



MASSACHUSETTS
GENERAL HOSPITAL

PSYCHIATRY ACADEMY

Efficacy of Clinical and Related Self-Help Interventions

John F. Kelly, PhD



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Disclosures

Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose.



Overview

1. **Background and Rationale**: Why “self-help” (“mutual-help”)?
2. **Efficacy and Mechanisms**: Do groups like AA confer real benefits?
If so, how?
3. **Clinical Interventions**: What can we do clinically to enhance
“self-help” participation and enhance outcomes?



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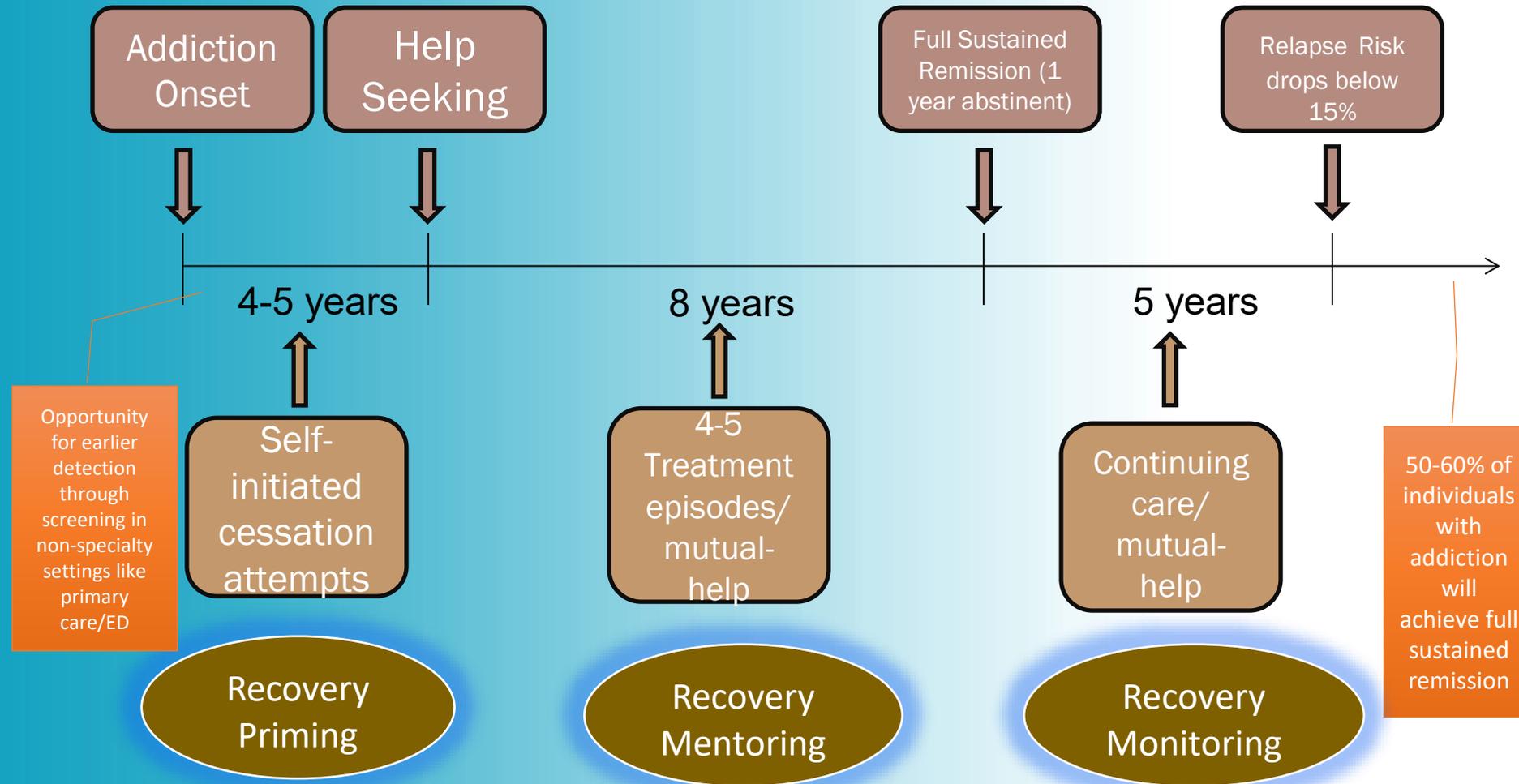


1. Why “Self-help”?

- Key Points
 - Achieving stabilization and recovery is demanding
 - Addiction is susceptible to relapse over the long-term
 - MHOs like AA are widely available – provide adaptive long-term indigenous community recovery support for free



The Clinical Course of Addiction and Achievement of Stable Recovery Can Take a Long Time...





STAGES OF CHANGE: RELATED TREATMENT & RECOVERY SUPPORT SERVICES

PRECONTEMPLATIVE

In this stage, individuals are not even thinking about changing their behavior. They do not see their addiction as a problem; they often think others who point out the problem are exaggerating.



CONTEMPLATIVE

In this stage people are more aware of the personal consequences of their addiction & spend time thinking about their problem. Although they are able to consider the possibility of changing, they tend to be ambivalent about it.



PREPARATION

In this stage, people have made a commitment to make a change. This stage involves information gathering about what they will need to change their behavior.



ACTION

In this stage, individuals believe they have the ability to change their behavior & actively take steps to change their behavior.

MAINTENANCE

In this stage, individuals maintain their sobriety, successfully avoiding temptations & relapse.



HARM REDUCTION

- * Emergency Services (i.e. Narcan)
- * Needle Exchanges
- * Supervised Injection Sites

SCREENING & FEEDBACK

- * Brief Advice
- * Motivational Interventions

SCREENING, BRIEF INTERVENTION, & REFERRAL TO TREATMENT (SBIRT)

CLINICAL INTERVENTION

- * Phases/Levels (e.g., inpatient, residential, outpatient)
- * Intervention Types
 - Psychosocial (e.g. Cognitive Behavioral Therapy)
 - Medications: Agonists (e.g. Buprenorphine, Methadone) & Antagonists (Naltrexone)

NON-CLINICAL INTERVENTION

- * Self-Management/Natural Recovery (e.g. self-help books, online resources)
- * Mutual Help Organizations (e.g. Alcoholics Anonymous, SMART Recovery, Lifering Secular Recovery)

CONTINUING CARE (3m- 1 year)

- Recovery Management Checkups, Telephone Counseling, Mobile Applications, Text Message Interventions

RECOVERY MONITORING (1-5+ yrs)

- Continued Recovery Management Checkups, therapy visits, Primary Care Provider Visits

CBT

MI

TSF



Potential Advantages of Community Mutual-Help

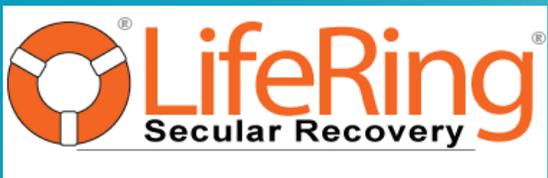
- Cost-effective – free; attend as intensively, as long as desired
- Focused on addiction recovery over the long haul
- Widely available, easily accessible, flexible
- Access to fellowship/broad support network
- Entry threshold (no paperwork, insurance); anonymous (stigma)
- Adaptive community based system that is responsive to undulating relapse risk

Substance Focused Mutual-Help Groups



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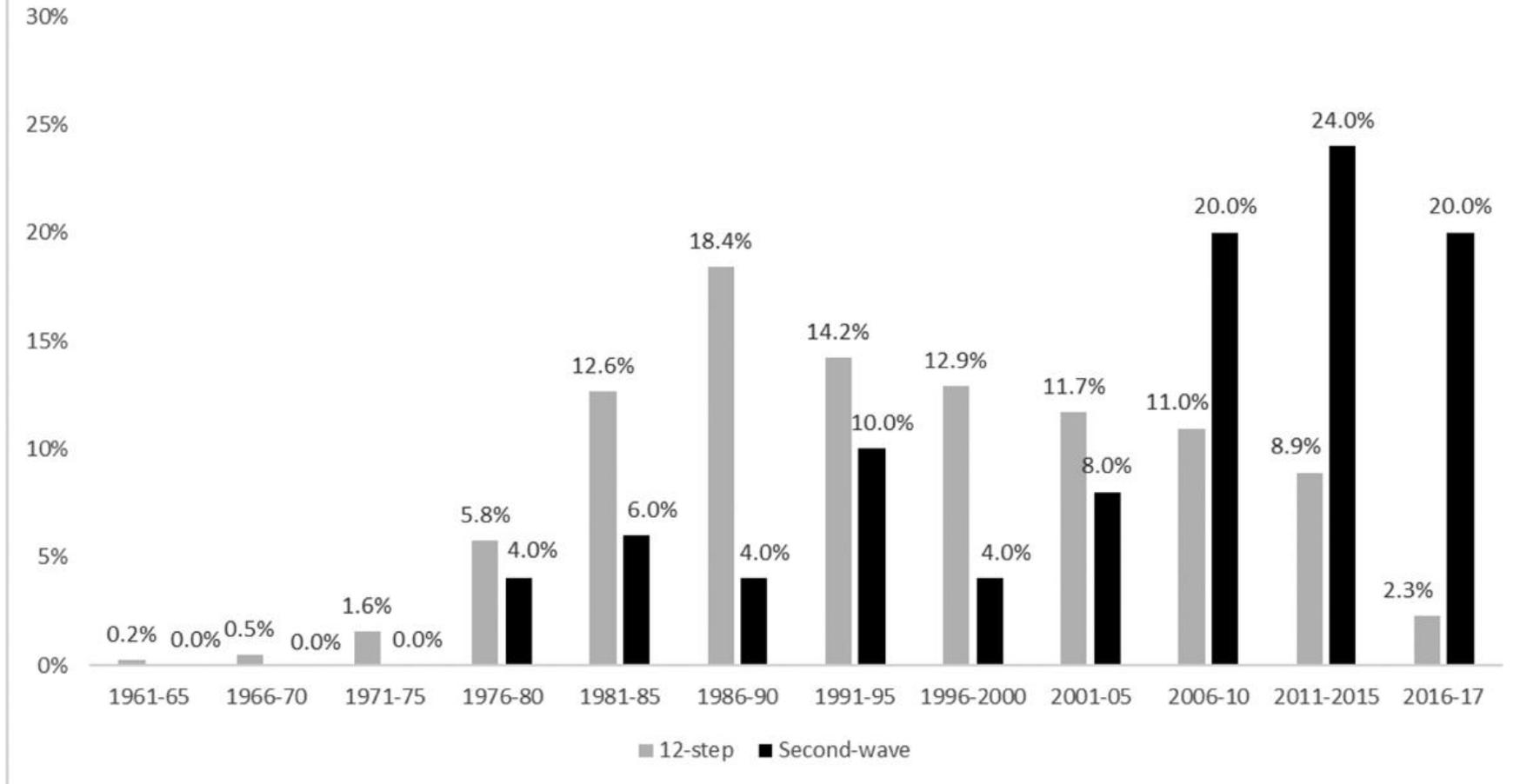


