

MENTAL HEALTH CLINICIANS' 12-STEP REFERRAL PRACTICES WITH DUALY DIAGNOSED CLIENTS*

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ABSTRACT

This study examines mental health clinicians' beliefs about dually diagnosed clients' self-efficacy and capacity for recovery and attitudes toward and referrals to traditional 12-step groups for such clients. Clinicians evidence moderate confidence in dually diagnosed clients' self-efficacy and capacity for recovery, positive attitudes toward 12-step groups, but rarely refer dually diagnosed clients to traditional 12-step groups. Clinicians' beliefs that dually diagnosed clients were unlikely to achieve total recovery are associated with less frequent 12-step referrals. Findings support the need for a dual-focus 12-step group that addresses both substance use and mental health disorders—such as Double Trouble in Recovery (DTR)—and the importance of staff training on client empowerment for recovery, including 12-step utilization.

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INTRODUCTION

Previous research demonstrates many benefits associated with participation in traditional 12-step groups (e.g., Alcoholics Anonymous [AA], Narcotics Anonymous [NA]) for those struggling with alcohol/drug addiction, including increased abstinence, decreased distress and psychiatric symptoms, and improved vocational functioning (Moos, Finney, Ouimette, & Suchinsky, 1999). Despite the benefits and wide availability of traditional 12-step groups, persons dually diagnosed with substance use and psychiatric disorders do not consistently attend traditional 12-step groups because they have difficulty bonding with other members, and because the important issues of dual recovery (including psychiatric medication management) are not addressed in traditional single-focus (i.e., substance use) 12-step groups (Vogel, Knight, Laudet, & Magura, 1998).

Moreover, clinicians in substance abuse and/or mental health treatment settings are reluctant to refer dually diagnosed clients to traditional 12-step groups for various reasons: they doubt clients' ability to engage in the 12-step process or associated social activities (Humphreys, 1977), they hold beliefs about the "dangers" of 12-step for their clients (e.g., lack of professionalism, becoming overly dependent on the group) (Chappel & DuPont, 1999), and they perceive clients' lack of motivation or readiness to change as an obstacle to 12-step participation (Laudet, 2003). Dually diagnosed clients and their mental health clinicians might be more amenable to a dual-focus 12-step group, such as Double Trouble in Recovery (DTR) (Vogel et al., 1998), which addresses issues relevant to recovery from both substance use and mental health disorders.

The purpose of this small-scale study was to examine: 1) mental health clinicians' beliefs about their dually diagnosed clients' self-efficacy and capacity for recovery/independent functioning; 2) clinicians' attitudes toward traditional 12-step groups; and 3) their referrals to traditional 12-step groups for their dually diagnosed clients. We anticipated that clinicians would hold favorable attitudes toward traditional 12-step groups, but that referrals to these groups would be low for their dually diagnosed clients; what was unknown was clinicians' beliefs about dually diagnosed clients' prospects for recovery and a possible association between those beliefs and referrals to traditional 12-step groups. The survey took place prior to intensive staff training on recovery from dual disorders and the implementation of a dual-focus 12-step group (Double Trouble in Recovery, or DTR) for consumers at the study clinics.

METHODS

Mental health clinicians in a Continuing Day Treatment Program and an Outpatient Mental Health Program in the Bronx, New York ($n = 28$), completed anonymous surveys regarding their beliefs about recovery and their attitudes toward and referral practices to 12-step groups for their dually diagnosed clients.

