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Facilitating Involvement in Twelve-Step Programs

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Abstract: Twelve-step programs represent a readily available resource for individuals with substance use disorders. These programs have demonstrated considerable effectiveness in helping substance abusers achieve and maintain abstinence and improve their overall psychosocial functioning and recovery. Despite these positive benefits associated with increased involvement in twelve-step self-help programs, many substance abusers do not affiliate or do so for only a short period of time before dropping out. Because of this, clinicians and researchers have sought ways to increase involvement in such self-help groups by facilitating meeting attendance and engagement in other twelve-step activities. The present chapter reviews the impact of treatment program orientation and specific interventions designed to facilitate twelve-step program involvement, subsequent meeting attendance, engagement in twelve-step activities, and alcohol and drug use. The findings of studies evaluating these approaches indicate that it is possible to increase twelve-step involvement and that doing so results in reduced substance use. The results suggest that incorporating these evidence-based interventions into standard treatment programs may lead to improved outcomes.

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1. Role of Twelve-Step Self-Help Groups in Substance Abuse Treatment and Recovery

Twelve-step and mutual self-help groups represent an important, readily available, and pervasive resource in substance abuse recovery, whether associated with formal treatment or not [1–3]. Substance abusers can become involved with twelve-step groups before entering professional treatment, as part of their professional treatment, as aftercare following professional treatment, or instead of professional treatment [4]. These groups, which include Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA), and a number of others, are highly accessible and are available at no cost in communities throughout the world. For some substance abusers, these meetings are the only resource ever used to resolve a drinking or drug problem [3, 5, 6]. The twelve-step philosophy has had a strong influence on the evolution of formal alcoholism treatment in the United States, primarily in the form of the Minnesota Model [7–9]. Many residential and outpatient substance abuse treatment programs include twelve-step meetings on-site and encourage clients to become involved in community-based twelve-step meetings and activities [4].

2. Effectiveness/Efficacy of Twelve-Step Self-Help Groups

Due to the ubiquity of twelve-step self-help groups, there has been an increased focus by clinicians, policy makers, and researchers over the recent past on their effectiveness and potential for integration within existing treatment systems. Fiscal factors and developments in clinical research have also contributed to this increased attention [1]. Recent cutbacks in funding for professional substance abuse treatment has accentuated twelve-step groups being seen as inexpensive and readily available complements to and as a source of support following formal treatment [1, 10–12]. Also, until recently there have been few well-controlled studies supporting the clinical effectiveness of twelve-step approaches [13]. However, more recent efficacy and effectiveness trials provide support for the effectiveness of twelve-step-oriented approaches [2, 14, 15]. Generally, these studies have found a positive relationship between twelve-step involvement and improvement on substance use outcomes for both alcoholics and drug abusers, even over extended periods of time ranging up to 16 years [16–37]. While the positive relationship between twelve-step involvement and clinical outcomes is encouraging, it is not possible to infer a causal relationship from correlational findings. A number of recent studies, using cross-lagged analyses of longitudinal data or structural equation modeling, have begun to elucidate the nature of this relationship [16, 37–39].

Such multi-wave longitudinal studies demonstrate that increased twelve-step meeting attendance and/or involvement appear to lead to a decrease in subsequent alcohol and drug use and that these reductions are not attributable

to the influence of other variables such as level of psychopathology or motivation. Attendance at twelve-step meetings, whether independent of formal treatment or as an adjunct to treatment, has also been found to be associated with reductions in health care costs, particularly those related to subsequent substance abuse treatment [40, 41].

3. Twelve-Step Meeting Attendance vs. Engagement in Twelve-Step Activities

McKellar et al. [39] have questioned whether measures of meeting attendance alone would predict the same substance use outcomes and to the same extent as involvement in twelve-step practices and activities (e.g., reading twelve-step literature, getting a sponsor, "working" the steps, or helping set up meetings). These two variables, though related, appear to have different relationships with subsequent substance use [37]. Involvement, rather than attendance, appears to be the better predictor of substance use outcomes: the greater the level of involvement in twelve-step activities, the better the outcome. This has been found for both alcoholics [25, 42–44] and cocaine abusers [37, 45]. As Emrick, et al. [18] concluded, "mere attendance at meetings may, in fact, be a fairly weak indicator of commitment" (p. 63). Tonigan, Connors, and Miller [46] note that measures of twelve-step attendance are likely to overestimate the extent of twelve-step engagement: More people are attending meetings than are getting actively involved in the program.