Name	Year of Origin	Number of groups in U.S.	Location of groups in U.S.	Evidence base* (0-3)
Alcoholics Anonymous (AA)	1935	52,651	all 50 States	1, 2, 3
Narcotics Anonymous (NA)	1940s	Approx. 15,000	all 50 States	1, 2
Cocaine Anonymous (CA)	1982	Approx. 2000 groups	most States; 6 online meetings at www.ca-online.org	0
Methadone Anonymous (MA)	1990s	Approx. 100 groups	25 States; online meetings at http://methadone-anonymous.org/chat.html	1, 2
Marijuana Anonymous (MA)	1989	Approx. 200 groups	24 States; online meetings at www.ma-online.org	0
Rational Recovery (RR)	1988	No group meetings or mutual helping; emphasis is on <i>individual</i> control and responsibility	-----	1, 2
Self-Management and Recovery Training (S.M.A.R.T. Recovery)	1994	Approx. 1000 groups	40 States; 50+ online meetings at www.smartrecovery.org/meetings/olschedule.htm	1, 3
Secular Organization for Sobriety, a.k.a. Save Ourselves (SOS)	1986	Approx. 480 groups	all 50 States; Online chat at www.sossobriety.org/sos/chat.htm	1
Women for Sobriety (WFS)	1976	150-300 groups	Online meetings at http://groups.msn.com/WomenforSobriety	1
Moderation Management (MM)	1994	Approx. 16 face-to-face meetings	12 States; Most meetings are online at www.angelfire.com/trek/mmchat/ ;	1



*0 = None 1 = Descriptive studies only 2 = Observational (correlational, longitudinal)
3 = Experimental (random assignment, controlled) Source: Kelly & Yeterian, 2008.

% of ever attenders who attended first lifetime meeting by year:
12-step vs. second-wave MHOs





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2. Do Groups Like AA Actually Confer Real Benefits? If So, How?

- Key Points
 - MHOs, like AA, confer benefits that are on par in magnitude with professional interventions
 - Interventions that promote MHO participation (i.e., TSF) often produce superior outcomes and higher rates of full remission
 - Participation in MHOs reduces reliance on professional care, reduces health costs and enhances remission
 - TSF/MHOs produce these better outcomes because they mobilize mechanisms mobilized by formal treatment (e.g., coping skills/motivation/abstinence self-efficacy) over the long-term



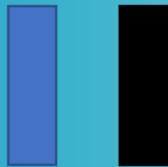


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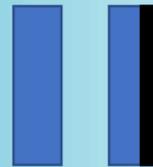
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TSF Delivery Modes

Stand alone
Independent therapy



Integrated into an existing
therapy



Component of a treatment
package (e.g., an
additional group)



As Modular appendage
linkage component



In past 35 years, AA research has gone from contemporaneous correlational research to rigorous RCTs and comparative effectiveness and sophisticated mechanisms research...



Cochrane Database of Systematic Reviews

Alcoholics Anonymous and other 12-step programs for alcohol use disorder (Review)

Kelly JF, Humphreys K, Ferri M

Kelly JF, Humphreys K, Ferri M.
Alcoholics Anonymous and other 12-step programs for alcohol use disorder.
Cochrane Database of Systematic Reviews 2020, Issue 3. Art. No.: CD012880.
DOI: 10.1002/14651858.CD012880.pub2.

www.cochranelibrary.com

Alcoholics Anonymous and other 12-step programs for alcohol use disorder (Review)
Copyright © 2020 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.

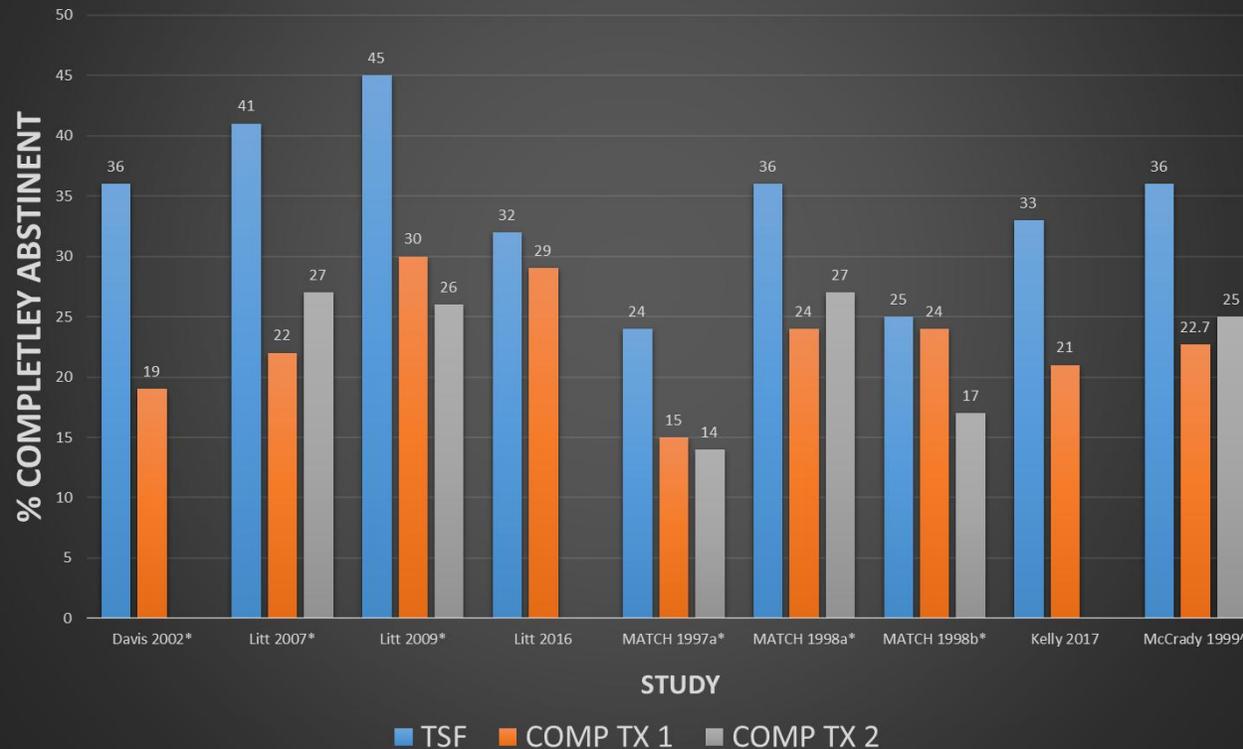
WILEY

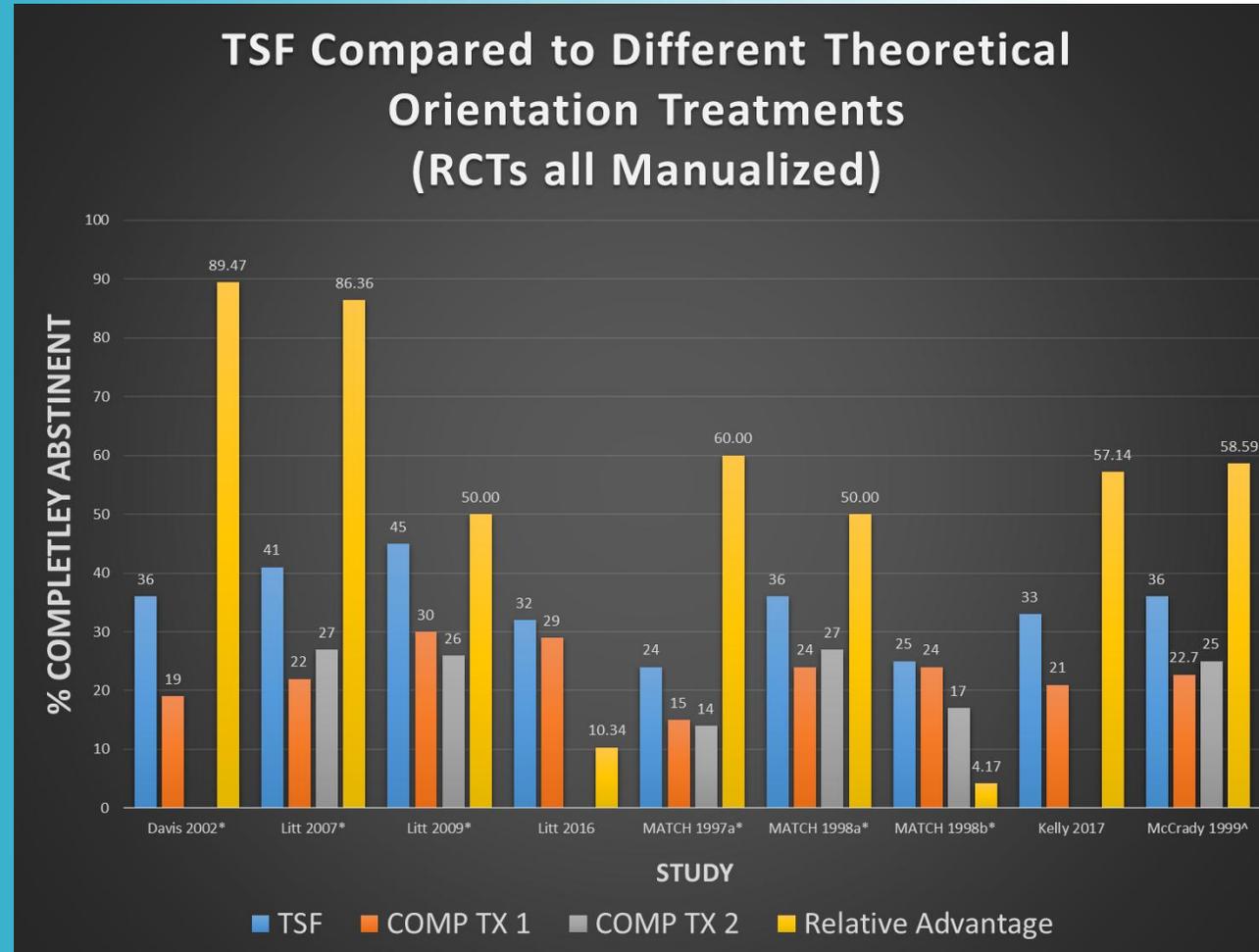
Cochrane Systematic Review on AA/TSF (2020)

- Kelly, JF
- Humphreys, K
- Ferri, M



TSF Compared to Different Theoretical Orientation Treatments (RCTs all Manualized)





Economic Studies

Healthcare Cost Savings

AA and similar
organizations are the

\$ closest thing public health s

in has to a “free lunch”



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Social Welfare Coordinating Group

12-step programs for reducing illicit drug use

Martin Bøg, Trine Filges, Lars Brännström, Anne-Marie Klint Jørgensen and
Maja Karrman Fredriksson

A Campbell Systematic Review
2017:2

Published: February 2017
Search executed: September 2016



WWW.MGHCMC.ORG



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Curative Factors of Group Therapy and...of MHOs?

