Clinicians' Referral and Matching of Substance Abuse Patients to Self-Help Groups After Treatment

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Objective: **The clinical practice guidelines for substance use disorders from the American Psychiatric Association (APA) recommend referral of some patients to self-help groups. The purpose of this study was to determine current patterns of referral to self-help groups in substance abuse treatment programs in the United States and compare them with referral recommendations in APA guidelines.** ***Methods:*** **Directors of all 389 substance abuse treatment programs in the Department of Veterans Affairs health care system completed a mailed survey on posttreatment self-help referral practices.** ***Results:*** **Survey responses indicated that a large proportion of substance abuse patients were referred to Alcoholics Anonymous (79.4 percent), with other self-help organizations receiving a smaller but significant number of referrals. Referrals to 12-step self-help organizations were more common in programs that endorsed a 12-step treatment orientation and that employed a higher proportion of staff members in recovery from substance use disorders. Consistent with APA practice guidelines, clinicians were less likely to make a referral to a 12-step self-help group if a patient was an atheist, had a comorbid psychiatric disorder, or had less severe substance abuse problems. In deciding whom to refer to self-help groups, clinicians also considered other variables that are not addressed in current practice guidelines, such as age and previous involvement in 12-step groups.** ***Conclusions:*** **Clinicians make extensive use of self-help groups for their patients, as recommended in APA practice guidelines. However, some differences between current practice and recommended practice warrant further investigation. (*Psychiatric Services* 48: 1445–1449, 1997)**

Extensive integration of self-help organizations with professional services distinguishes the substance abuse treatment system in the United States from those of most other developed nations (1). This interconnection can be seen in the many programs that call themselves 12-step treatment, that hire staff members who are in recovery, that allow self-help groups to hold meetings at treatment sites, and that refer patients to self-help groups for continuing support after professional treatment, which is becoming ever briefer, has ended (1–6). Referral of patients to self-help groups is supported by a growing body of evidence linking involvement in such groups to better substance abuse and psychosocial outcomes (7–10).

The American Psychiatric Association (APA) recently issued clinical practice guidelines for substance use disorders (11) that address how self-help groups can be used as adjuncts to treatment. The guidelines are generally supportive of referrals to self-help groups, but they note that some matching of patients to groups may be necessary to optimize outcomes.

For example, the guidelines caution that dually diagnosed patients should not be referred to groups that view taking psychotropic medication as a form of substance use, which is the case in some 12-step groups. The guidelines also suggest that patients who are uncomfortable with the spiritual focus of Alcoholics Anonymous (AA) should be referred to alternatives such as Rational Recovery. In contrast, patients who are concerned about spiritual matters and have more severe substance abuse problems may be particularly good candidates for referral to AA. The guidelines acknowledge that other patient characteristics, such as age and gender, are important in determining level of care for patients in substance abuse treatment, but that no current research evidence exists to support recommendations for how these characteristics should be considered in the self-help referral process.

Unfortunately, at the time the APA recommendations were made, no systematic information about clinical practice patterns of referral to self-help groups in the United States was available. Thus it is not clear whether clinical practice was similar to that recommended before the guidelines or whether some front-line clinicians had discovered effective practices that might have been integrated into national guidelines, such as guide-

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lines for matching patients to self-help groups.

This paper reports survey data on the referral practices to self-help groups in a national substance abuse treatment system and examines how these practices are implemented in different settings. Because the survey was administered just before the APA practice guidelines were issued, the data also provide a baseline against which to judge the effect of the guidelines in the future. The study investigated three key questions: How often do clinicians refer substance abuse patients to self-help groups, and to which types of groups are they referred? What program factors influence self-help referral policies? Do clinicians match patients to self-help groups, and if so, how?

Methods

Sample

The sample consisted of all 389 U.S. Department of Veterans Affairs substance abuse treatment programs in operation on October 1, 1994. A total of 212 inpatient and residential programs and 177 outpatient programs were included. All but 22 of the outpatient programs had a primarily drug-free orientation; the remainder were methadone maintenance clinics.

The mean±SD number of staff members per program was 13±10.5, and 24±22 percent of staff members were in recovery from substance abuse problems. The programs treated a mean±SD of 414±568 patients a year and reported that 49.1±25.2 percent of their patients were dependent on both alcohol and other drugs. Almost all VA substance abuse patients are male (98 percent), and about half of the patients are Vietnam-era veterans (12).