However, regular attendance may be a precursor for involvement for many. Individuals who attend AA daily in early recovery are more likely to embrace both the program and fellowship dimensions of AA, while those who have dropped out or who attend meetings infrequently or erratically tend to be less accepting of all aspects of AA [42]. This latter group also appears to do less well than those who have frequent and consistent attendance [17, 22, 26, 45, 47]. Fiorentine [11] found that weekly or more frequent meeting attendance was associated with drug and alcohol abstinence among clients at outpatient drug treatment programs. Kelly, et al. [16] found a dose–response relationship between the extent of twelve-step involvement and the derived benefits: even small amounts of participation were helpful in increasing abstinence but higher doses appeared necessary to reduce relapse intensity. Similarly, Moos [26] found that more frequent participation in AA (e.g., attending two or more meetings per week) during the first year after seeking help was associated with a higher likelihood of subsequent abstinence at 1- and 8-year follow-ups.

Furthermore, the timing of this attendance was crucial. Early involvement was important; individuals who delayed participation for a year or more and then eventually entered AA had outcomes that were no better than those of individuals who never entered AA. Continued attendance and the duration of involvement in twelve-step activities over time were predictive of a broader range of substance use and psychosocial outcomes than was attendance. It also

appears that participation in AA has a positive influence on alcohol-related outcomes over and above the effects attributable to professional treatment [17, 26]. This is consistent with the finding that drug abusers who participated concurrently in both drug treatment and twelve-step programs had higher rates of abstinence than those who participated only in treatment or in twelve-step programs [20].

4. Low Rates of Twelve-Step Attendance and Involvement Following Treatment as Usual

A clinical implication of these findings is that it is important not only to get substance abusers to attend twelve-step meetings but to do so shortly after they have sought treatment and to encourage consistent attendance over time. It is also important to have substance abusers become actively involved in the twelve-step process beyond meeting attendance. However, interventions that are effective in increasing attendance may be insufficient to ensure active involvement. Individuals who are attending AA but are having difficulty embracing key aspects of the program may need professional assistance that focuses more on twelve-step practices, principles, and tenets and less on meeting attendance [42].

Despite the potential benefits associated with twelve-step involvement and attendance, approximately 60%–70% of substance abusers have never attended a twelve-step meeting. Harris, et al. [21] found that while about 75% of alcoholics entering residential treatment reported that they had attended AA meetings previously, only 16% indicated that they had ever worked on any of the twelve steps. Of the 150 patients who were interviewed, only 38% reported a positive attitude toward AA, while 36% were neutral, and 26% held a negative attitude. Even if substance abusers initially attend meetings, there are typically high rates of attrition, which may prevent individuals from receiving the maximum benefit from twelve-step involvement [48]. Approximately 40% of a cohort of nearly 3,000 individuals who had attended twelve-step meetings in the 90 days prior to or during treatment dropped out over the following year [49]. Low rates and unstable patterns of twelve-step meeting attendance have been found among both alcoholics [22] and drug abusers [11, 26, 50, 51]. Individuals who fail to become involved at all, have sporadic and inconsistent attendance, or delay their becoming involved in twelve-step groups tend to have poorer outcomes. Individuals who initiate twelve-step behaviors during the course of formal treatment are significantly less likely to drop out during the subsequent year [49]. Early attrition from attending meetings may, in part, be due to individuals' inability to embrace or utilize other aspects of the twelve-step program [42].

These findings suggest that early engagement during and/or shortly after treatment and sustained involvement in twelve-step groups contribute positively to substance use outcomes. They have prompted treatment providers

and clinical researchers to recommend that treatment programs emphasize the importance of self-help groups and encourage twelve-step group attendance and participation [1, 12, 15, 19, 45, 52, 53]. Such low rates of attendance during or after treatment are found despite the fact that most treatment programs incorporate a twelve-step philosophy and provide orientations to twelve-step groups [54, 55] and that professional staff report a high rate of referral to twelve-step meetings [56, 57]. However, referral by professionals is not always introduced to clients in a manner that fosters acceptance of twelve-step groups [52]. This is of concern since substance abusers appear less likely to become involved in twelve-step activities if left to do so on their own than if more active encouragement and referral are provided in treatment [1, 33, 34, 58].