- **Universality**
- **Altruism**
- **Instillation of hope**
- **Imparting information**
- **Recapitulation of the primary family experience**
- **Development of socializing techniques**
- **Imitative behavior**
- **Cohesiveness**
- **Existential factors**
- **Catharsis**
- **Interpersonal learning**
- **Self-understanding**



Facilitating involvement in Alcoholics Anonymous during out-patient treatment: a randomized clinical trial

Kimberly S. Walitzer, Kurt H. Dermen & Christopher Barrick

Research Institute on Addictions/University at Buffalo, The State University of New York, Buffalo, NY, USA

Addiction (1998) 93(9), 1313–1333

RESEARCH REPORT

Network support for drinking in Alcoholics Anonymous and long-term

RICHARD LONGABAUGH¹, PHILIP WALITZER², ALLEN ZWEBEN³ & ROBERT L. STODOLSKY⁴

¹Brown University, Center for Alcohol & Addiction Studies, Providence, RI, USA

²George Washington University, Washington, DC, USA

³University of Maryland, Center for Addiction & Behavioral Health Research, Butler Hospital, Center for Alcohol & Addiction Studies, Baltimore, MD, USA

Abstract

Aims. (1) To examine the matching hypothesis that Twelve Step Facilitation (TSF) is more effective than Motivational Enhancement Therapy (MET) for clients with networks supportive of drinking 3 years following treatment; (2) to test the matching hypothesis.

Design. Outpatients were re-interviewed 3 years following treatment.

Setting. Outpatients from five clinical research sites.

Participants. Eight hundred and six alcohol-dependent clients were assigned to one of three 12-week, manually-guided, individualized treatments: TSF, MET, or CBT.

Measurements and Main Results. Network support for drinking prior to treatment, Alcoholics Anonymous (AA) involvement during and following treatment, percentage of days abstinent and drinks per drinking day during months 37–39.

Findings. (1) The a priori matching hypothesis that TSF is more effective than MET for clients with networks supportive of drinking was supported at the 3 year follow-up; (2) AA involvement was a partial mediator of this effect; clients with networks supportive of drinking assigned to TSF were more likely to be involved in AA; AA involvement was associated with better 3-year drinking outcomes for such clients.

Conclusions. (1) In the long-term TSF may be the treatment of choice for alcohol-dependent clients with networks supportive of drinking; (2) involvement in AA should be given special consideration for clients with networks supportive of drinking, irrespective of the therapy they will receive.

TSF often produces significantly better outcomes relative to active comparison conditions (e.g., CBT)

Although TSF is not “AA”, it’s beneficial effect is explained by AA involvement post-treatment.

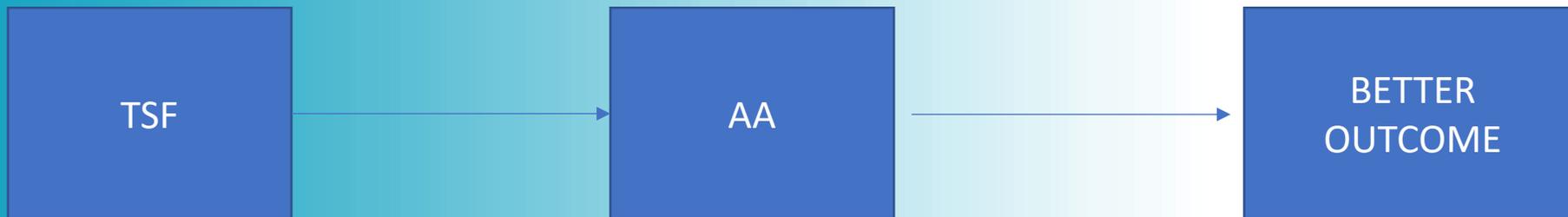


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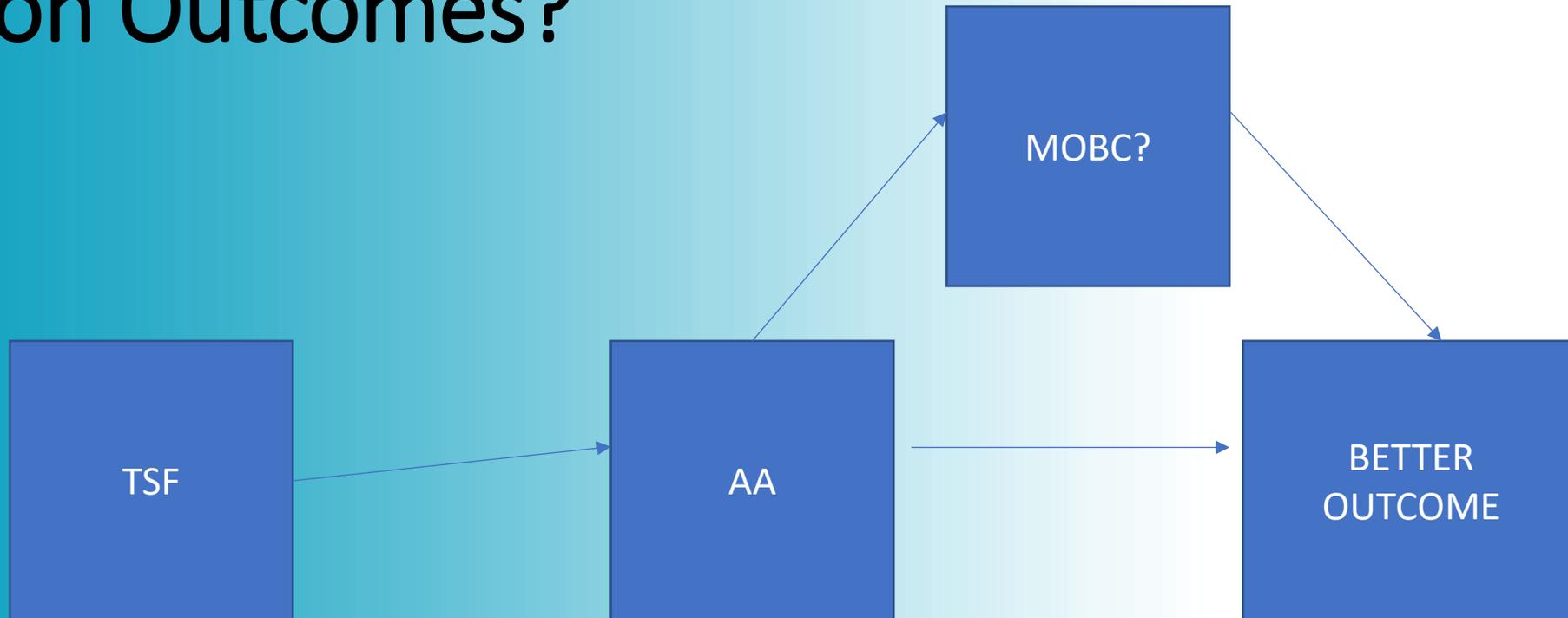


TSF-AA-OUTCOME Causal Chain Supported...





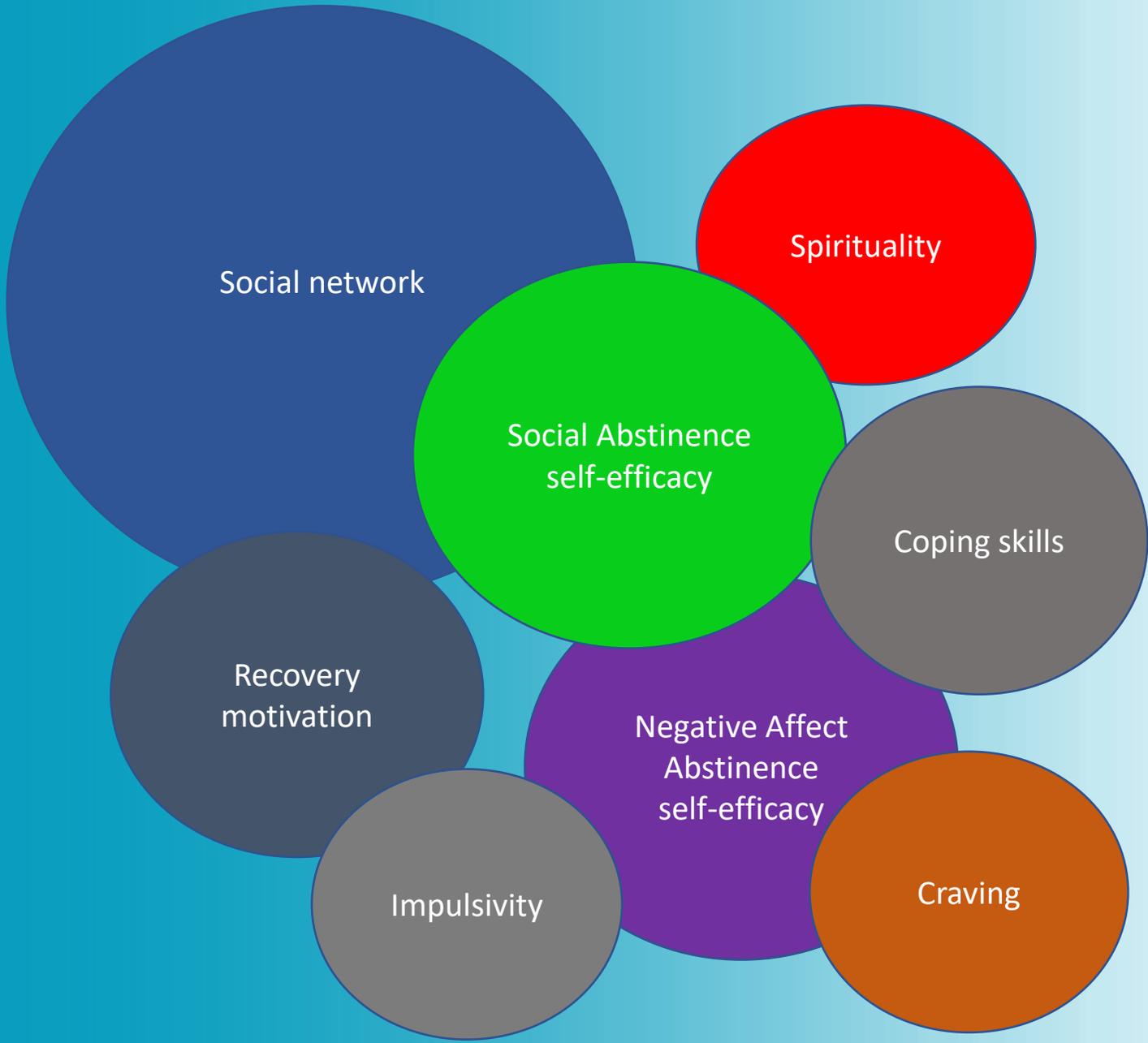
What About Support for Causal Chain of Purported MOBC of AA on Outcomes?



