psychiatric and substance use disorders. The most common psychiatric diagnoses in order of frequency are major depression, schizophrenia and bipolar disorder; about one-half also have substance abuse disorders. Specific groups such as “Substance Abuse Awareness” and “Relapse Prevention” are offered to dually diagnosed persons,” more general mental health groups are offered to all consumers, such as “Coping with Mental Illness” and “Building Self Esteem.”

As part of a larger controlled trial of DTR with a 6 months follow-up, two weekly DTR groups were initiated by the research team; the results of this trial are reported in Magura, Rosenblum, Villano, Vogel, Fong, & Betzler (2008). An afternoon DTR group began in April 2004 and a morning DTR “orientation” group in February 2005. The afternoon group was consumer-led from the outset (i.e., a patient chaired and facilitated the meeting), although a research staff member often attended as a non-participant to observe the group's progress. The morning DTR orientation group, initially led by a clinical supervisor and the research project director, was started to help orient consumers to DTR and encourage their attendance at the afternoon group; this was a “billable” group. By October 2005, the morning group had been transformed into a consumer-led DTR group, with the provision that a program staff member continue to attend to maintain the morning group's billable status. The DTR groups were voluntarily available to all consumers in the CDTP and were the only consumer-led groups in the facility.

Procedures

A week prior to the group survey the study's project director informed members at the start of their respective meetings that a voluntary anonymous survey would be conducted the following week to determine members' impressions of DTR and how it might be affecting their recovery. The DTR groups were surveyed in December 2004 ($n = 19$) and January 2006 ($n = 61$). Persons attending DTR for the first time were not recruited and were asked to return to the next regular meeting. Otherwise, all consumers at the DTR meetings were observed to complete the survey. Since the surveys were anonymous, we could not prevent DTR members who had completed the first survey in 2004 from completing the second survey in 2006. However, we observed little overlap between the two samples, especially since the sample at the first meeting was small. At both times the surveys were completed in a group format; the research project director read the survey aloud and two research assistants helped consumers with individual questions as needed. (The research staff was independent of the clinic and had no clinical responsibilities.) The surveys took approximately 45 minutes to complete with a total of 80 surveys obtained. Consumers received \$5 in food coupons as an incentive.

Subject participation was voluntary based on informed consent. The study was approved by NDRI's and the host site's Institutional Review Boards (IRBs).

Measures

To acquire information on involvement in the treatment program, consumers were asked how many years they had been attending the treatment facility and how many total groups they attended in a typical week, including DTR. Number of months attending DTR was obtained by asking consumers, "how many months have you been attending DTR in this clinic?" with a 13-point response scale, from 0 ("less than 1 month") to 12 ("one year or more").

The perceived usefulness of DTR for recovery from co-occurring disorders (DTR Usefulness) was measured by asking consumers to rate the statement, "I feel that DTR is helping me in my recovery" (11-point visual analogue scale, from 0, "totally disagree," to 10, "totally agree"). Three established self-help process scales (Magura et al., 2003) were employed to measure consumers' engagement in the DTR group: the Helper-Therapy Scale, measuring the extent to which consumers assumed a helping role; the Reciprocal Learning Scale, measuring the extent to which consumers shared and learned from other group members; and the Emotional Support Scale, measuring consumers' experience of feeling supported and accepted by other group members. Self-efficacy for Recovery was measured with 5 selected items from the Mental Health Confidence Scale (Carpinello et al., 2000) representing the Optimism, Coping Advocacy subscales and two new items addressing confidence to cope with substance use and psychiatric medication adherence. The items were anchored to consumers' participation in the DTR group; Cronbach's alpha, a measure of internal consistency reliability, equaled .86. (Examples of items along with the response codes are included in the Appendix.) Changes in Recovery Behaviors were measured with an 11-item scale created by the authors, asking participants to what extent specific recovery behaviors (e.g., taking psychiatric medications; drug/alcohol use; attending NA/AA outside of the study setting; self-care, etc.) had changed since starting DTR; Cronbach's alpha = .72. (Examples of items are shown in Table 3.) Respondents were also asked to rate their Overall Satisfaction with Program (i.e., with treatment and services received at the CDTP) (11-point visual analogue scale, from 0, "totally dissatisfied," to 10, "totally satisfied").

