4.11 Attending AA: encourage but don't coerce

Findings The first attempt to combine results from studies which compared Alcoholics Anonymous (AA) approaches with other treatments (or no treatment at all) found AA either no better or less effective. Coercing drinkers into AA may be counterproductive.

21 studies were combined in a meta-analysis of abstinence outcomes 12 months after treatment. Most weight was placed on randomised studies because these eliminate self-selection bias. The three of AA groups all involved clients coerced by employers or courts. Findings suggested that coerced clients do significantly worse in AA than in formal treatment and no better than when left to their own devices. In contrast, the non-randomised studies in which alcoholics chose to attend AA recorded significant advantages over other treatments. This pattern suggests AA looks better in some studies just because those who attend are more motivated, or that people coerced into AA do worse than those coerced into other treatments, perhaps because AA relies on the commitment of its members.

A similar pattern characterised studies of AA-based residential Minnesota Model programmes: no advantage compared to other residential treatments when patients were randomised, a significant advantage when patients were free to choose. Five other studies tested elements of the AA/Minnesota approach, most notably using ex-alcoholic therapists, a practice supported by the results.

In context The meta-analysis suggests coerced patients do worse in 12-step groups than in other treatments. Other 'matching' studies found AA specially beneficial for people with relatively few other social resources of the kind which might maintain abstinence. With respect to residential 12-step programmes, the study adds to evidence suggesting there is little to choose between modern psychosocial approaches, perhaps because they have similar effects on the psychological variables underlying recovery. The benefits of Minnesota Model and allied programmes are partly (in some studies, almost entirely) due to their facilitating AA's continuing care/aftercare role.

LINKS Nugget 4.3

Most studies have assessed outcomes using an 'AA-friendly' measure – abstinence. Those which also measured non-problem drinking found the extra benefits of AA disappeared or were far less impressive. One way AA attenders may differ from non-attenders is in their motivation to become abstinent. Some studies have controlled for this and still found AA effective, sometimes better than professional aftercare. These and other more positive findings have generally involved AA as aftercare, a role not included in the meta-analysis.

Practice implications For the study's authors, the main implication is that people should not be coerced into AA. On the other hand, though the evidence for AA as a standalone treatment is weak, the fact that it is virtually free means there is no reason why clients should not be told about AA and encouraged to try it if they wish to do so. In terms of outcomes, there is also no reason to discourage referral to Minnesota Model programmes, but here cost is an issue. The presumption for most individuals (exceptions include those with very poor social or physical environments or serious psychiatric and medical conditions) is that non-residential options should be tried first. These are generally found just as effective, are cheaper, and patients can still be encouraged to attend AA as aftercare.

The evidence for AA as aftercare (particularly following 12-step treatment) is strong enough to support routinely encouraging its uptake. Only a small minority of alcohol clients in the UK attend AA, a proportion which treatment providers might be able to considerably increase. Tactics include stressing the concrete benefits of mutual support rather than AA's spiritual aspects, escorting patients to 'taster' meetings (the escort could be a former patient now attending AA), arranging an introductory meeting at the unit, and inviting AA members to address patients. Patients who attend AA during treatment are more likely to continue attending as aftercare.

Featured studies Kownacki R.J., *et al*. "Does Alcoholics Anonymous work? The results from a meta-analysis of controlled experiments." *Substance Use and Misuse*: 1999, 34(13) p. 1897–1916. Copies: apply Alcohol Concern.

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