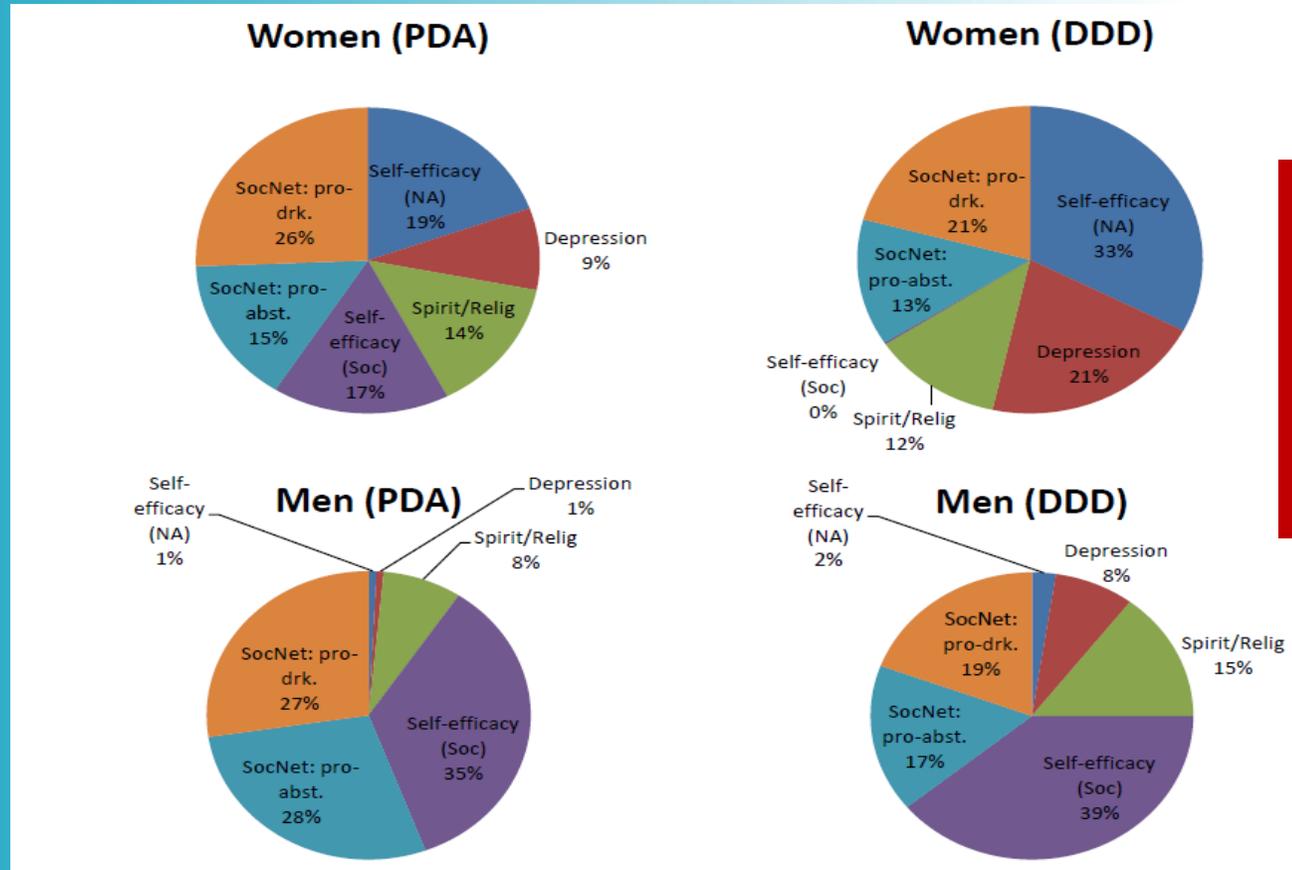


Empirically-Supported MOBCs Through Which AA Confers Benefit

AA participation in turn is explained by these factors which are similar to the mechanisms operating in formal treatment, and probably other MHOs as well....



Similar to psychotherapy outcomes research, AA works differently for different people/people make AA work for them in different ways.



From a clinical science standpoint, we know now that TSFs and AA confer meaningful relapse prevention benefits and how it does it, but what if you don't want to go to AA?

Kelly and Hoepfner (2013). Drug and Alcohol Dependence.



Do Fitness Centers Keep People Fit?



- Of course!
- If you go and if you work out regularly
- Perennial challenge is engaging and retaining people in some kind of ongoing exercise regimen...
- Fitness Centers therefore provide not just one, but an array, of different classes, spaces, equipment, pools, and courts, so that people can find something appealing



12-Step Alternatives

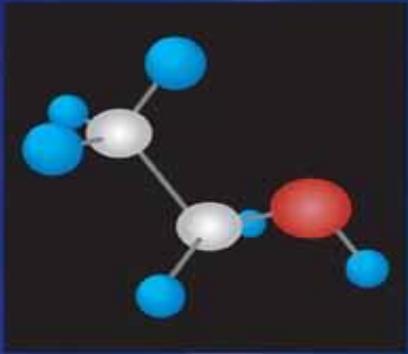
Main Findings

- **SMART RECOVERY RCT**
- **One study found no difference between SR meetings only and SR meetings + an online SR intervention^[23]**
- **PEER ALTERNATIVES COMPARATIVE EFFICACY STUDY**
- **Adults with AUD who were members of WFS, LifeRing, SMART, or 12-step^[24]**
 - Overall, primary group affiliation and involvement did not predict substance use outcomes over the 1-year period
 - SMART Recovery and LifeRing members were less likely than 12-step members to be abstinent at 1-year follow-up; however, these effects were negated when controlling for baseline abstinence goal

Alternatives to 12-step are likely to be as helpful as 12-step involvement at helping people manage SUDs. However, more research is needed on alternatives to 12-step, including research on facilitation to these groups.

ALCOHOL

CLINICAL & EXPERIMENTAL RESEARCH



Different organizations may attract and engage different SUD phenotypes...

ACER

The Official Journal of the Research Society on Alcohol and the International Society for Biomedical Research on Alcoholism



Founded in 1977 by the National Council on Alcoholism (Now National Council on Alcoholism and Drug Dependence, Inc.)

RESEARCH ARTICLE



Who affiliates with SMART recovery? A comparison of individuals attending SMART recovery, alcoholics anonymous, both, or neither

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Funding information

National Institute on Alcohol Abuse and Alcoholism, Grant/Award Number: K24AA022136 and R01AA026288; Massachusetts General Hospital Recovery Research Institute

Abstract

Background: Mutual-help organizations (MHOs) play a crucial role for many individuals with alcohol use disorder (AUD) or other substance use disorders in achieving stable remission. While there is now substantial research characterizing who uses 12-step MHOs, very little is known about who becomes affiliated with newer and rapidly growing MHOs, such as Self-Management and Recovery Training ("SMART" Recovery). More research could inform knowledge regarding who may be best engaged by these differing pathways.

Methods: We conducted a cross-sectional analysis of participants ($N = 361$) with AUD recruited mostly from the community who were starting a new recovery attempt and self-selected into one of four different recovery paths: (1) SMART Recovery ("SMART-only"; $n = 75$); (2) Alcoholics Anonymous ("AA-only"; $n = 73$); (3) Both SMART and AA ("Both"; $n = 53$); and (4) Neither SMART nor AA ("Neither"; $n = 160$). We compared the groups on demographics, clinical history, treatment and recovery support service use, and indices of functioning and well-being. We computed descriptives and conducted inferential analyses according to the data structure.