Two open-ended questions were asked: “What would help you to attend DTR more often (in your own words)?” and “What do you get out of coming to DTR—how does it help you (in your own words)?”

Bivariate and partial correlations were computed to determine associations among length of DTR attendance, ratings of DTR usefulness, the five scales representing self-help processes, Self-Efficacy for Recovery and Changes in Recovery Behaviors. Statistical significance was set at $p < .05$ (2-tailed).

Results

Mean scores for the variables representing length of treatment attendance, number of groups attended per week, months attending DTR, and the scales are shown in Table 1. Patient tenure in the CDTP was fairly diverse with a mean of 2 years, a standard deviation of 2.5 years and a range from less than 1 year to 9 years. Subjects had attended DTR groups for a mean of 5 months; 17% of subjects reported attending DTR less than one month, and 15% of subjects reported attending DTR 12 months or more. Mean scores of the self-help process measures, self-efficacy, and recovery behaviors were all relatively high except for Reciprocal Learning which had a mean of 2.5 out of a possible range of 1 to 5.

Examples of responses on the Changes in Recovery Behaviors scale are shown in Table 2.

Bivariate (Pearson) correlations showing associations of the various scales with length of DTR Attendance and ratings of DTR Usefulness are shown in Table 3.

More months of participation in DTR was significantly associated with higher ratings on the Self-efficacy for Recovery and Changes in Recovery Behaviors scales. In order to help rule out length of treatment in the CDTP as accounting for these associations, we computed partial correlations between DTR Attendance and the self-efficacy and recovery behavior measures, with “years attending current treatment program” as the control variable. Both correlations with DTR Attendance remained significant as partial correlations (Table 3).

Ratings of DTR Usefulness were significantly associated with higher ratings on the three self-help process scales and on the Self-efficacy for Recovery and Changes in Recovery Behaviors scales. The correlation between DTR Usefulness and Overall Satisfaction with the Program was relatively high, $r = .60$. In order to help rule out overall satisfaction with treatment as accounting for the associations shown in the table, we computed partial correlations between DTR Usefulness and the other measures, with Overall Satisfaction with Program as the control variable. All of the correlations with DTR Usefulness remained significant as partial correlations, except the one involving Changes in Recovery Behaviors (Table 3).

Additional analysis was conducted to better understand the non-significant result for Changes in Recovery Behaviors. An ordinary least squares regression analysis was conducted where Overall Satisfaction with Program and DTR Usefulness were entered as the independent variables and Changes In Recovery Behaviors as the dependent variable. Neither of the independent variables was significant individually in the analysis (i.e., neither explained unique variance in the dependent variable), but the two independent variables jointly were significantly correlated with the dependent variable (multiple $R = .31$, $P < .05$).

In response to the question, “What would help you to attend DTR more often (in your own words),” 38% of consumers indicated that “more DTR groups” in the program would help them to attend more frequently. Less frequent responses were: no problems with attending

(13%); if people “kept it real” (12%); if I focused more on my recovery (7%); if I could change my schedule (7%).

In response to the question, “What do you get out of coming to DTR—how does it help you (in your own words),” the most frequent responses were that DTR was helpful to them in “staying clean and sober” (36%) and in providing peer support (25%). Less frequent responses were: learning about dual diagnosis (13%); staying focused on recovery (12%); allowing sharing and self-expression (9%); and increased self-esteem (6%).

Discussion

This survey of psychiatric outpatients with a dual diagnosis attending voluntary DTR meetings within their treatment facility found certain significant associations among length of DTR attendance, self-efficacy for recovery and changes in recovery-oriented behaviors. In addition, participants rated DTR as relatively helpful to their recovery (mean of 7.8 on a 10-point scale). In particular, ratings of DTR usefulness were positively associated, independently of overall treatment satisfaction, with greater engagement in self-help processes (Helper-Therapy, Reciprocal Learning, Emotional Support) and increased self-efficacy for recovery, though not with changes in recovery behaviors.