Since very few measures have been developed to measure the aforementioned constructs, we utilized and adapted instruments from previous small-scale studies, all of which demonstrated excellent face validity. The Mental Health Confidence Scale (MHCS) (Carpinello, Knight, Markowitz, & Pease, 2000), a valid and reliable scale measuring consumers' mental health related self-efficacy beliefs (i.e., optimism, coping, and advocacy), was adapted to measure clinicians' beliefs about dually-diagnosed clients' self-efficacy. The Clinician Optimism Scale (COS) (Grusky, Tierny, & Spanish, 1989) was used to measure clinicians' beliefs about clients' capacity for improvement and positive outcomes (i.e., recovery), with four items added by the authors. A scale measuring beliefs on the Positive and Negative Aspects of 12-step groups (PNS-12S) had been created and utilized previously by one of the authors (Laudet, 2003), and was administered in the current study. Because a literature search yielded no instruments measuring the extent of providers' 12-step referral activities, we created the Referral to Self-Help Practices Scale (RSHPS) based on reviews of the extant literature and from pilot interviews with both clients and staff members (Laudet, 2000). Sample items and scoring for each scale are listed in the Appendix. All items for the quantitative measures were scored on a 5-point Likert scale, with the higher endorsement indicating affirmative beliefs and more referral activities. In addition, clinicians were asked if they ever attended a 12-step meeting for personal reasons, and were asked open-ended questions regarding potential benefits and obstacles to dually diagnosed clients' participation in 12-step groups.

RESULTS

Demographics for the clinician sample are reported in Table 1. Fifty-three percent of clinicians were under the age of 40; 64% were clinical social workers, 18% clinical supervisors (also social workers), 14% community mental health workers, and 4% were psychiatrists; 82% held Master's Degrees. Seventy-five percent were female, 50% reported Caucasian race, 25% each reported African-American race and Hispanic ethnicity. They reported a mean of 7 years' clinical experience at the current mental health treatment setting. Twenty-three percent of clinicians reported that they referred their dually diagnosed clients to any traditional 12-step groups. The clinicians estimated that 56% of clients on their caseloads were dually diagnosed, with 13% of these clients currently attending 12-step groups (virtually all AA or NA) in the community.

All scales demonstrated high internal reliability, as listed in the Appendix. Mean scores for the various scales are presented in Table 2. Clinicians revealed "some" confidence in dually diagnosed clients' mental health related efficacy (MHCS mean = 2.9, $sd = .51$, range 1.8 to 3.9); "few to some" dually diagnosed clients had the capacity for improved and independent functioning (COS mean = 2.7, $sd = .64$, range 1.4 to 3.8); they "rarely to sometimes" made 12-step referrals (RSHPS mean = 2.5, $sd = .87$, range 1.2 to 4.1). Clinicians rated the

Table 1. Descriptive Statistics for the Sample ($n = 28$)

Mental Health Clinicians	Percent		
Under age 40	53		
Female	75		
Caucasian	50		
African American	25		
Hispanic	25		
Clinical social workers	64		
Clinical supervisors	18		
Community mental health workers	14		
Psychiatrists	4		
Master's Level	82		
Ever attended a 12-step meeting ^a	43		
Clients on caseload who are dually diagnosed	56		
Referred dually diagnosed clients to traditional 12-step groups	23		
Dually diagnosed clients currently attending traditional 12-step groups	13		
	Mean	SD	Range
Years at Current Treatment Setting	7.3	9.58	0-32 years
Number of clients on caseload	76	86.4	2-300 clients ^b

^aClinicians who attended at least one 12-step meeting reported positive attitudes toward 12-step groups than those who never attended.

^bPsychiatrist reported a maximum of 300 clients on caseload.

positive aspects of 12-step involvement significantly higher than its negative aspects (PNA-12S; 3.4 vs. 2.5, $t = -7.8$, $p < .01$, for paired samples), indicating favorable attitudes toward 12-step groups. Clinicians who attended at least one 12-step meeting for personal reasons (43%) reported more positive attitudes toward 12-step groups (PNS-12S) than those who had never attended (3.9 vs. 3.3, $t = -2.1$, $p < .05$, for independent samples). Clinicians' beliefs about dually-diagnosed clients' capacity for recovery (COS) were correlated with the frequency of 12-step referrals (RSHPS) ($r = .41$, $p < .05$); the belief that only "few to some" dually diagnosed clients could achieve total recovery was associated with less frequent 12-step referrals.