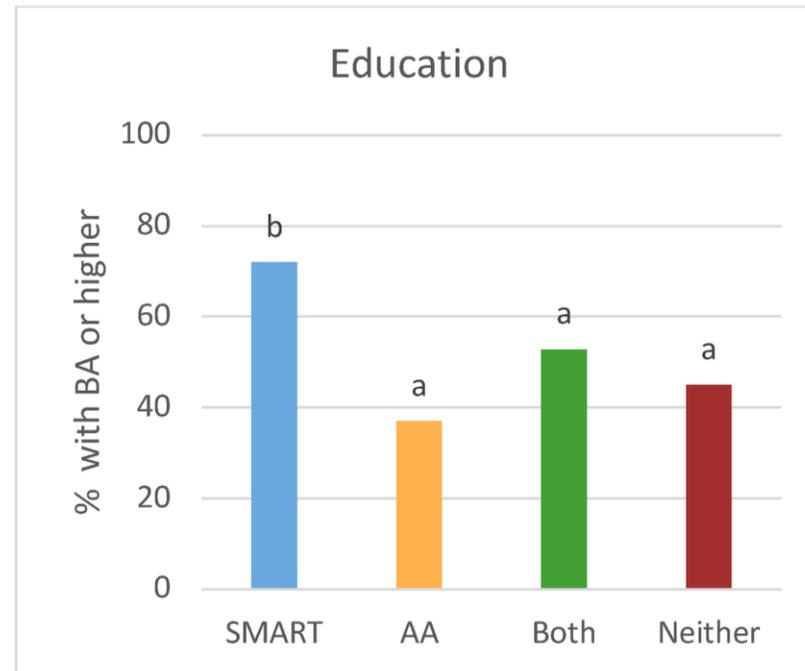
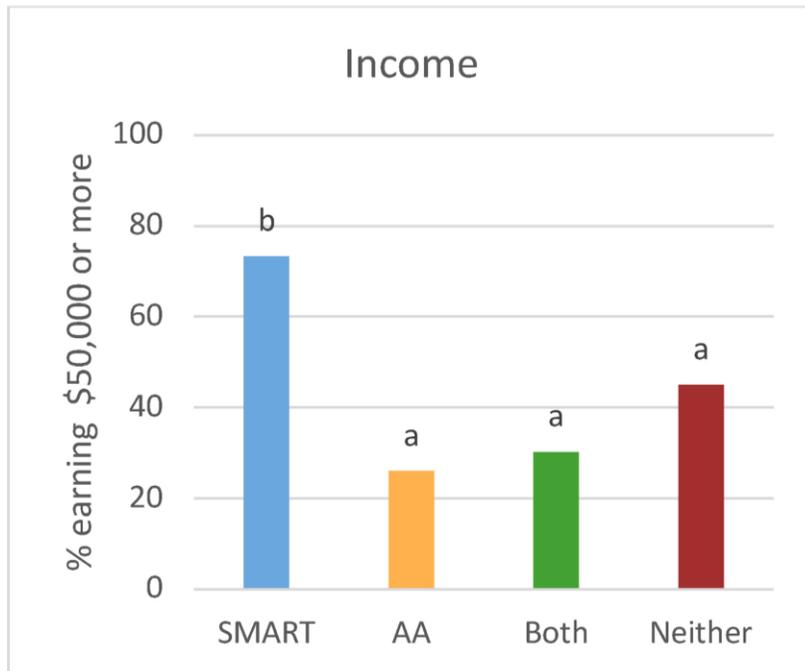
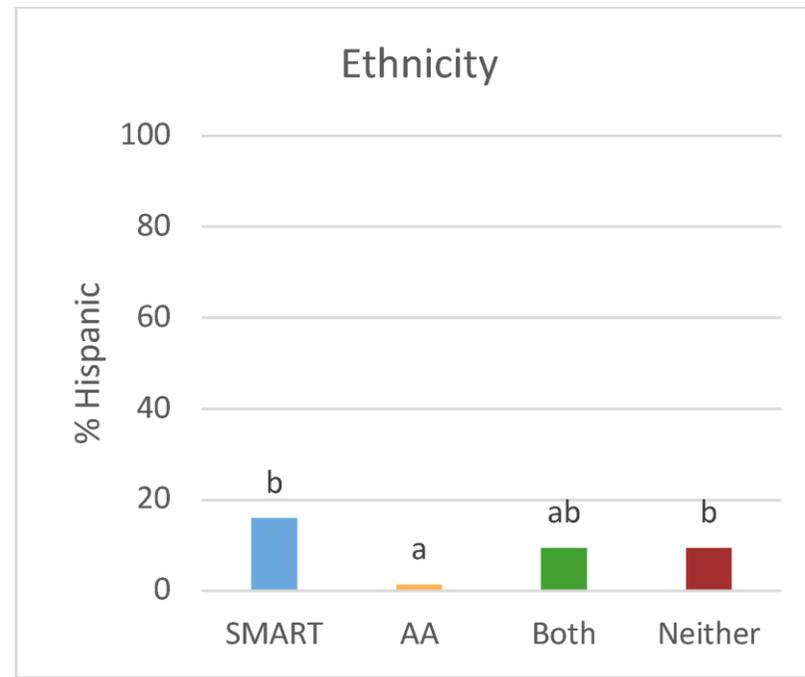
Results: Compared to study participants choosing AA-only or Both, SMART-only participants were more likely to be White, married, have higher income and more education, be full-time employed, and evince a pattern of lower clinical severity characterized by less lifetime and recent treatment and recovery support services usage, lower alcohol use intensity and fewer consequences, and less legal involvement. AUD symptom levels, lifetime psychiatric diagnoses, psychiatric distress, and functioning were similar across MHO-engaged groups.

Conclusion: SMART Recovery appears to attract individuals with greater psychosocial stability and economic advantage and less severe histories of alcohol-related impairment and legal involvement. Findings suggest that certain aspects specific to the SMART Recovery group approach, format, and/or contents may appeal to individuals exhibiting this type of profile. As such, SMART appears to provide an additional

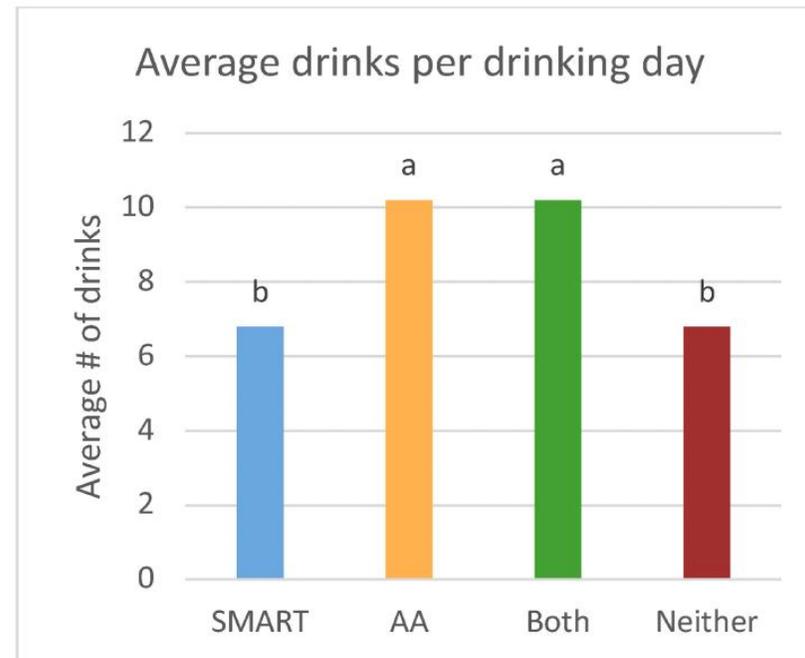
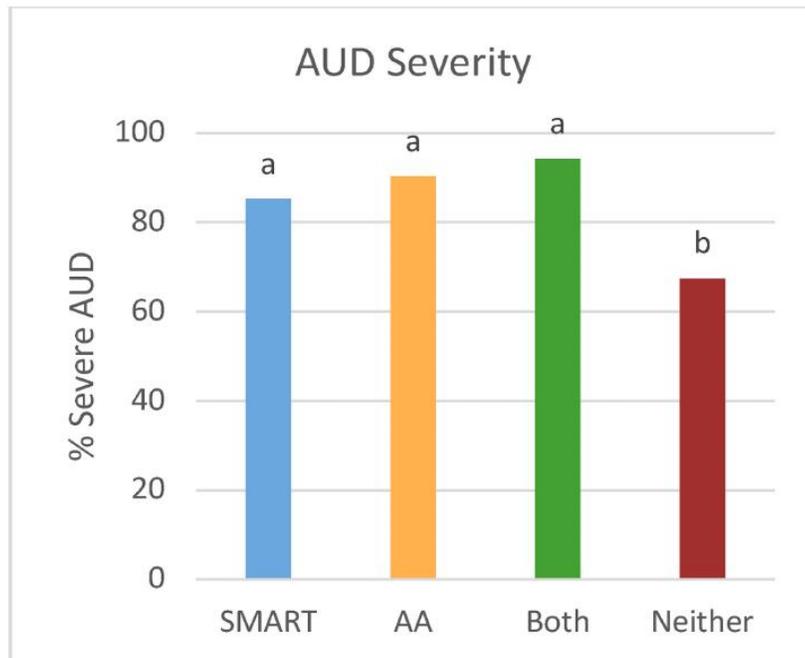
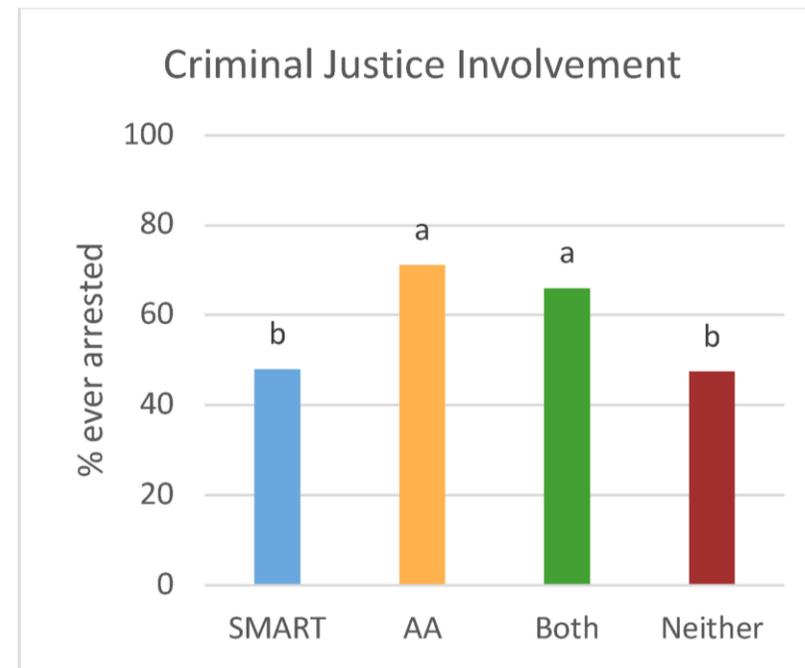
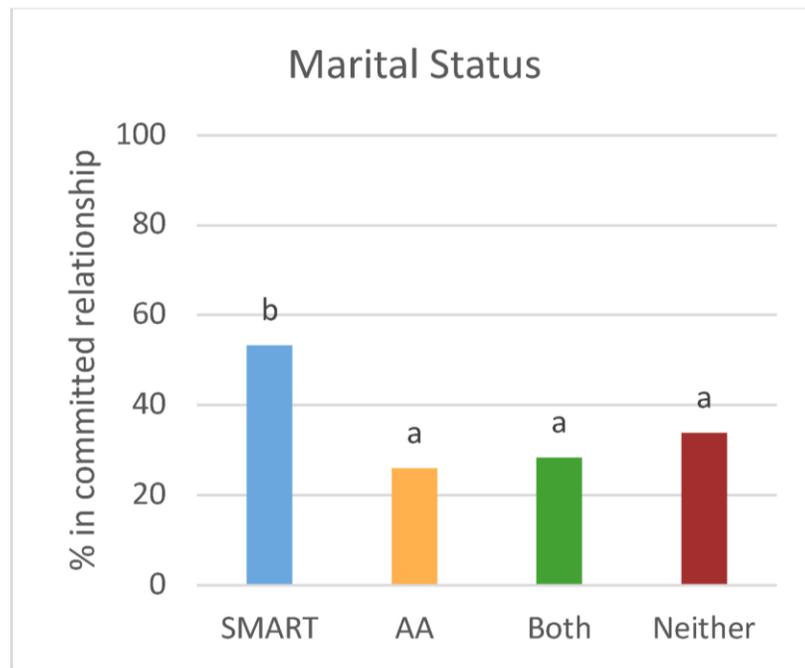
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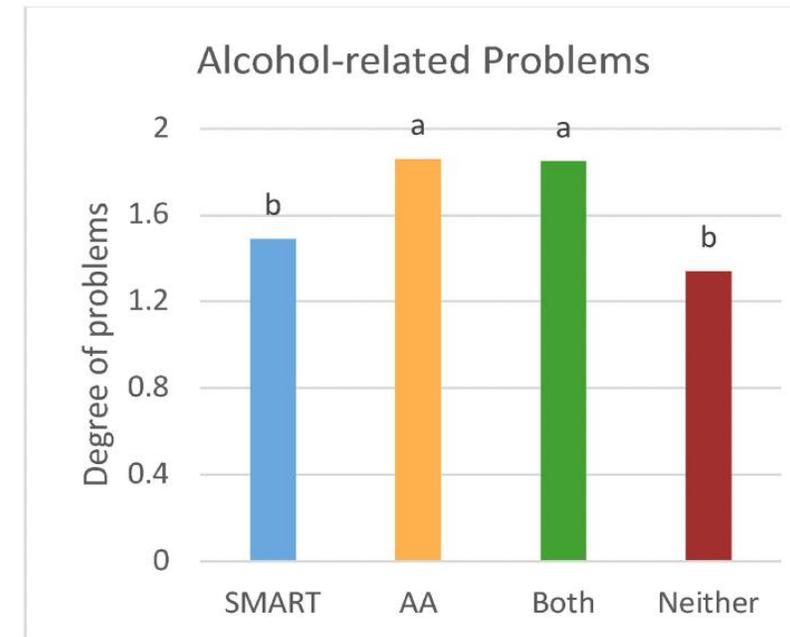
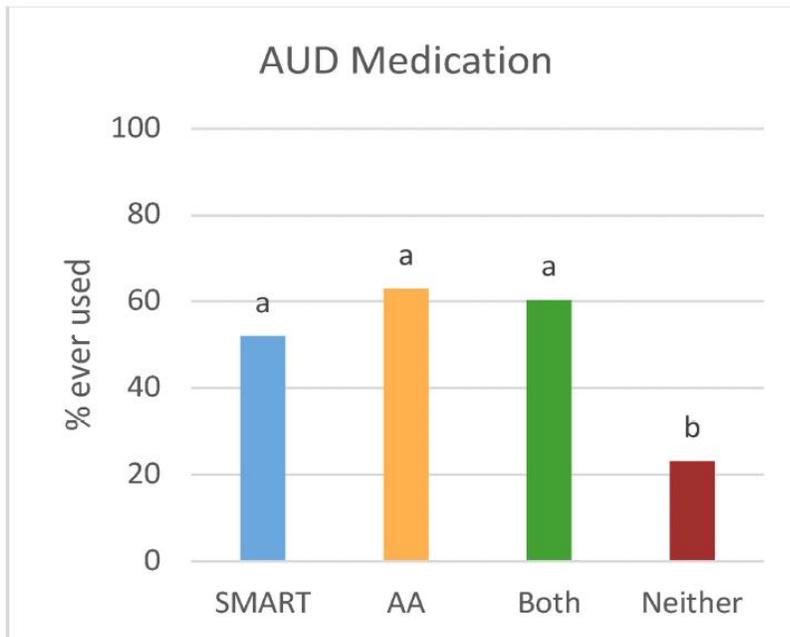
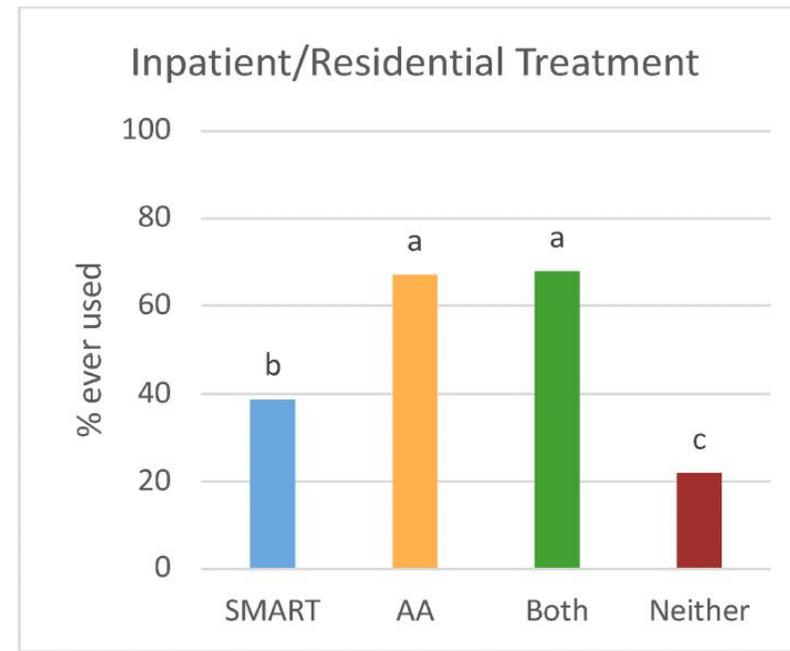
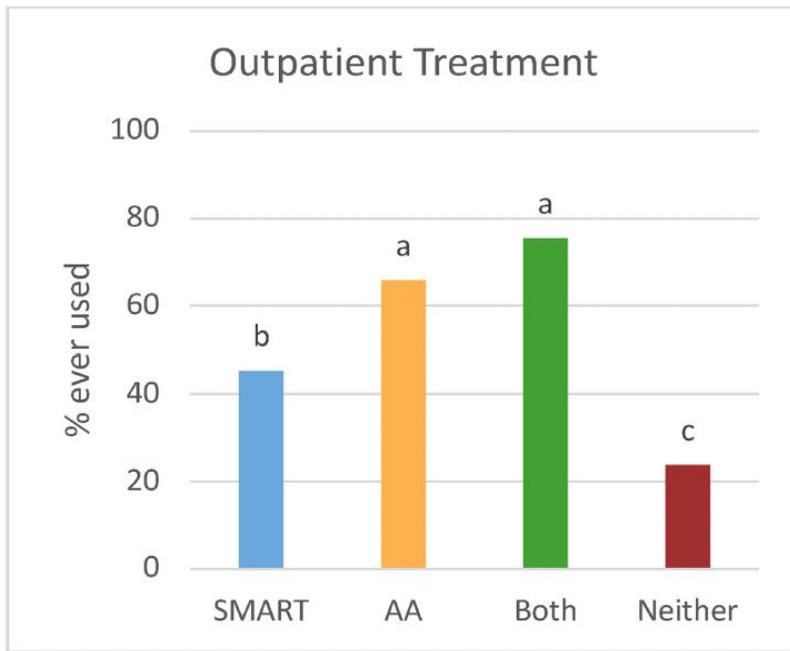
Results