Procedure

A survey was mailed to all VA program directors in October 1994 along with a letter explaining its purpose. The programs that initially did not respond received follow-up phone calls and letters. This report analyzes the following four types of data from the survey.

Self-help group referral rates. Program directors were presented with a list of self-help groups and asked to indicate the percentage of their patients who were referred to each after treatment during the previous fiscal year (October 1, 1993 to September 30, 1994). The list included 12-step self-help groups such as Narcotics Anonymous (NA), non-12-step groups that address substance abuse such as the Secular Organization for Sobriety, and groups that focus primarily on other psychiatric problems such as GROW and the Depressive and Manic-Depressive Association. This category was included because many VA substance abuse patients have comorbid psychiatric disorders (13).

Rules for matching patients with 12-step self-help groups. These survey items focused on the most common type of substance abuse self-help organization: 12-step groups such as NA and AA. Program directors were presented with a series of patient characteristics, such as Caucasian race, male, or unemployed, and asked whether a patient in substance abuse treatment who had such a characteristic would be more or less likely to be referred to a 12-step self-help group than would a patient without that characteristic.

Dominant treatment orientation. This variable reflected the dominant theoretical orientation of the program's treatment approach. Three eight-item treatment goals and activities scales of demonstrated validity were drawn from the Drug and Alcohol Program Treatment Inventory (14). The treatment orientations studied were cognitive-behavioral approaches (sample item: "Staff coach or shadow while patients rehearse assertiveness or communication skills"), AA and 12-step approaches (sample item: "Staff and patients discuss ways of making contact with one's higher power"), and insight-psychodynamic approaches (sample item: "Staff focus on the unconscious meaning of patients' thoughts and feelings"). Programs were classified into one of the three categories based on the orientation the program director endorsed most strongly.

Program size and staff recovery status. Program size was indexed by the number of patients treated each year and by the number of staff members. Program directors also reported on the number of staff in their program who were in recovery from personal problems with alcohol or other drugs.

Results

All of the self-help organizations received a nonnegligible number of referrals except for GROW, to which only three programs reported referring any patients. (All three reported a 1 percent referral rate). On average, posttreatment referrals rates were high, particularly for AA, to which 79.4 percent of patients were referred. Substantial proportions of patients were also referred to other 12-step groups for people with substance abuse problems—44.9 percent to Narcotics Anonymous and 24.3 percent to Cocaine Anonymous.

Referrals to 12-step groups for spouses and children of alcoholic individuals were less common, averaging 10.6 percent of caseload for Adult Children of Alcoholics and 12.7 percent of caseload for Al-Anon. Finally, patients were less commonly referred to non-12-step groups for substance abuse or comorbid disorders; 5.9 percent were referred to Rational Recovery, .8 percent to the Secular Organization for Sobriety, .8 percent to the Depressive and Manic-Depressive Association, and .3 percent to Recovery Inc. Because the sum of the percentages for all groups exceeded 100 percent, many patients must have been referred to more than one self-help group.

Subsequent analyses attempted to determine whether program features predicted referral patterns to self-help groups. To minimize spurious results in these exploratory analyses, a conservative significance standard was used ($p<.005$ for significance and $p<.01$ for a trend). Continuous variables (number of patients a year, number of staff, and proportion of staff in recovery) were correlated with the referral rates for each of the nine self-help organizations that received a nonnegligible number of referrals. Only two correlations were statistically significant. The proportion of recovering staff in the program was correlated with more referrals to AA and to Adult Children of Alcoholics (for both, $r=.16$, $p=.002$).

Categorical variables were examined using one-way analyses of variance. Inpatient and outpatient programs did not differ significantly in the rate of referral to any self-help organization. However, a program's dominant treatment orientation was associated with referral patterns to some self-help organizations. Programs that worked primarily from an AA–12-step treatment orientation referred a higher proportion of patients to AA (86.8 percent) than did the other two types of programs ($F=15.80$, $df=2,386$, $p<.001$). At the same time, it is worth noting that in absolute terms a high proportion of patients in both cognitive-behavioral programs (77.1 percent) and insight-psychodynamic programs (62.2 percent) were referred to AA.

A total of 13.8 percent of patients in programs with an AA–12-step orientation were referred to Adult Children of Alcoholics, compared with 8.7 percent of patients in cognitive-behavioral programs and 8.4 percent of patients in psychodynamic programs ($F=4.81$, $df=2,386$, $p=.009$). The other significant difference in referral pattern associated with dominant treatment orientation was for Rational Recovery, to which more patients in cognitive-behavioral programs were referred (8.7 percent) than were patients in insight-psychodynamic programs (5.9 percent) and AA–12-step programs (2.1 percent) ($F=5.98$, $df = 2,386$, $p=.003$).