Table 2. Basic Statistics

Scale	Mean	SD	Range	Mean rating
1. Mental Health Confidence Scale (MHCS)	2.9	.51	1.8-3.9	"Some confidence in clients' self-efficacy"
2. Clinician Optimism Scale (COS)	2.7	.64	1.4-3.8	"Few/some clients would improve"
3. Positive/Negative Aspects of 12-Step Scale (PNA-12S)				
a. Positive aspects	3.4*	.56	2.0-4.3	"Somewhat true that 12-step has positive aspects"
b. Negative aspects	2.5	.43	1.5-3.5	"Not true that 12-step has negative aspects"
4. Referral to Self-Help Practices Scale (RSHPS)	2.5	.87	1.2-4.1	"Rarely made 12-step referrals for dually diagnosed clients"
Bivariate Correlation Clinician Optimism Scale AND Referral to Self-Help Practices Scale				
	$r = .41^{**}$			

* $p < .01$, paired samples t -test. ** $p < .05$

An analysis of the open-ended items indicated that 53% of clinicians cited "additional social support/support from the community" as the most frequent potential benefit of traditional 12-step participation for dually diagnosed clients; 36% cited "obtaining sobriety/responsibility for recovery" as the second most frequent potential benefit. "Stigma because of mental illness" (21%), "getting misinformation about psychiatric medications" (18%), and "mental illness symptoms would interfere with functioning in the group" (14%) were the most frequently reported potential obstacles dually diagnosed clients might encounter in traditional 12-step groups.

DISCUSSION

Few studies have documented mental health clinicians' beliefs and attitudes regarding dually diagnosed clients, and their ensuing 12-step referral activities with these clients (Laudet, 1999-2000). This small-scale survey of community

mental health clinicians revealed moderate confidence in dually diagnosed clients' mental health-related efficacy (i.e., clients' abilities to cope with mental illness/substance abuse, advocate for their needs, and remain optimistic about recovery). Clinicians also indicated the belief that only a minority of dually diagnosed clients could achieve improved and independent functioning (i.e., overall recovery). Despite generally positive attitudes toward traditional 12-step groups, which have been documented previously (Salzer, McFadden, & Rappaport, 1994), clinicians in this sample rarely referred their dually diagnosed clients to any 12-step groups. Clinicians' personal attendance at 12-step meetings was associated with more positive attitudes toward 12-step groups, but did not influence 12-step referral activities with their clients.

Clinicians' skepticism regarding clients' prospects for independent functioning was associated with fewer 12-step referrals. Clinicians may refrain from referring dually diagnosed clients to 12-step groups because they regard clients' multiple impairments as chronic and resistant to change. Knowing that traditional 12-step groups typically do not encourage sharing of mental illness symptoms and/or psychiatric medication issues, clinicians may then avoid referring their dually diagnosed clients to these groups.

Clinicians' concerns about dually diagnosed clients' functioning in traditional 12-step groups support the need for dual-focus 12-step groups that address both substance use and mental health disorders. Recent research shows that participation in Double Trouble Recovery provides dually diagnosed clients with opportunities to learn about dual disorders, "freedom to talk about mental illness," mutual support and acceptance, and a forum where they participate more actively than in traditional 12-step groups (Laudet, Magura, Vogel, & Knight, 2003). In addition, consistent DTR attendance is associated with improved psychiatric medication adherence and decreased psychiatric symptom severity (Magura, Laudet, Mahmood, Rosenblum, & Knight, 2002), and can facilitate participation in traditional 12-step fellowships (Laudet et al., 2003). Referring dually diagnosed clients to a dual-focus 12-step group such as DTR may be an optimal, low-threshold introduction to mutual aid fellowships.