Results



Results

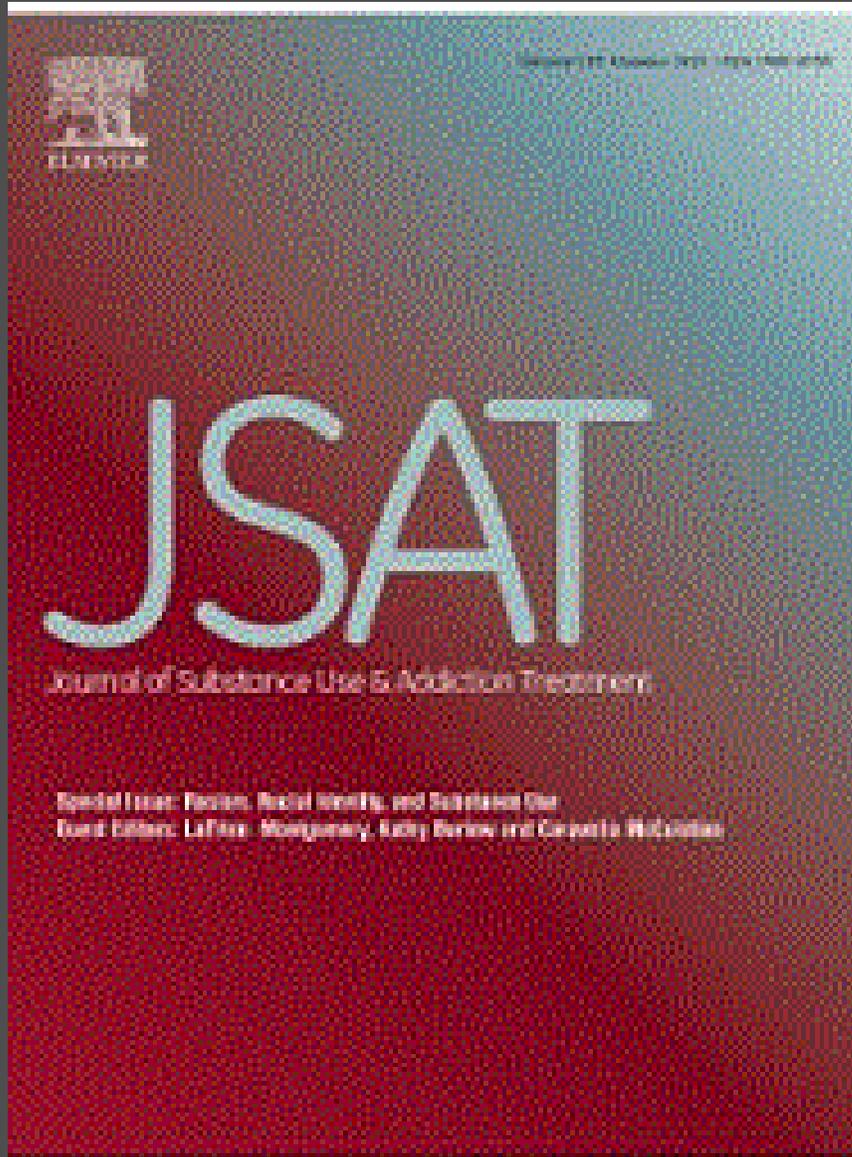


Summary - Predictors of Recovery Pathway Participation



- Relative to AA-only or those attending both AA+SMART, SMART-only participants tended to evince a pattern of:
- Fewer addiction-related impairments and formal AUD service utilization
- Greater levels of recovery capital
- Greater psychosocial stability
- SMART may provide a valuable additional recovery support service option for individuals with this or similar psychosocial/clinical profiles





A systematic qualitative study investigating why individuals attend, and what they like, dislike, and find most helpful about, smart recovery, alcoholics anonymous, both, or neither

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ARTICLE INFO

Keywords:

SMART Recovery
Alcoholics Anonymous
Mutual help
Mutual aid
Self help
Addiction
Substance use disorder
Treatment
Recovery

ABSTRACT

Background: Some individuals seeking recovery from alcohol use disorder (AUD) attend Alcoholics Anonymous (AA) while others choose newer alternatives such as Self-Management and Recovery Training ("SMART Recovery"). Some even attend both, while some choose not to attend either. Little is known about why people choose which pathway(s), and what they like, dislike, and find helpful. Greater knowledge could provide insights into the phenomenology of recovery experiences and enhance the efficiency of clinical linkage to these resources.