5. Methods of Facilitating Twelve-Step Involvement

5.1. General Facilitation Through Program Orientation

There has been relatively little focus in the past on the extent to which formal substance abuse treatment may facilitate twelve-step utilization [59]. However, there is evidence that the overall philosophy and orientation of a treatment program is one avenue for increasing twelve-step involvement. In a naturalistic study of substance abuse treatment within the Department of Veterans Affairs (DVA), inpatient programs were categorized into one of three groups based on their underlying philosophy and treatment practices [60]: twelve-step, cognitive-behavioral, and eclectic (eclectic programs blended twelve-step and cognitive-behavioral philosophies and practices). Patients in the twelve-step and eclectic treatment programs had higher rates of subsequent participation in twelve-step self-help groups than did patients treated in cognitive-behavioral programs [61]. There were also a higher percentage of patients from the twelve-step-oriented programs who had sponsors, read twelve-step literature, and had self-help group members as friends. The three treatment approaches had comparable substance use and psychosocial outcomes at a 1-year follow-up, except that individuals treated in the twelve-step-oriented programs had significantly higher rates of substance abstinence at the follow-up than did those in the cognitive-behavioral programs [31]. There were no treatment-by-client attribute matches found [62]. Furthermore, the theoretical orientation of the treatment program moderated the outcome of self-help group participation: the greater a program's emphasis on twelve-step approaches, the stronger the positive relationship between twelve-step participation and better substance use outcomes. Also, twelve-step-oriented programs and those having a higher percentage of staff in recovery were more likely to make referrals to twelve-step groups than were cognitive-behavioral or eclectic programs [56]. Thus, it appears possible to enhance the attendance and effectiveness of twelve-step self-help groups, particularly when involved in a formal treatment program that has a strong twelve-step orientation [19, 20, 61]. This finding is consistent with that in the NIDA Collaborative Cocaine Treatment

Study in which the combined effects of participating in a treatment that emphasized twelve-step involvement plus actual engagement in self-help activities were associated with the best outcomes [37].

Many programs and counselors present themselves as "already doing" some form of twelve-step facilitation or referral [41]. The fact that a program indicates that its treatment is guided by twelve-step philosophy does not necessarily mean that twelve-step practices, let alone twelve-step facilitation practices, are actually being employed [63–65]. In practice, efforts are often unsystematic, consisting, for example, of a counselor providing the patient with a list of local self-help groups and suggesting that he or she attend a meeting [34, 41, 58]. Even practitioners who describe themselves as "twelve-step oriented" typically consider only a subset of twelve-step processes important for clients [15, 65]. Typically, when counselors do attempt to support twelve-step self-help group involvement in standard treatment, they rarely use empirically supported methods. When clinicians use empirically validated techniques to support mutual help group involvement, it is far more likely to occur [1].

5.2. *Specific Facilitation Through Targeted Interventions*

5.2.1. Twelve-Step Facilitation Therapy (TSF) Based on Project MATCH

5.2.1.1. Individually Delivered TSF with Alcohol Dependence. While there have been guidelines published for treatment providers on methods to attempt to facilitate twelve-step involvement for some time [53], this approach was systematized in twelve-step facilitation (TSF) therapy developed by Nowinksi and Baker [66] and evaluated in Project MATCH [32, 67, 68]. A common misconception is that TSF is the *same* as AA. While the content of TSF therapy was designed to be consistent with AA and other twelve-step groups and with treatment programs based on the Minnesota Model, they are not equivalent. TSF is a structured, manual-guided therapy, originally developed to be delivered over 12–15 individual sessions by a trained counselor, designed to facilitate early recovery from alcohol and other drug abuse or dependence.

TSF has a number of goals and objectives related to the first three steps of AA [67, 69, 70]. The primary goal is to promote abstinence by facilitating the client's (1) "acceptance," which includes the realization that substance dependence is a chronic, progressive disease over which one has no control, that life has become unmanageable because of alcohol or drugs, that willpower is insufficient to overcome the problem, and that abstinence is the only alternative; (2) "surrender," which involves giving oneself over to a higher power, accepting the fellowship of other recovering alcoholics, and following the recovery activities laid out by the twelve-step program; and (3) active involvement in twelve-step meetings and related activities. Furthermore, the therapy process attempts to instill hope for recovery. Clients are given an opportunity to examine their thinking patterns (e.g., rationalization, denial), emotions, behaviors,

interpersonal relationships, social activities, and spirituality and to consider how each is related to drinking and how changes in each would enhance their chances of sobriety. In addition to helping the individual incorporate the AA belief system, TSF emphasizes active participation in AA activities and the twelve steps as a primary means to recovery. The person is encouraged to turn to AA to gain support in changing old habits that maintain drinking and to increase social involvement with other AA members.