Table 1 presents data on clinical matching rules for 12-step programs such as AA and NA. Few respondents indicated that demographic variables such as race, education, and marital status influenced the likelihood of referral. When clinicians did agree that a patient characteristic influenced the likelihood of referral, they sometimes disagreed about the direction of influence. For example, 3.6 percent of respondents said that they would be somewhat or much more likely to refer a woman than a man to a 12-step self-help group, whereas 3 percent said just the opposite.

Between 15 and 35 percent of clinicians identified five patient characteristics as influential in the referral process: being unemployed, over 65 years old, homeless, and dually addicted (dependent on both alcohol and other drugs) and having attended NA or AA in the past. Although some contrary opinions were expressed, the general trend was for clinicians to be more likely to refer patients with these characteristics to 12-step self-help groups.

Three other patient characteristics were reported as being important by more than a third of clinicians: having relatively minor substance abuse problems, being an atheist, and having a comorbid psychiatric diagnosis. Although some diversity of opinion existed, the strong trend was for patients with these characteristics to be less likely to be referred to 12-step self-help groups.

Table 1

Responses of 389 directors of VA substance abuse treatment programs to survey questions about the likelihood of referring patients with certain characteristics to 12-step self-help organizations for substance abuse such as Alcoholics Anonymous and Narcotics Anonymous, in percentages

Characteristic	Much less likely	Somewhat less likely	No effect	Somewhat more likely	Much more likely
Caucasian	0	0.3	92.8	2.6	3.1
Less than a high school education	0.3	2.1	91.8	2.1	2.6
Married	0.3	1.0	91.0	3.9	2.6
Female	1.5	1.5	91.0	1.5	2.1
Under 30 years old	0.8	2.6	90.2	2.6	2.1
Unemployed	0	1.0	85.6	6.4	5.4
Over 65 years old	0.5	4.1	85.3	5.7	2.6
Homeless	1.3	1.3	83.5	6.4	6.2
Dually addicted[1]	0	1.5	78.7	8.2	10.3
Attended Alcoholics Anonymous or Narcotics Anonymous in the past	0	0	66.1	16.5	16.2
Minor substance abuse problems	4.4	22.4	63.8	4.1	1.8
Atheist	10.8	24.9	60.7	0.8	1.3
Comorbid psychiatric diagnosis	0.3	37.3	54.0	2.6	2.3

[1]To alcohol and other drugs

Conclusions

This study provides the first comprehensive data on self-help group referral practices in substance abuse treatment programs in the United States and confirms Mäkelä and colleagues' observation (1) that there is extensive intermingling of self-help groups with professional services in the U.S. The generally positive attitude toward referrals to self-help groups that is evident in APA practice guidelines apparently is shared by many clinicians in the substance abuse treatment field (15). All or virtually all substance abuse patients are referred to a self-help group at the end of treatment, and many patients receive referrals to more than one group. Twelve-step organizations, particularly AA and NA, receive the lion's share of referrals, whereas smaller proportions of substance abuse patients are referred to non-12-step organizations such as the Secular Organization for Sobriety.

One reason why 12-step organizations receive so many referrals is that many of the professional staff making the referrals have personal experience with these groups. Treatment programs with larger proportions of recovering staff referred higher proportions of patients to AA and Adult Children of Alcoholics. The 12th step asks members who have recovered through AA or NA to spread the message of these organizations to nonrecovering individuals who have substance abuse problems. To follow the 12th step, recovering staff members may be more inclined than other staff to encourage involvement in 12-step groups. Staff members not in recovery whose colleagues are 12-step "success stories" may also be more inclined to refer patients to these groups.

Treatment orientation also seems to influence referral patterns, with programs being more likely to direct referrals to self-help organizations that share their philosophy. AA–12-step treatment programs refer heavily to 12-step self-help groups. In contrast, cognitive-behavioral programs are more likely than AA–12-step programs to refer to Rational Recovery, an organization that uses cognitive techniques derived from Albert Ellis' rational-emotive therapy (16).