The clinicians in this sample appear relatively well informed regarding 12-step processes, as evidenced in their responses to the qualitative items. They recognized that traditional 12-step groups could provide additional social support for dually diagnosed clients, which is essential to both short and long-term recovery. They cited mental illness stigma and misinformation regarding psychiatric medication as the two most frequent obstacles to traditional 12-step participation, which is consistent with previous research (Vogel et al., 1998).

A major limitation of this study is the small sample from a single study site. While the small sample precludes generalization to other community mental health settings, the dearth of empirical research on clinicians' beliefs and practices recommends that such small-scale studies be disseminated and expanded upon. Similarly, the lack of validated instruments to measure the constructs of interest

necessitated our using and adapting non-standardized instruments, and creating new items and scales. While the instruments used in this study demonstrated adequate internal reliability, they have not been validated or normed on other samples (the Mental Health Confidence Scale is an exception). We encourage the use of these measures in future studies. In addition, it may have been useful to compare clinicians' views on and referral activities for traditional (single-focus) versus dual-focus 12-step groups; however, dual-focus 12-step groups like DTR are rare in the general community, and therefore we assumed that clinicians would have little experience making dual-focus 12-step referrals. At a later time point, clinicians in this treatment setting will be surveyed again to determine any changes in beliefs regarding clients' recovery, any changes in traditional 12-step referral activities, and beliefs about the benefits of DTR for dually diagnosed clients.

In summary, this small-scale study indicates that mental health clinicians' skeptical attitudes toward dually diagnosed clients' recovery potential deter making referrals to traditional 12-step groups. Clinicians may be more inclined to refer dually diagnosed clients to a dual-focus 12-step fellowship such as Double Trouble in Recovery, which in turn may facilitate subsequent participation in traditional 12-step groups. Providing clinicians with education and training on clients' empowerment for recovery, including traditional and dual-focus 12-step group participation, could increase expectations that clients can assume responsibility for recovery and achieve more independent functioning. Implementation of staff training on client empowerment for recovery and 12-step utilization, and the initiation of client-led DTR groups are currently underway at the study clinics, and will be reported at a later time.

APPENDIX: Scales & Sample Items

1). Mental Health Confidence Scale (MHCS) (Cronbach's alpha = .90)

"How many of your dually diagnosed clients . . ."

- A). Can be happy
- B). Are hopeful about the future
- C). Can set goals for themselves
- D). Can get support when they need it
- E). Are able to boost their self-esteem

[Responses: 1 = None to 5 = Almost all]

2). Clinician Optimism Scale COS) (Cronbach's alpha = .80)

"How many of your dually diagnosed clients . . ."

- A). Will remain in the mental health system the rest of their lives
- B). Will be able to greatly increase their involvement in the community
- C). Will be able to function very well in the community
- D). Will need to be hospitalized again in the future

E). Will remain pretty much as they are now
[Responses: 1 = None to 5 = Almost all]

3). Positive/Negative Aspects of 12-step (PNS-12S) (Cronbach's alpha = .80)

“How true is each item in your opinion . . .”

- 3). The best person to help an addict or alcoholic is a recovering addict/alcoholic (P)
- 4). 12-Step/Self-Help groups can be dangerous because the leaders are not adequately trained (N)
- 6). 12-Step is a treatment modality (P)
- 7). 12-step groups can lead clients to pick up or relapse (N)
- 15). Referring clients to 12-Step/Self-Help is a good idea (P)

[Responses: 1 = Not true to 5 = Very true]

4). Referral to Self-Help Practices Scale (RSHPS) (Cronbach's alpha = .96)

“Thinking about your dually diagnosed clients, how often do you . . .”

- 2). Give a client a meeting list
- 4). Give client literature/pamphlets about 12-step/Self-Help program
- 7). Address clients' concerns, reservations and objections to the program
- 12). Talk about the importance of connecting with other members
- 13). Connect client with someone who is affiliated with the group

[Responses: 1 = Never to 5 = Every time]

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