Project MATCH compared TSF to cognitive behavioral therapy (CBT) and motivational enhancement therapy (MET) in both outpatient ($n = 952$) and aftercare ($n = 774$) alcohol dependence treatment settings [32]. Participants in all three Project MATCH therapies demonstrated significant and relatively comparable reductions in the number of drinks per drinking day and increases in the percent days abstinent. In a result consistent with that of the naturalistic DVA study [31], those Project MATCH participants who received TSF had significantly higher rates of continuous abstinence when compared to the other two treatments at a 1-year follow-up, while being comparable to MET and CBT on the other drinking-related outcomes.

This differential benefit for the TSF group appears to have been related to differences in the treatments' ability to engage clients in twelve-step activities [59]. Outpatients in Project MATCH who received TSF as their primary treatment had significantly higher rates of twelve-step attendance overall during the year following treatment compared to the CBT and MET therapies. In contrast, outpatients in CBT showed no increase in AA attendance across the three months of treatment or the subsequent follow-up. Outpatients in MET demonstrated a small increase in attendance during the 3-month treatment phase. Over half of the CBT (55%) and MET (52%) outpatients had no AA attendance over the entire 15-month treatment and follow-up period, while only 19% of those in TSF failed to attend an AA meeting over this same period. Participants in the outpatient TSF also reported significantly more involvement in twelve-step activities than those in either CBT or MET. AA participation, in turn, positively predicted the frequency of abstinent days in the post-treatment period [38]. An examination of the putative active ingredients of TSF [71] indicated that TSF had features unique from CBT and MET. Compared to these other two interventions, TSF resulted in a greater awareness of a higher power, endorsement of total abstinence, and engagement in AA practices. Two of these active ingredients, emphasis on abstinence and commitment to AA practices, were predictive of greater abstinence, and commitment to AA practices mediated TSF clients' significantly higher abstinence rates 6 months after treatment relative to CBT and MET.

5.2.1.2. Individually Delivered TSF with Combined Drug and Alcohol Dependence. Carroll and colleagues [63, 64] extended the use of individually delivered TSF to individuals who were dependent on both cocaine and alcohol. Five groups were involved: TSF ($n = 25$), TSF plus disulfiram ($n = 25$), CBT

($n = 19$), CBT plus disulfiram ($n = 26$), and clinical management plus disulfiram ($n = 27$). The TSF intervention followed a manual adapted from Project MATCH for use with cocaine-dependent clients [72]. The results indicated that TSF treatment was effective in promoting patients' involvement with self-help groups over the twelve-week treatment period [64]. Self-help involvement during treatment was significantly higher for patients assigned to TSF (13.8 days mean days of self-help group attendance) compared to those assigned to CBT (1.1 days) or patients assigned to clinical management (5.4 days). Furthermore, 58% of all participants reported attending at least one AA or self-help meeting over the follow-up period, with a mean of 3.9 days per month in which a self-help meeting was attended. The mean total days of self-help attendance during the 1-year follow-up was higher for participants who had been assigned to TSF compared with participants assigned to clinical management or CBT, but not significantly so (48.7 days vs. 33.2 days vs. 24.2 days, respectively) [63]. Both TSF and CBT were associated with substantial and significant reductions in alcohol and cocaine use over the course of the twelve-week treatment period compared to the clinical management condition; the substance use outcomes for TSF and CBT were comparable. At a 1-year follow-up, while still favoring the TSF and CBT conditions, the differences between these two groups and the clinical management condition were no longer significant, and TSF and CBT had comparable outcomes [63]. Participants who attended any self-help groups, regardless of treatment condition, had significantly better cocaine outcomes during follow-up than those who did not [63, 64].