Consumers reported high ratings of self-help engagement (i.e., Helper-Therapy, Reciprocal Learning, Emotional Support) and improvements in self-efficacy after a relatively short duration of DTR attendance (i.e., mean of 5 months). Individuals with chronic co-occurring disorders often have inadequate social support and low self-efficacy and self-esteem; thus the interpersonal opportunities for acceptance, support, and learning available in DTR may contribute key elements to the recovery process. Increasing self-efficacy – the individual’s “functional sense of self” (Davidson & Strauss, 1992) – has been identified as a crucial component in mental health recovery. DTR engages even the most impaired consumers with dual diagnoses, including those struggling with active psychiatric symptoms and substance use, which may be a reason why the current sample reported benefits after a relatively short period of DTR attendance. The support of peers has been identified as a key factor facilitating recovery from mental illness (Corrigan et al., 2005), and high levels of social support have been associated with decreased substance use among persons participating in DTR (Laudet et al., 2004). As one DTR member in the current study stated, “it makes me feel comfortable being around people with mental illness and substance abuse histories.” DTR also encourages members to take an active role in the group early on (Vogel et al, 1998), which promotes mutual aid and personal responsibility, while fostering members’ self-efficacy and self-esteem. As another member stated, DTR aids in recovery from dual diagnosis by “build[ing] self esteem.”

Previous research has indicated that greater DTR affiliation is associated with increased engagement in self-help processes (Helper-Therapy, Reciprocal Learning), higher abstinence, improved self-efficacy for recovery, and improved quality of life (Magura et al., 2003; Magura et al., 2005). Thirty-eight percent of consumers indicated that they would attend DTR more frequently if more DTR groups were available in the outpatient treatment setting. Since patients in this study program usually have a 3 times a week, half-day schedule either in the morning or afternoon, many patients were not scheduled on the days or times of the day that the DTR groups met. While it was not possible for the study to initiate more DTR groups, this situation indicates that the ready availability of mutual aid groups will encourage greater utilization of them in treatment programs. Among dually-diagnosed persons who may have difficulty being fully accepted in traditional 12-step groups (AA, NA), establishing DTR groups within treatment settings provides immediate opportunities to experience and potentially benefit from self-help. Previous research has

shown that mutual aid groups complement, rather than compete with, professional mental health services (Hodges, Markward, Keele, & Evans, 2003); the current study reinforces this conclusion and helps demonstrate the benefits of integrating consumer-led mutual aid into a mental health treatment setting.

There was no significant association between DTR's perceived usefulness and length of DTR attendance. Consumers may indeed perceive DTR as useful even though they have not been attending very long, or alternatively, there may be some positive response bias in answering the question on usefulness.

As indicated above, the correlation between DTR Usefulness and Changes in Recovery Behaviors became non-significant when controlling for Overall Satisfaction with the Program. This seems to be because DTR Usefulness and Overall Satisfaction were relatively highly correlated and because the correlation between usefulness and recovery behaviors was relatively low, making it difficult to distinguish statistically between the possible effects of DTR versus the treatment program itself in this size sample. Note that conceptually, overall satisfaction with the treatment program includes satisfaction with DTR, perhaps accounting for the correlation between these factors. While we cannot conclude that the perceived usefulness of DTR explains a unique amount of variance in recovery behaviors, the supplementary regression analysis did indicate that DTR usefulness and overall satisfaction with the program together were significantly correlated with recovery behaviors.

The major conclusions that can be drawn from this study are that: DTR can be implemented successfully in a day treatment setting; within several months consumers report that these meetings are helpful to their recovery; and both DTR attendance and perceived usefulness showed significant correlations with certain recovery-oriented beliefs and behaviors, although no causal inferences can be made from this small cross-sectional study.

Limitations of the Study

The current study is limited by modest sample size; cross-sectional, non-experimental design; possibly overlapping groups in the two survey administrations; and some non-validated scales. It was conducted in one treatment setting with a unique sample; thus, caution should be exercised in attempting to generalize to other settings. The short survey did not include psychiatric diagnoses, substance abuse diagnoses, mental health or addiction treatment histories, quantitative measures of use or consequences of use, either objective or subjective, thus making comparisons with other dually diagnosed treatment samples difficult.

It would have been useful to compare the same consumers' impressions of DTR benefits over time, but since group attendance and survey completion were voluntary and anonymous, it was not possible to obtain such data. The study is based on the perceptions of the DTR participants, which may be biased towards optimism. However, it is important to know whether even self-perceptions of DTR are positive or not. Over-interpreting the data should be avoided; for instance, although 70% reported that their drug use was "a lot better" (Table 2), that does not necessarily mean abstinence.

Since the survey was announced the week before it was conducted, it is possible that some with negative views of DTR did not attend on the day of the survey, or alternatively, made sure they did attend.

