# Self help

## Self-help is so important that professionals should intervene to promote and support it and can do so without undermining self-help principles, argues a team of experts convened by the US government. They offer an agenda for services and policymakers to make the most of a powerful free resource.

## don't leave it just to the patients

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Adapted from Humphreys K. *et al.* "Self-help organizations for alcohol and drug problems: toward evidence-based practice and policy." *Journal of Substance Abuse Treatment*: 2004, 26(3), p. 151–158, with permission from Elsevier. A free version of the original report is available at www.chce.research.med.va.gov/chce/pdfs/VAsma_feb1103.pdf.

Preparation of the original paper was supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Dept. of Health and Human Services, and the Mental Health Strategic Healthcare Group and Health Services Research and Development Service, US Dept. of Veterans Affairs (VA). Conclusions do not necessarily represent official views of SAMHSA, the VA, or the organisations to which any author or commentator is affiliated. For their comments we are grateful to: Sonya A. Baker, T. Robert Burke, Herman Diesenhaus, Dona M. Dmitrovic, R. John Gregrich, Tom Hill, Mike Hilton, George Kosniak, John Mahoney, Kate Malliarakis, J. Paul Molloy, Harold Perl, Rick Sampson, and Richard Suchinsky.

**BASED PRIMARILY ON THE CONCLUSIONS** of a work-group of US experts on substance abuse self-help organisations convened in Washington in November 2001,[6] this paper summarises key research findings on addiction-related self-help groups and assesses their implications for services, government agencies, and policymakers.

A substantial minority of Americans participate in self-help groups for chronic health problems,[13] but addiction-related groups are most common.[12 20] The largest and best known is Alcoholics Anonymous or AA, a 12-step organisation founded in 1935 which inspired many similar organisations. Others are also abstinence-based but eschew any spiritual content, or conceptualise addiction not as a disease but as maladaptive behaviour. At least one US organisation targets drinking reductions rather than abstinence. Rather than the 12 steps, some groups adopt cognitive-behavioural or feminist strategies.

As well as varying in approach, philosophy, and size, self-help organisations also vary in their governance, traditions (eg, willingness to accept outside financial support, encouragement of lifetime membership) and racial and ethnic diversity. However, none charge fees, require appointments, or limit the number of visits. Members can attend indefinitely, critical in light of the emerging view that, like diabetes and hypertension, addiction is best treated as a chronic health problem.[16] Acute care interventions (eg, hospitalisation) are important for immediate medical needs, stabilisation, and encouraging continuing care, but are not a cure. Rather, chronic health problems are managed by extended, lower intensity support.[11] Self-help groups are an important, enduring support for recovery from substance dependence, complementing rather than competing with acute care interventions.

A final important point about self-help organisations is that their growth can be fostered or limited by external forces. For example, AA experienced a major increase in membership in 1941 following a highly favourable magazine article. Non-profit, self-help clearinghouses have referred many potential members to self-help groups and helped found many groups. Many members affiliate after being referred by a clinician, while negative clinician attitudes can discourage participation. Countries including Australia, Canada, Germany, Poland, and Japan have funded the infrastructure of self-help organisations and promoted their growth.[7]

For clinicians, agencies and policy makers, the important messages are that:

- a diverse set of self-help organisations has developed for all substances of significant public health concern;
- collectively, these are both appealing and affordable to a broad spectrum of people;
- clinical, agency, and governmental procedures and policy influence the prevalence, stability, and availability of addiction-related groups.



## A cost-effective continuing care resource

The effectiveness of any intervention for substance abuse must be understood in light of two facts. First, like other chronic health problems,[16] addictive disorders are difficult to resolve and no intervention produces complete and permanent abstinence in all cases, or even in most. Second, given constrained financial resources, any judgment about an intervention needs to factor in costs as well as effectiveness.

The 'effectiveness' of a self-help organisation can be conceptualised in a number of ways, including how fast it grows, how it handles change, and member satisfaction, but clinicians, agency managers and policy makers are primarily interested in three issues. Does self-help group participation reduce substance abuse? If so, at what fiscal cost? Do self-help groups produce other benefits for their members and for society?

Research is limited in the degree to which can answer these questions. Most work has focused on AA and to a lesser extent NA. Groups outside the 12-step tradition have rarely been studied. Also, nearly every study has been conducted on adults, leaving the possible effects of groups on adolescent substance users much under-studied.

### RANDOMISED CONTROLLED TRIALS

Considered by some to be the most rigorous test of effectiveness, there have only been three randomised controlled trials of community-based self-help groups. All involved AA and people coerced in to treatment. In the late 1960s, the first showed that, compared with individuals assigned to treatment or to no treatment, a court order to attend five AA meetings did not reduce arrests for chronic drunkenness.[3] Unfortunately, there was no information on alcohol use *per se*. The other two trials documented a range of outcomes and compared AA alone to professional treatment combined with AA attendance.[2 22] Both suggested worse clinical outcomes for AA alone: in one, more individuals dropped out; in the other, more relapsed. But in both, individuals assigned to AA alone improved in absolute terms and incurred significantly lower health care costs than those assigned to treatment plus AA.