Methods: Cross-sectional, qualitative, investigation ($N = 80$; $n = 20$ per condition; 50%female) of individuals attending either AA-only, SMART-only, both, or neither. Participants were asked why they initially chose that pathway, what they like and dislike, and what helps. Responses were coded using an inductive grounded theory approach with utterances recorded and categorized into superordinate domains and rank-ordered in terms of frequency across each question and recovery pathway.

Results: AA participants reported attending due to, as well as liking and finding most helpful, the common socio-community aspects, whereas SMART attendees went initially due to, as well as found most helpful, the different format as well as the CBT/science-based approach. Similar to AA, however, SMART participants liked the socio-community aspects most. "Both" participants reported liking and finding helpful these perceived relative strengths of each organization. "Neither" participants reported reasons for non-attendance related to lower problem severity – perceiving no need to attend, and anxiety about privacy, but reported using recovery-related change strategies similar to those prescribed by AA, SMART and treatment (e.g., stimulus control, competing behaviors). Common dislikes for AA and SMART centered around irritation due to other members behaviors, a need for more SMART meetings, and negative experiences with SMART facilitators.

Conclusion: Common impressions exist among individuals selecting different recovery pathway choices, but also some differences in keeping with the group dynamics and distinct approaches inherent in AA and SMART. AA attendees appear to go initially for the recovery buoyancy derived from the social ethos and camaraderie of lived experience and may end up staying for the same reason; those choosing SMART, in contrast, appear to attend initially for the CBT/science-based content and different approach but, like AA participants, may end up staying due to the same camaraderie of lived experience. Those participating in both AA and SMART appear to capitalize on the strengths of each organization, suggesting that some can psychologically accommodate and make use of theoretically distinct, and sometimes opposing, philosophies and practices.

1. Introduction

Mutual help organizations are the most frequently sought source of help for people suffering from alcohol or other drug use disorders in many countries, including the US (Humphreys, 2004; Kelly et al., 2017;

Makela, 1996; SAMHSA, 2022). Some of the reasons for this include their widespread availability and easy local accessibility (including increasingly online), as well as their flexibility and low or no cost to participants (Humphreys, 2004; Kelly & Yeterian, 2008, 2012; Kelly, 2022). Empirical evidence is also strong regarding the clinical and

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<https://doi.org/10.1016/j.jsat.2024.209337>

Received 31 July 2023; Received in revised form 1 March 2024; Accepted 12 March 2024

Available online 14 March 2024

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Question 1: "Why did you attend?"

Question 1: Why did you attend AA/SMART/Both?									
AA	AA % (n)	SMART	SMART % (n)	Both	Both Both % (n)	Both AA % (n)	Both SMART % (n)	Neither - Why do you not attend any MHO?	Neither % (n)
Universality/Recovery Community	43% (19)	Universality/Recovery Community	11% (5)	Universality/Recovery Community	14% (4)	33% (23)	-	No perceived need/low problem severity	32% (13)
Maintaining sobriety	16% (7)	Maintaining sobriety	5% (2)	Culture, approach, format	-	-	35% (30)	Anxiety about attending/concerns about privacy	20% (8)
Provides structure	5% (2)	Culture, approach, format	34% (15)	CBT/science-based	-	-	53% (45)	Previous negative experiences	7% (3)
12 Steps as vehicle for change	5% (2)	CBT/science-based	30% (13)	As acknowledgment of problem	-	10% (7)	-	Has other methods of support	7% (3)
Existential reflection	5% (2)	As acknowledgment of problem	9% (4)	Desperation to stop; desire to engage with multiple pathways	79% (23)	-	-	Perceived AA as old-fashioned/non-scientific	7% (3)
Recovery information	5% (2)	Option for non-abstinent goals	5% (2)	AA's availability	-	27% (19)	-	Other	27% (11)
Availability	5% (2)	Other	7% (3)	Requirement to go to AA	-	7% (5)	-		
Other	18% (8)			12 Steps as vehicle for change	-	6% (4)	-		
				Other	7% (2)	17% (12)	12% (10)		

Kelly et al. (2024)



Question 2: "What do you like about attending?"

Question 2: What do you like about attending AA/SMART/Both meetings?						
AA	AA % (n)	SMART	SMART % (n)	Both	Both AA % (n)	Both SMART % (n)
Universality/Recovery Community	63% (26)	Universality/Recovery Community	32% (18)	Universality/Recovery Community	57% (26)	14% (9)
Provides structure	10% (4)	CBT/science-based	23% (13)	CBT/science-based	-	29% (18)
Instillation of hope	5% (2)	Culture, approach, format	16% (9)	Culture, approach, format	-	43% (27)
Recovery information	5% (2)	Recovery information	7% (4)	12 Steps as vehicle for change	9% (4)	-
Other	17% (7)	Other	21% (12)	AA's availability	7% (3)	-
				Instillation of hope	7% (3)	-
				Other	22% (10)	14% (9)

Kelly et al. (2024)



Question 3: "How does attending help you?"

Question 3: How does attending AA/SMART/Both meetings help you?								
AA	AA % (n)	SMART	SMART % (n)	Both	Both AA % (n)	Both SMART % (n)	Neither - What do you do that's helpful in your recovery?	Neither % (n)
Universality/Recovery Community	40% (16)	Universality/Recovery Community	23% (10)	Universality/Recovery Community	30% (13)	17% (6)	Competing activities, focus on healthy behaviors	27% (12)
Maintaining sobriety	13% (5)	CBT/science-based	28% (12)	CBT/science-based	-	31% (11)	Use of other programs, online resources	23% (10)
Catharsis	8% (3)	Accountability	7% (3)	Culture, approach, format	-	29% (10)	Avoiding triggers to drink	11% (5)
Provides structure	8% (3)	Provides structure	7% (3)	12 Steps as vehicle for change	11% (5)	-	Use of psychotropic and anti-craving/anti-relapse medications	9% (4)
AA facilitating deeper connection with personal faith	8% (3)	Reminder of negative alc/drug consequences	7% (3)	Accountability	7% (3)	-	Receive guidance from clinicians, mental health professionals, or therapy groups	7% (3)
Emotion regulation	8% (3)	Feelings of usefulness	5% (2)	Recovery information	7% (3)	6% (2)	Religious/spiritual structures outside of MHOs	7% (3)
Instillation of hope	5% (2)	Recovery information	5% (2)	Requirement to go to AA	7% (3)	-	Having responsibilities that could be harmed by substance use	7% (3)
12 Steps as vehicle for change	5% (2)	Thematic coherence and consistency with other recovery resources	5% (2)	AA's availability	7% (3)	-	Social support from family and friends	5% (2)
Other	8% (3)	Other	14% (6)	Reminder of negative alc/drug consequences	5% (2)	-	Other	5% (2)
				Existential reflection	5% (2)	-		
				Provides structure	5% (2)	-		
				Instillation of hope	-	6% (2)		
				Other	18% (8)	11% (4)		

People may start attending a mutual-help group for certain specific reasons (science-based aspects of SMART) but stay for common reasons (e.g., camaraderie/universality)

Kelly et al. (2024)



Overview

1. Background and Rationale: Why “self-help” (“mutual-help”)?
2. Efficacy and Mechanisms: Do groups like AA confer real benefits?
If so, how?
3. Clinical Interventions: What can we do clinically to enhance
“self-help” participation and enhance outcomes?



3. What Can We Do Clinically to Enhance “Self-Help” Participation and Thereby Enhance Clinical Outcomes?

- Key points
 - Broach the topic of MHO participation
 - Discuss what to expect (if patient never been)
 - Actively prescribe participation
 - Link with active members whenever possible
 - Monitor attendance and reaction

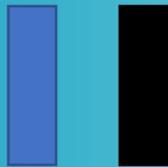


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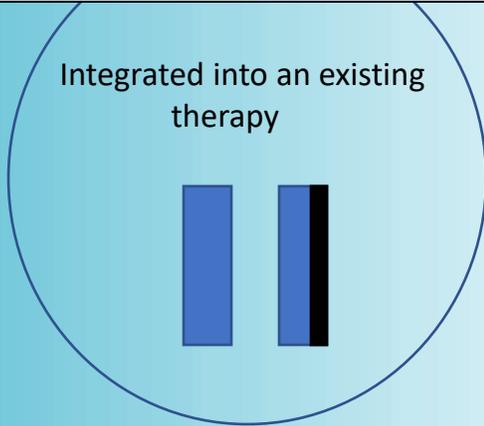
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TSF Delivery Modes

Stand alone
Independent therapy



Integrated into an existing
therapy



Component of a treatment
package (e.g., an
additional group)



As Modular add-on
linkage component





Strategies for Facilitating Outpatient Attendance of AA

(Wallitzer et al. 2008)