Because this survey did not include a control or comparison group, the reported changes could also be partly attributable to participation in the treatment program or to 12 step group

participation outside the program (since one-quarter of consumers in this program do report recent 12 step meeting experience).

Overall, the study provides additional evidence for the benefits of implementing consumer-led dual focus groups in treatment programs.

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APPENDIX

Sample Items from Various Scales

Helper-Therapy Process Scale

I learn a lot about myself by helping other DTR members.

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

Helping others makes me feel good about myself.

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

Reciprocal Learning Scale

In the past month, how often did....

Another DTR member tell you how they felt in a similar situation.

1	2	3	4	5
Not at all	Once or twice a month	About once a week	A few times a week	Every day

In the past month, how often did....

You offer advice to another DTR member about how to deal with something.

1	2	3	4	5
Not at all	Once or twice a month	About once a week	A few times a week	Every day

Emotional Support Scale

We are all here to help each other in the DTR group.

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

We all respect each other in this DTR meeting.

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

Self-Efficacy for Recovery

Since coming to DTR, I am:

1	2	3	4	5

Self-Efficacy for Recovery

Much less confident   somewhat less confident   no change in confidence   somewhat more confident   much more confident

that I can stay out of the hospital.

Since coming to DTR, I am:

1   2   3   4   5

Much less confident   somewhat less confident   no change in confidence   somewhat more confident   much more confident

that I can deal with my mental health symptoms.

Since coming to DTR, I am:

1   2   3   4   5

Much less confident   somewhat less confident   no change in confidence   somewhat more confident   much more confident

that I can stay clean and sober.

TABLE 1**Mean Scale Scores**

Variable	Mean	SD	Range
Years attending current treatment program	2.0	2.5	(0–9)
Number of groups attended per week (includes DTR)	10.2	4.6	(1–20)
DTR Attendance (months)	5.4	4.1	(0–12)
DTR Usefulness	7.8	2.4	(0–10)
Overall Satisfaction with Program	7.5	2.7	(0–10)
Helper-Therapy Scale	3.3	.6	(1–4)
Reciprocal Learning Scale	2.5	.9	(1–5)
Emotional Support Scale	3.2	.5	(1–4)
Self-Efficacy For Recovery Scale	3.1	.6	(1–4)
Changes in Recovery Behaviors Scale	2.4	.4	(1–3)

* For all scales, higher score indicates more positive result.

TABLE 2**Recovery Behaviors Scale, Sample Items and Responses**

Since you started coming to DTR, has taking your psychiatric medications as prescribed CHANGED?	
1. A lot worse at taking my meds as prescribed	2%
2. A little worse	0%
3. A little better	29%
4. A lot better at taking my meds as prescribed	69%
Since you started coming to DTR, has your drug use CHANGED?	
1. A lot worse (using drugs more)	0%
2. A little worse	5%
3. A little better	25%
4. A lot better (using drugs less)	70%
Since you started coming to DTR, has dealing with mental health issues CHANGED?	
1. A lot worse at dealing with mental health issues	1%
2. A little worse	2%
3. A little better	39%
4. A lot better at dealing with mental health issues	58%
Since you started coming to DTR, has taking care of yourself (eating, getting enough sleep, personal hygiene) CHANGED?	
1. A lot worse taking care of myself	0%
2. A little worse	7%
3. A little better	40%
4. A lot better taking care of myself	53%
Since you started coming to DTR, has your ability to be assertive or stand up for yourself CHANGED?	
1. A lot less assertive	2%
2. A little less	3%
3. A little more	42%
4. A lot more assertive	53%

TABLE 3

Correlations (Pearson r and partial r)

	DTR Attendance	Control for <u>treatment length</u>	DTR Usefulness	Control for Overall Satisfaction <u>with Program</u>
		DTR Attendance		DTR Usefulness
DTR Attendance (months)	-	-	.10	n/a
Helper-Therapy Scale	-.01	n/a	.52**	.45**
Reciprocal Learning Scale	.10	n/a	.49**	.29*
Emotional Support Scale	-.01	n/a	.47**	.45**
Self-Efficacy for Recovery	.25*	.25*	.55**	.44**
Changes in Recovery Behaviors	.23*	.24*	.24*	.09

**
=p<.01;

*
=p<.05