### OTHER CONTROLLED TRIALS

Because randomised trials usually enrol only a small, unrepresentative subset of addicted patients, some researchers have instead compared outcomes among otherwise similar individuals who did or did not become involved in mutual help groups.

One study compared two sets of 887 substance dependent patients treated in inpatient programmes which either did or did not stress 12-step self-help group involvement.[9] At treatment intake, the two sets were comparable on treatment history, alcohol, drug and psychiatric problems, demographic variables, and motivation. A year later, those encouraged to join groups were significantly more likely to abstain from drugs and alcohol. They also relied more on self-help groups and less on treatment services for support after discharge, reducing health care costs by almost $5000 a year per patient. This study was confined to men, most of whom were African-American or Hispanic. However, very similar outcomes and cost-offset findings were found in a study of alcohol abusers, most of whom were Caucasian and about half women.[10]

**HEALTH COSTS WERE CUT BY ALMOST $5000 A YEAR WHEN PATIENTS WERE ENCOURAGED TO JOIN 12-STEP GROUPS**

### CORRELATIONAL STUDIES

A third type of study simply observes whether becoming involved in self-help groups is related to substance use. These may have lacked a comparison group of non-participants and sometimes did not track changes over time. Almost all link AA attendance to better alcohol-related outcomes, and NA or Cocaine Anonymous attendance to better drug-related outcomes.[7] They also show that members who engage in other group activities in addition to attending meetings – reading programme literature, sponsoring new members, applying the 12 steps to daily life – are more likely to abstain than individuals who do not. However, such studies cannot prove that self-help participation *caused* the positive outcomes.

### SELF-HELP INFLUENCED TREATMENTS

Although treatment is not self-help, studies of treatments *influenced* by self-help principles provide relevant evidence.

Best known is Project MATCH, which for three months randomly assigned US alcohol-dependent patients to 12-step facilitation, cognitive-behavioural, or motivational enhancement therapy.[1 19] In terms of increased days of abstinence and fewer drinks per day, outcomes over the following year were broadly similar after all three treatments. However, individuals treated in 12-step facilitation therapy attended more 12-step self-help meetings and were more likely to have maintained continuous abstinence. Over the three years after treatment, more continued to maintain abstinence and, compared to cognitive-behavioural patients, they abstained on more days. Regardless of assigned treatment condition, attending more 12-step self-help groups was associated with better outcomes.

Encouraging results were also found in a major US study of cocaine dependent patients. Those randomly assigned to counselling which strongly encouraged participation in self-help groups showed more consistent attendance, and more consecutive months of cocaine abstinence during follow-up, compared with patients treated only by professionally administered therapies.[23 24]

Three other studies warrant mention. In one, compared with usual aftercare, drug dependent patients randomly assigned to a programme incorporating a self-help style group and a network of supportive former patients were about 40% less likely to relapse over the next six months.[15] A second found that alcohol dependent patients randomly assigned to a treatment which emphasised peer responsibility and mutual help engaged more with treatment and incurred dramatically lower health care costs at one-year follow-up.[5] A third involved adult substance dependent patients who had been raised by substance dependent parents. They were randomly assigned either to 12-step self-help groups for adult children of alcoholics or to substance abuse education classes.[14] Self-help group patients were significantly less likely to use drugs and alcohol after leaving treatment.

These studies suggest that self-help group involvement reduces substance use and also lowers health care costs. With other studies, they also document benefits relating to self-efficacy, social support, depression and anxiety, and coping with stress.[7] However, the research has focused on AA and NA. Findings may generalise to other mutual help organisations but relevant research is lacking ▸ *What the research tells us*, p. 6.


**GOLDEN BULLETS** Key points and practice implications

- Research on 12-step self-help groups documents substance use reductions, other psychological benefits, and cost-effectiveness relative to professional support.
- Such groups provide an important long-term anti-relapse support of the kind rarely available through treatment services. As such they complement rather than replace time-limited professional treatments.
- How therapists behave, their beliefs and their attitudes, affect how many of their patients participate in self-help groups. Training and incentives should be implemented to extend the use of evidence-based methods to promote participation.
- Policymakers can promote and support self-help organisations without compromising their traditions or independence, improving health outcomes while containing costs.

## How services and policymakers can promote self-help groups

Given their likely health and cost benefits, clinicians, treatment providers, and policymakers may wish to increase the likelihood that addicted individuals seek out mutual help organisations and that they spread and become accessible to a broad array of people. What follows are some potential courses of action for different constituencies.