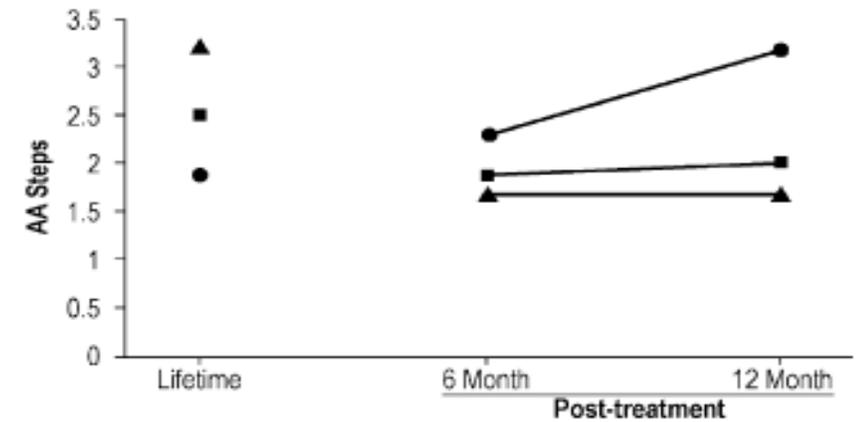
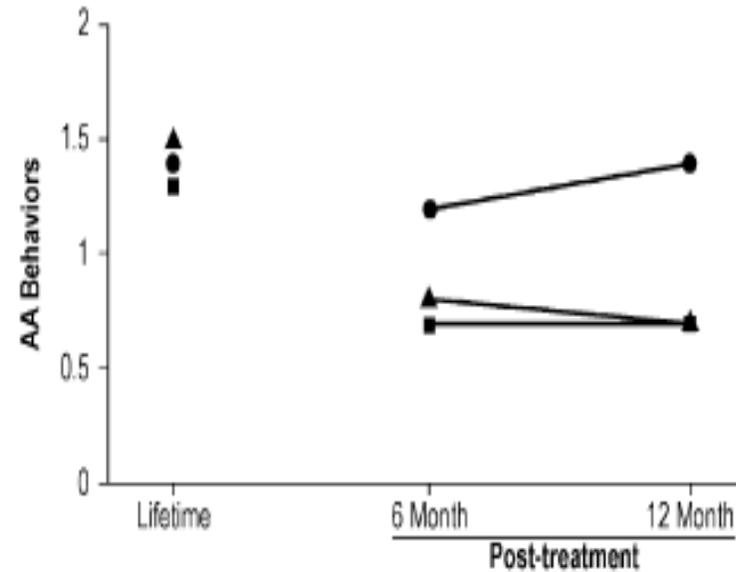
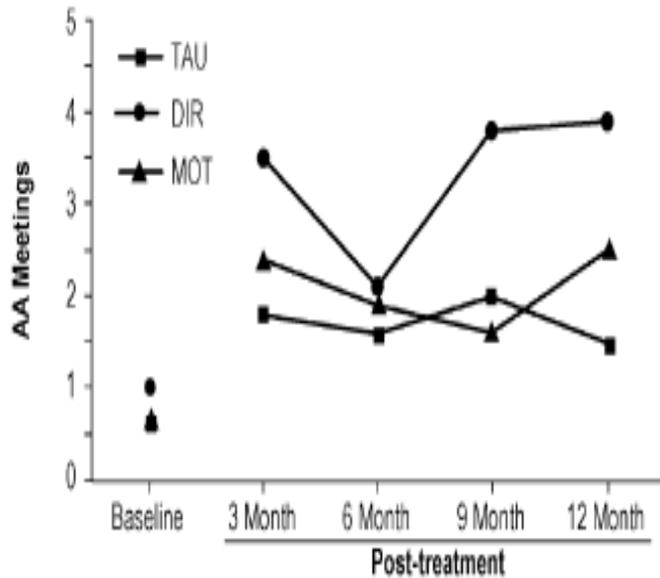
- Approaches to assist in involvement in AA
- 169 adult alcoholic outpatients randomly assigned to one of three treatment conditions
- All clients received treatment that included:
 - 12 sessions
 - Focus on problem-solving, drink refusal, relaxation
 - Recommendation to attend AA meetings



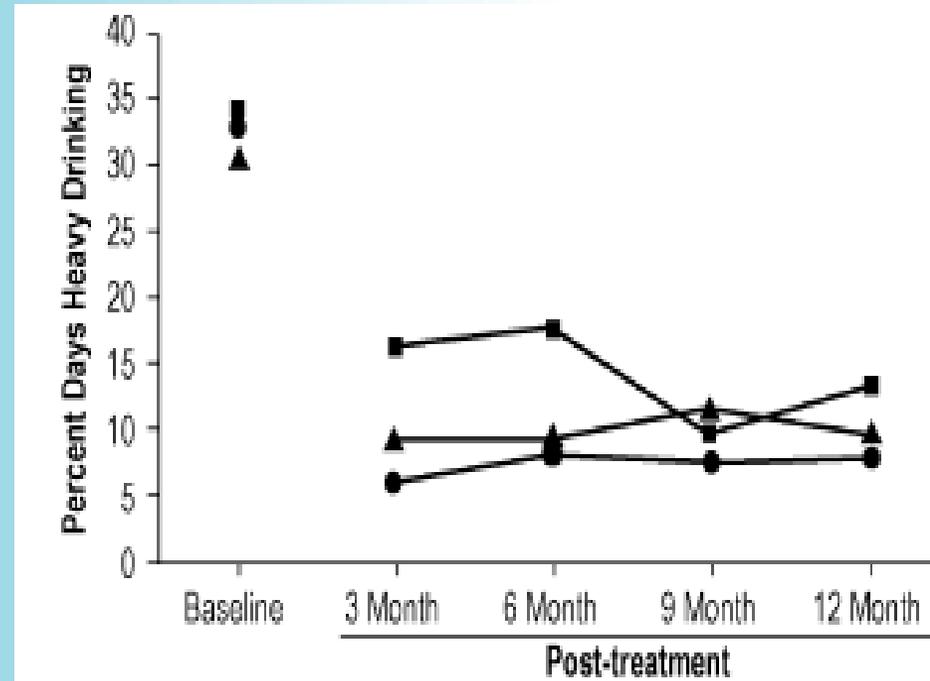
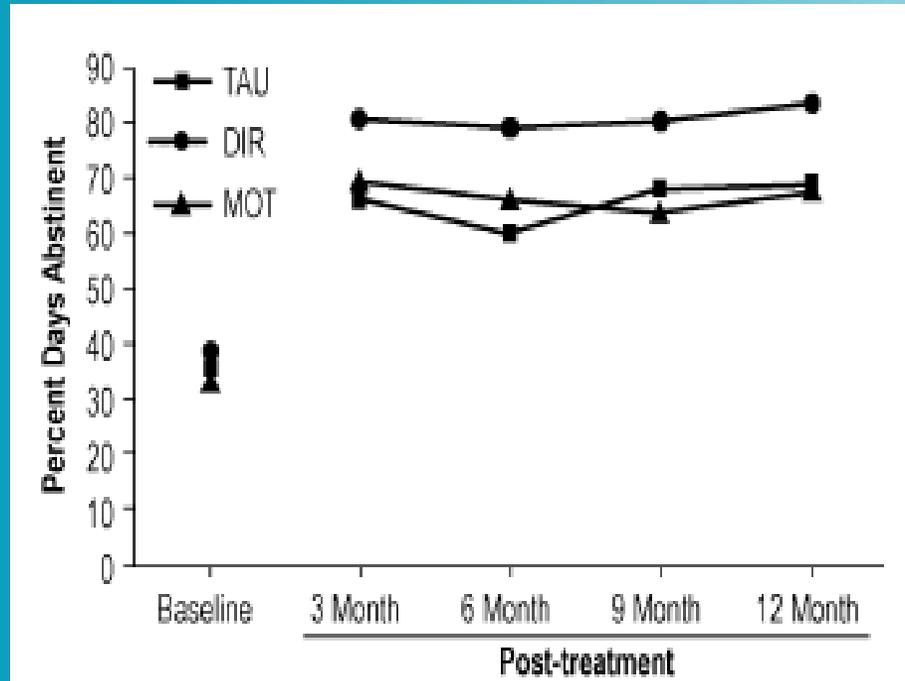
Strategies for Facilitating Outpatient Attendance of AA

- Treatment varied between 3 conditions in terms of how the therapist discussed AA and how much information about AA was shared
 - **Condition 1: Directive approach**
 - “I’d like you to attend 3 meetings this week and keep a diary of your experience....”
 - **Condition 2: motivational enhancement approach (more client centered)**
 - “How do you think groups like AA might help you in your change attempts/recovery?”
 - **Condition 3: CBT treatment as usual, no special emphasis on AA**
 - Throughout treatment, therapist briefly inquires about AA and encourages client to attend AA

Strategies for Facilitating AA Attendance During Outpatient Treatment



Strategies for Facilitating AA Attendance During Outpatient Treatment



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TSF Delivery Modes

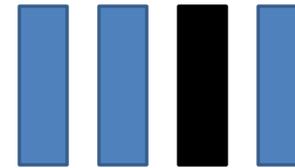
Stand alone
Independent therapy



Integrated into an existing
therapy



Component of a treatment
package (e.g., an
additional group)



As Modular add-on
linkage component



Precursor to current TSF research (Sisson and Mallams, 1981)

- » 20 patients randomly selected from outpatient tx program for alcohol use disorder
- » Randomly assigned to:
 - > 1: Standard referral
 - given information about AA including time, date, location of meetings, encouraged to attend meetings
 - > 2: Systematic encouragement and community access
 - In addition to standard procedure, clients had phone conversation with AA member during a session - client and AA member met before first meeting, member provided client with ride; client also received a reminder phone call from the member

Precursor to current 12-Step facilitation research

» Results:

- > 0% clients in standard referral attended a meeting during the target week
- > 100% clients in systematic encouragement and community access group attended meeting during target week
- > Mean AA meeting attendance rate for 4 week period:
 - + 0 for standard referral group vs 2.3 for systematic encouragement group



Drug and Alcohol Dependence 126 (2012) 131–137



Contents lists available at SciVerse ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdp



Does active referral by a doctor or 12-Step peer improve 12-Step meeting attendance? Results from a pilot randomised control trial[☆]

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ARTICLE INFO

Article history:

Received 22 December 2011

Received in revised form 2 May 2012

Accepted 3 May 2012

Available online 6 June 2012

ABSTRACT

Background: Active engagement in 12-Step self-help groups (SHG) is associated with improvements in substance use outcomes during and after treatment, yet levels of participation in SHG meetings in the UK remain low.

Method: An RCT investigating the impact of active referral to SHG, delivered by doctors or 12-Step peers during inpatient treatment on both inpatient and post-treatment meeting attendance was conducted. 151



ACTIVE REFERRAL TO 12-STEP GROUPS (MANNING ET A, 2012)

- Active linkages (Peer [PI] or doctor [DI]) produced higher attendance rates than no intervention (NI) (**88% vs 73%**; $p < .05$); although NI was still high
- Those attending during tx sig more likely to attend post-tx (**59% versus 20%**; $\chi^2 = 9.9$, $p < .01$).
- Sig group differences in post-discharge attendance rates (**PI = 64%, DI = 48%, NI = 33%** $p < .05$)
- **Among those without prior 12-Step experience, 33% of PI, 73% of DI, and 0% of NI, group, attended meetings post-tx ($p < .01$).**



Summary

- MHOs, like AA, are effective public health resources helping to mitigate relapse risk, and reduce health care costs.
- Research demonstrates AA works by mobilizing similar therapeutic mechanisms as those mobilized by professional interventions, but does so over the long-term for free in the communities in which people live.
- Number of empirically-supported manualized interventions exist shown to stimulate mutual-help participation during and following treatment and thereby improve outcomes and reduce health costs over long-term.
- Evidence for other MHOs is beginning to emerge; different MHOs may be suited to different SUD phenotypes/personal preferences

Enhancing Recovery Through Science



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