5.2.1.3. Group-Delivered TSF. While the results of studies evaluating individually administered TSF are quite positive, they may have limited generalizability to many clinical settings where group therapy is the modal method of treatment delivery [73–76]. Brown and colleagues [77, 78] have evaluated a group-delivered twelve-step facilitation aftercare intervention. Substance abusers (22% alcohol dependent; 78% dependent on alcohol and cocaine and/or marijuana) from three community-based treatment programs were randomly assigned to either a structured cognitive-behavioral relapse prevention ($n = 61$) or a twelve-step facilitation ($n = 72$) aftercare condition. Both interventions were delivered in a closed-group therapy format, consisting of 10 weekly 90-min group sessions. The twelve-step condition followed the TSF manual developed in Project MATCH [67]. Both interventions were associated with substantial and significant reductions in alcohol and drug use at a 6-month follow-up. The two conditions were comparable, however, with no differences found between the two conditions on any of the substance use outcomes (days of use, ASI Alcohol and Drug Composite Scores, days to first lapse, and days to first relapse). Significant treatment-by-client attribute interaction effects were found. Women, individuals with a multiple substance abuse profile (primarily combined cocaine and alcohol), and those with higher levels of psychiatric severity had better substance use outcomes when treated in the TSF condition than in

the relapse prevention condition. iven the findings that the outcomes of TSF were comparable to or better than those seen with relapse prevention, Brown et al. [77, 78] concluded that the adoption of a well-supervised and structured TSF-inspired aftercare program seems a reasonable strategy for most clients.

Maude-Griffin, et al. [79] found that a combined group plus individual TSF intensive outpatient program ($n = 69$) for crack cocaine addicts modeled after the Project MATCH manual had poorer outcomes overall than a cognitive-behavioral therapy program ($n = 59$). However, two significant client attribute-by-treatment interactions favored the TSF condition. Those individuals with lower levels of abstract reasoning ability and African American clients with higher levels of religious beliefs did better in the TSF condition than in the CBT condition.

With the exception of the findings of Maude-Griffin, et al., the results from the other trials indicate that interventions designed specifically to facilitate involvement in twelve -step groups, whether delivered as individual or group therapies, achieve this goal and result in significant and substantial reductions in substance use comparable to and often better than the outcomes of more established, evidenced-based treatments such as CBT and relapse prevention.

5.2.2. Briefer Twelve-Step Interventions to Fit Current Clinical Constraints: Issues of Sustainability

Based on these findings, it has been recommended that clinicians use empirically validated approaches such as TSF derived from Project MATCH when seeking to foster self-help group involvement [15]. However, both Humphreys [1] and the DVA-CSAT Workgroup on self-help groups [15] have suggested that it would be appropriate not only to investigate the effectiveness of twelve-step facilitative interventions further but also to consider briefer interventions that may fit better within existing clinical practice and reimbursement models than do previously employed TSF interventions. TSF as developed in Project MATCH is a formal individual psychotherapy approach that is not without costs to incorporate into clinical programs [69, 80], although the system-level cost offsets associated with subsequent reductions in substance abuse treatment services utilization may justify the initial expenses of adopting TSF [41, 81]. Such concerns contributed to Humphreys' [1] argument that in order to make twelve-step facilitative interventions more useful in practice, researchers and clinicians should develop and evaluate briefer forms of such interventions.

5.2.2.1. Motivational Enhancement Targeting Increased Twelve-Step Involvement. One potential approach consistent with this recommendation that has been evaluated recently is brief motivational enhancement therapy targeting twelve-step involvement. Brief motivational interventions, which have the goal of reducing client ambivalence toward therapy and changing and enhancing commitment to and motivation for treatment, have been found to

facilitate alcohol dependence treatment entry and retention [82–86]. Kahler and colleagues [87] felt that such a brief intervention would be especially relevant in alcohol detoxification facilities in which time and resources available to provide treatment are limited. They compared a 60-min motivational enhancement intervention targeting involvement in twelve-step self-help programs ($n = 24$) to a 5-min brief advice condition ($n = 24$), both in the context of an inpatient detoxification program. In the brief advice condition, the counselors stressed the severity of participants' alcohol problems and the importance of abstinence as a goal, described twelve-step programs and their potential benefits, recommended active involvement, and provided AA and NA meeting schedules. The motivational intervention consisted of three main components. The first focused on increasing commitment to abstinence, as lack of commitment could be a major barrier to twelve-step involvement. The second component used motivational interviewing techniques to increase commitment to engage in twelve-step activities. The final component consisted of a letter that summarized the session and reinforced the individuals' self-motivational statements and change plan; this was sent to them within 2 days of the session.