### TREATMENT SERVICES: COULD DO BETTER

Much can be done to make treatment better at facilitating self-help group involvement. Practitioners who describe themselves as '12-step oriented' commonly see only a subset of 12-step processes as important. Few report operating a pure 12-step approach, preferring instead a mix of, for example, 12-step, cognitive-behavioural, motivational, psychodynamic, and family systems approaches. These findings have been confirmed in video studies revealing that counsellors emphasise some aspects of the 12 steps (such as AA affiliation) but not others (such as spirituality).[17] When counsellors do support 12-step group involvement, they rarely use evidence-based methods. Finally, many clinicians are not aware of alternatives to 12-step groups.

Research clearly shows that when clinicians use empirically validated techniques to support mutual-help group involvement, it is far more likely to occur.[18 21 23 24] Educating clinicians about such techniques may sometimes be helpful, but merely providing guidelines rarely changes practice significantly. Provider interventions must address attitudes, beliefs and behaviours.

Clinicians' beliefs influence their patients' transitions from treatment to self-help groups. Some believe self-help groups foster unhealthy dependence or detract from personal autonomy, others that AA is the only self-help organisation, or the only one of any value. Other misconceptions are that all self-help organisations have a spiritual component, or that spirituality must be central for every member. In reality, there are many pathways to recovery involving a variety of self-help groups and treatments.[4]

Any provider intervention strategy must recognise two points. First, most investigations have focused on specialist substance abuse treatment providers. Little is known about whether or how non-specialists (eg, emergency unit doctors) refer addicted patients to self-help groups. Second, due to cultural differences (such as spiritual beliefs, expectations about self-disclosure) and other diversity issues, all self-help organisations may not be equally appealing or helpful to all patients. Some (for example, SMART Recovery, Women for Sobriety, and Moderation Management) are almost entirely Caucasian and middle class. AA and NA have a higher proportion of people of colour, but individual chapters may not be diverse. Clinicians should be sensitive to potential discomfort among patients going to a self-help group with few or no people of their racial or ethnic background. Similarly, gay and lesbian patients may prefer special meetings, such as AA offers.

**AS AN ENDURING SUPPORT, SELF-HELP GROUPS COMPLEMENT RATHER THAN COMPETE WITH ACUTE TREATMENT**

### EFFECTIVE REFERRAL TO A MENU OF CHOICES

The following strategies could be employed by clinicians, clinical supervisors, and service managers.

- Clinicians should use empirically validated methods (eg, 12-step facilitation counselling, motivational enhancement) to foster self-help group engagement.
- Given the variety of pathways to recovery, clinicians should have available a menu of alternative treatments and self-help groups to select from in consultation with the client and other stakeholders.
- Efforts to train clinicians about facilitating self-help group involvement should include incentives for changing clinical practice and be sensitive to cultural diversity among clients.
- Effective referrals to self-help groups should occur in both specialist and non-specialist health care programmes.
- Clinicians should recognise and communicate to patients that many individuals recover through AA, but also that others recover through alternative self-help groups, or without attending any.
- Even treatment programmes which see themselves as '12-step oriented' should evaluate whether their current practices actively promote involvement in 12-step groups.

### POLICYMAKERS CAN MAKE A DIFFERENCE

Several countries have implemented policies to foster the growth of mutual help organisations.[7] Beyond the usual challenges, one is peculiar to this area: by tradition, 12-step organisations do not accept direct outside financial support. Even for self-help organisations which do, it is important not to bureaucratise or co-opt an essentially grassroots movement.

Like the organisations themselves, the infrastructure supporting self-help varies in strength and structure. In some areas, non-profit self-help clearinghouses provide information about, referrals to, and technical support for, mutual help organisations for addictions and other health problems. Helplines and welfare agencies may also provide information.

'Recovering' counsellors and groups of former patients at addiction treatment centres are another important component of the self-help infrastructure. Whether individuals who are not in recovery typically have the knowledge and skills to facilitate connections between addicted patients and self-help groups is unknown.

### INFRASTRUCTURE ENHANCEMENT

Given the above context, it may be desirable to implement policies to strengthen the infrastructure supporting mutual help. The following have been implemented in some areas and might be replicated elsewhere.

- Invest in self-help clearinghouses. These can support a broad variety of alcohol and drug-related self-help groups without violating the traditions of those which do not accept funding.
- Make public facilities and institutions 'self-help group friendly' – not only allowing groups space for meetings, but also inviting them to hold groups where they may not have a historical presence, for example, in some clinics, hospitals, and religious or community centres.
- Disseminate information on self-help groups. Government and other relevant agencies could display lists of self-help organisations, post them on their web sites, and/or provide links to sites operated by self-help organisations. They could also provide information on evidence-based practices related to self-help groups as a recovery resource.
- Adopt the principle of 'informational parity'. All dissemination efforts should include information on the full range of mutual help groups as long as they are voluntary in nature, respect the civil rights of participants, address substance abuse, are not mislabelled professional treatments, and have some evidence of effectiveness.