Treatment personnel are somewhat more likely to refer patients to self-help groups that have a similar approach to substance abuse problems; however, in absolute terms, 12-step self-help groups receive a substantial number of referrals from cognitive-behavioral and insight-psychodynamic programs. This referral pattern may be due to the availability of these groups. Alcoholics Anonymous has 94,000 chapters, and Narcotics Anonymous has 25,000, whereas none of the non-12-step organizations listed in the survey have more than 1,000 chapters (17). Thus even professionals who disagree with the 12-step approach may feel that it is "the only game in town."

Alternatively, the conflicts between the 12-step approach and the psychodynamic and cognitive-behavioral approaches may be more apparent than real. Twelve-step groups adhere to different values than do many treatment professionals; however, they often use similar helping techniques such as identifying situations that lead to relapse and confronting immature behavior such as grandiosity (18).

In terms of matching patients to 12-step self-help groups, only a few strong patterns were identified. In the U.S., matching seems to represent an attempt to fine tune the referral process in the context of a high overall referral rate. Because research on 12-step groups has not consistently validated a typology of groups that meet the needs of patients at different levels of care, the practice pattern of encouraging virtually all patients to at least try a self-help group is appropriate at this point.

However, to the extent that programs engage in matching patients to self-help groups, the survey found striking similarities between clinical practice and the recommendations in the APA clinical practice guidelines. Both the survey and the guidelines identified atheism, a comorbid psychiatric disorder, and relatively minor substance abuse problems as patient characteristics that should reduce the likelihood of referral to a 12-step group.

Intuitively, all three characteristics potentially limit substance abuse patients' likelihood of successfully affiliating with 12-step groups. Atheists are not forbidden to attend 12-step self-help groups, but they may be uncomfortable with the spiritual emphasis of the 12 steps, even though 12-step programs do not mandate any particular interpretation of spirituality. Individuals with psychiatric problems may encounter skepticism from some 12-step members who view all mood-altering chemicals, prescribed or otherwise, as a threat to recovery. Individuals with relatively minor substance abuse problems may have difficulty identifying with members' stories of very severe substance abuse problems, which are a staple of many 12-step meetings.

If these hypotheses are supported by future evaluation studies, it may be necessary to develop and empirically validate interventions that promote involvement in non-12-step groups for patients for whom 12-step groups are inappropriate or ineffective. Such interventions could then be incorporated in future editions of APA clinical practice guidelines.

Other patient characteristics had some influence on the likelihood of referral to self-help groups. For example, unemployed, homeless, and dually addicted individuals were referred more frequently, probably because they have severe problems for which it makes sense to engage all available helping resources. In contrast, divergent clinical practices concerning older patients were not so readily understood. When asked whether they would be more or less likely to refer an elderly patient than a nonelderly patient to a 12-step self-help group, 5 percent of clinicians reported being less likely, whereas about 9 percent reported being more likely. Qualitative research may be necessary to understand how a significant number of clinicians come to employ contradictory and somewhat nonintuitive matching rules. Once such clinically derived matching hypotheses are articulated, they can be subjected to systematic study. Those that are supported empirically can be integrated into future editions of APA practice guidelines.

In addition to studying the origins of referral policies, future evaluations should focus on the content of referrals. Sisson and Mallams (19) randomly assigned outpatients either to a standard referral or to an intensive referral to a self-help group. The therapist making the standard referral suggested that patients attend a 12-step group and gave them information on locations and times of group meetings. To make the intensive referral, during a therapy session the therapist and the patient telephoned an experienced 12-step group member who offered to accompany the patient to a group meeting. All ten patients who received the intensive referral became 12-step group members, whereas none of the ten patients who received the standard referral became members. If such differences could be replicated in the field, more specific guidelines could be developed to help clinicians make effective referrals to self-help groups.

The limitations of this study deserve comment. First, program directors' reports of self-help group referral rates may have been inflated by social desirability. Future investigators in this area could increase confidence in their study results by validating directors' reports through chart reviews or interviews with patients. Second, because of the characteristics of the VA patient population, the VA system could not provide generalizable information on national practice patterns of referral to groups for women, such as Women for Sobriety (20), or adolescents, such as Alateen. Comparative data on referrals to self-help groups in other treatment systems with different patient populations would increase our knowledge of national self-help referral practices. At the same time, because the VA sample covered an entire national system composed of all current

modalities of substance abuse treatment, it provided important information about U.S. clinical practice patterns.

As practice guidelines addressing self-help groups are promulgated, and as the substance abuse treatment system continues to change, charting the interplay of professional services and self-help groups will be an important task for program evaluators and policy makers. ♦

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