No differences overall were found between the standard brief advice to attend AA (which reflected standard practice) and the motivational enhancement condition with respect to either twelve-step group attendance or drinking outcomes over the subsequent 6-month follow-up period. However, a significant interaction was found between the type of intervention received and prior experience in twelve-step groups. The motivational enhancement approach was more effective for individuals with relatively little prior self-help involvement, while the brief advice was better for those who have more twelve-step experience.

5.2.2.2. Intensive Referral and the "Buddy System". Another alternative that is more directly related to the twelve-step recovery model than is motivational enhancement therapy involves the use of twelve-step members serving as the "bridge" between formal treatment and individuals' entrance into the twelve-step program. It has been a common practice in many treatment programs to use AA or NA members who serve as volunteers in a "buddy system" or as temporary sponsors [88–90]. One particular form of this type of intervention recommended by Humphreys [1] and Miller [91] for further study is "systematic encouragement and community access" (SECA), an intensive referral procedure developed by Sisson and Mallams [58]. In one of the first studies to evaluate such a volunteer buddy system, alcoholic outpatients or their significant others were randomly assigned to a "simple" or "enhanced" referral procedure. In the simple condition, a counselor suggested that the patient attend AA or Al-Anon and provided a printed list of meeting times and locations. In the enhanced condition, the counselor supplemented the aforementioned intervention with an in-session telephone call to a current member of AA or Al-Anon, who talked to the patient briefly and arranged to attend a meeting with him or her. The twelve-step group member contacted the patient with a

reminder telephone call the night before the meeting and drove the patient to the meeting. During the month following the intervention, 100% of the participants in the enhanced referral condition attended at least one meeting (average 2.3 meetings), compared with none of the participants in the simple referral condition. Although the study was based on a small sample (n = 20) and followed patients for only 1 month, the results suggested that such a fairly brief intervention can have a significant impact.

Timko and colleagues [34] have recently completed a larger and more thorough evaluation of a manualized intensive twelve-step referral procedure in a two-site randomized trial with individuals entering outpatient substance abuse treatment. Clients were randomized to receive three sessions of either standard referral (n = 164) or intensive referral (n = 181) to twelve-step meetings over a 1-month period. In the first session of the standard referral condition, the counselor gave the client a schedule of AA and NA meetings in the local area and encouraged him/her to attend twelve-step self-help group meetings; subsequent sessions focused on relapse prevention and general educational issues around substance abuse and treatment.

The initial session of the intensive referral condition also included the provision of a schedule of local self-help meetings. In addition, the client was given a handout that provided an introduction to twelve-step philosophy and the structure and terminology of twelve-step groups, addressed common concerns about participation, and encouraged patients to set goals for attending self-help meetings and working the first Steps. It also involved the counselor and client calling a twelve-step volunteer during the session to arrange for the volunteer to meet the client before a twelve-step meeting so that they could attend the meeting together. The second and third sessions served as "check-ins." If the client had met with the volunteer and attended a meeting, the counselor reinforced the individual for attending, explored reactions to the meeting, set goals for future meeting attendance, and encouraged the client to begin seeking out a temporary sponsor. If the client had not met with the volunteer and/or had not attended a meeting, the focus was on the barriers that prevented these events from occurring. The procedure of contacting a volunteer again during the session to arrange a meeting and to accompany the client to a meeting was repeated. A written agreement was also made between counselor and client about the meetings the client committed to attend in the following week.

Individuals assigned to the intensive and standard referral conditions did not differ on measures of twelve-step meeting attendance over the initial 6-month follow-up period; however, those in the intensive referral condition demonstrated greater engagement in twelve-step activities (e.g., doing service work, having experienced a spiritual awakening, and overall involvement). Those in the intensive referral condition also had significantly greater reductions on the alcohol and drug use composite scores of the Addiction Severity Index and had significantly higher rates of abstinence from drugs, although not alcohol, than individuals who received the standard referral. A subsequent

evaluation at the 1-year follow-up [33] indicates that these initial differences in favor of the intensive referral intervention were maintained. Those in the intensive referral, compared to standard referral, were more likely to have attended one meeting per week, had higher levels of involvement in other self-help activities, and had higher rates of abstinence. Furthermore, the increased twelve-step involvement associated with the intensive referral process appeared to account for the improved substance use outcomes.