### WHAT THE RESEARCH TELLS US

Many improvements remain to be made in self-help group research, but the following represent reasonable conclusions based on research so far.

- Longitudinal studies associate participation in AA and NA with a greater likelihood of abstinence, improved social functioning, and greater self-efficacy. Participation seems more helpful when members engage in other group activities in addition to meetings.
- Twelve-step self-help groups significantly reduce health care utilisation and costs, relieving demand on the health care system.
- Self-help groups are best seen as a form of continuing care rather than as a substitute for acute treatment services.
- Randomised trials with coerced populations suggest that AA combined with professional treatment is superior to AA alone.
- Self-help groups outside the 12-step fold have not been subjected to longitudinal evaluation, but it is reasonable to suspect they also benefit members.

## Alcoholics Anonymous

THREE MEN sat around the bed of an alcoholic patient in the psychopathic ward of Philadelphia General Hospital one afternoon a few weeks ago. The man in the bed, who was a complete stranger to them, had the drawn and slightly stupid look the inebriates get while being defogged after a bender. The only thing that was noteworthy about the callers, except for the obvious contrast between their well-groomed appearances and that of the patient, was the fact that each had been through the defogging process many times himself. They were members of Alcoholics

Anonymous, a band of ex-problem drinkers who make an avocation of helping other alcoholics to beat the liquor habit ...

THEY MADE it plain that if he actually wanted to stop drinking, they would leave their work or get up in the middle of the night to hurry to where he was. If he did not choose to call, that would be the end of it. The members of Alcoholics Anonymous do not pursue or coddle a malingering prospect, and they know the strange tricks of the alcoholic as a reformed swindler knows the art of bamboozling ...

Jack Alexander
*The Saturday Evening Post*
March 1, 1941


**This famous article in a popular US magazine helped propel Alcoholics Anonymous into a major national network, proving that access to self-help can be altered by publicity.**

**William Griffith Wilson (Bill W), co-founder and driving force behind AA and author of the 'Big Book' with its 12 steps "suggested as a Program of Recovery".**

- Create and support innovative services that promote self-help group involvement. Examples include the 'recovery coaches' funded by Arizona Medicaid, and funding in Philadelphia for an organisation with responsibility for transitioning individuals into self-help groups. Similarly, the US Center for Substance Abuse Treatment launched the Recovery Community Services Program to fund groups developing innovative peer-to-peer services. Examples include: recovery coaching and mentoring; peer case management; peer education in health topics and life skills; and assistance and referral with housing, employment, education, and related activities.
- Certificate and train health care professionals in linking patients to self-help groups. Staff with strong connections to local self-help groups may not always be available, so all health professionals should know how to effectively refer patients to groups.
- Foster self-help organisations for underserved populations. New York State's Mental Health Empowerment Project successfully assisted mental health service users to organise self-help groups for dually diagnosed people. Similar programmes which provide support without professionalising or bureaucratising might be tried with other underserved populations, such as adolescents and people living in rural areas.
- In conjunction with treatment, expand opportunities for self-help organisations in criminal justice settings. For example, groups might be invited to hold meetings in youth detention centres, prisons, and probation facilities.
- Discourage the use of self-help groups as a replacement for treatment. Many clients require support from both. Using the success of self-help groups as a pretext for delaying or withdrawing support for treatment is therefore inappropriate. Addiction self-help organisations typically see themselves as allies rather than competitors to professional treatment. Other stakeholders should do the same.
- Expand the research base. This includes research on the outcomes of 12-step and other self-help groups, on how self-help groups effect change, and on policy interventions to promote effective practices and self-help group involvement. A national centre could provide an important focus for such activities.
- Expand residential self-help options. We already have some successful models for peer-managed residential services for addicted individuals. Fostering the development of more self-help based housing could be a cost-effective strategy for providing recovery-supportive environments, including for homeless clients.
- Support opportunities for the families of addicted people to be involved in mutual help organisations. One of the discoveries of the Recovery Community Services Program was that families do not always feel part of the recovering person's self-help involvement. Accordingly, all the above efforts should include a focus on family members and family-focused mutual help organisations.

### SUPPORT WITHOUT CO-OPTION

Addiction self-help organisations are a major resource for addicted individuals, as well as for those who treat, work with, or care about them. Research suggests that self-help groups can be beneficial, but also cautions that we have much more to learn about how they work and how they can be supported. The strategies presented here are a set of initial steps but are neither the final word nor a panacea. Yet they do hold significant promise for strengthening addiction self-help groups and thereby helping more individuals recover from drug and alcohol problems.

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