5.2.2.3. Making AA Easier (MAAEZ). Kaskutas and Oberste [92] have developed a relatively brief group-based intervention aimed at increasing twelve-step meeting attendance and engagement. This intervention, named Making Alcoholics Anonymous Easier (MAAEZ), consists of six sessions – an introductory session, four "core content" sessions (spirituality, principles not personalities, sponsorship, and living sober), and a review/graduation session. Unlike the TSF intervention developed in Project MATCH, which focuses on individuals gaining a cognitive understanding and appreciation of twelve-step tenets such as surrender and acceptance, MAAEZ instead targets active steps toward involvement, focuses on preparing clients to engage in the culture of AA and twelve-step groups, and deals with potential barriers of or ambivalence toward involvement. This focus is consistent with the model of the stages of AA affiliation presented by Rudy [93], which suggests that these activities may be earlier and more basic stages in the affiliation process than is true of the type of cognitive processes involved in the Project MATCH TSF, which are thought to be more advanced stages occurring over a period of 3–4 months.

Initial pilot data have been collected regarding homework completion (assessed at ongoing MAAEZ sessions). Homework compliance was nearly 100% for AA meeting attendance and assignments related to attendance (e.g., talking to someone after the meeting). The proportion of clients completing reading assignments ranged from 25% to 80%, depending largely on whether the client was in a residential or outpatient program. As a preliminary assessment of MAAEZ effectiveness, 6-month AA involvement and outcomes were compared between MAAEZ pilot clients and clients who had participated in a 6-month follow-up survey 18 months earlier in the same program. MAAEZ clients (n = 11) reported deeper AA involvement and higher 30-day total abstinence (both alcohol and drugs) than clients studied before MAAEZ was implemented (n = 67). At the 6-month follow-up, respective proportions (statistical tests not run) were as follows: 100% vs. 71% had attended a meeting; 55% vs. 33% had called someone from AA/NA/CA in the last 30 days; 82% vs. 29% currently had a sponsor; and 100% vs. 67% reported total abstinence in the last month. Thus, MAAEZ appears to be a potentially effective, relatively brief intervention that increases twelve-step meeting attendance and engagement and reduces substance use while being easily integrated into ongoing treatment programs. The 6- and 12-month outcomes from a larger randomized controlled trial evaluating the efficacy of MAAEZ are still in the process of being

collected and analyzed, so it is necessary to await the results to determine the potential utility of this intervention.

6. Summary and Conclusions

Miller, serving as a discussant for a symposium on AA involvement and change mechanisms [91], provided the following conclusions about the current status and future direction of research and clinical practice in this area (p. 531):

1. AA cannot be ignored in understanding treatment outcomes. At the very least, studies should carefully inquire about AA involvement, to examine its relationship to treatments and outcomes.
2. It is possible to facilitate AA attendance. Without question, there are counseling procedures that significantly increase AA attendance, at least during and often after treatment. TSF therapy clearly did this in Project MATCH. Systematic encouragement can significantly increase attendance.
3. Treatment is the time to initiate AA attendance. If AA attendance is not initiated during the period of treatment, it is quite unlikely to happen. Treatment, then, is a good time to encourage sampling of the program and meetings of AA.
4. Attendance is not involvement. When frequency of AA meeting attendance is measured separately from behavioral indicators of involvement in the program and fellowship of AA, the two measures are moderately correlated. In fact, among more frequent AA attenders during Project MATCH treatment, AA attendance declined over the course of follow-up while AA involvement remained steady or increased. This suggests a gradual process of internalization of the AA program and surely indicates that conclusions cannot be drawn from attendance alone.
5. AA involvement predicts better outcomes. Longitudinal studies usually, although not always, find that AA involvement after treatment is associated with higher rates of abstinence regardless of the kind of treatment received. When AA attendance and AA involvement are both measured, the latter tends to be the stronger predictor of outcome.

Twelve-step programs serve as cost-effective resources that complement, support, and extend the cognitive and behavioral changes made in treatment [94]. However, given the low rates of involvement in and high rates of attrition from twelve-step programs, it is necessary to develop and evaluate methods to help substance abusers and treatment programs take full advantage of self-help groups [1]. Implementation of systematic, structured, and manual-guided twelve-step interventions, integrated within treatment, represents one such method to increase engagement and retention in self-help

groups. If successfully implemented, such structured, manual-guided interventions would augment the more general twelve-step orientation characterizing many community-based providers and promote better treatment outcomes.

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