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How does the 12-step model of recovery Benefit and Complicate Harm Reduction
Strategies for Substance Abusing Adolescent Youth?

by

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Abstract

Alongside harm reduction strategies, the abstinence-based 12-step model of recovery has become an increasingly prominent means of addressing substance abuse among American adolescent youth. These two different models of recovery are commonly being implemented in tandem with one another as a means of treating substance abuse for adolescent youth. Despite the common occurrence of dual implementation, there has been limited research into the impact these modalities have upon one another. Using a narrative review, this study utilizes existing literature to highlight key means through which the 12-step model of recovery works as both an asset and a hindrance to harm reduction strategies, such as opioid replacement therapy, for substance abusing adolescent youth.

Keywords: Harm reduction, 12-Step, Adolescent youth.

Drug and alcohol treatment availability has become increasingly relevant as the United States (U.S.) is currently in the midst of an opioid epidemic. This epidemic is of particular importance where adolescence is concerned. According to the University of Michigan's annual, nationwide, survey of adolescents, "by the time students are seniors, almost 70% will have tried alcohol, half will have taken an illegal drug... and more than 20% will have used a prescription drug for a nonmedical purpose" (Winters, Tanner-Smith, Bresani, & Meyers, 2014). The 21st century has seen an alarming rise in the abuse of alcohol, prescriptive, and illicit drugs among our nation's minors. According to the Centers for Disease Control and Prevention (CDC), overdose deaths have quadrupled since 1999 and more than a half million people have been killed by drug overdoses between 2000 and 2015 (Understanding the Epidemic, 2016). Additionally, the World Health Organization finds that alcohol consumption has a direct relationship with worldwide mortality rates –accounting for 3.2% total. And, while the most severe impact of alcohol-related abuse is found among adults, its beginnings can be traced to adolescence (Patton, Deluca, Kaner, Newbury-Birch, Phillips, & Drummond, 2014). While experts acknowledge that the foundations of alcohol/drug abusing behaviors are present during adolescence, the nature of how necessary interventions should be conducted has been a topic of wide discussion. To date, harm reduction strategies have been the most prominent evidence-based practice for intervention. As opposed to eliminating drug use or ensuring abstinence, the practice aims to reduce the negative consequences associated with drug abuse while respecting the individual's decisions. As an alternative, or in conjunction with harm reductionist models of treatment, adolescents

also have 12-step self-help groups available to them as a means of support. The 12-step model has been a prominent source of recovery for substance abusers across the country for decades. However, as harm reduction models become more prominent, and used more often in combination with 12-step programs, it is of major concern how these two modalities interact with one another. To date, there has been a distinct lack of communicative channels between professionals driving harm reductionist practices and members of the 12-step community. Consequently, there are many misperceptions and distrustful attitudes that the two share of one another. This work aims to investigate the relationship between harm reduction strategies and 12-step models of recovery – hypothesizing that 12-step models work as both an asset and hindrance to harm reduction strategies.

Key Concepts: 12-Step Models and Harm Reduction Strategies

Role of the 12-step program in recovery

Originating in 1935, the 12-step model of recovery (commonly referring to Alcoholics/Narcotics Anonymous) is a spiritually based self-help group emphasizing the value of one addict helping another as one without parallel. The 12-step program is widely recognized as a prominent abstinence-based recovery model, available free of charge to members of all ages. The only requirement for membership in this program is a desire to stop using mind-altering substances. The program itself is based around a 12-step model that has been adapted over the past few decades for various recovery purposes through substitution of the word “alcohol” (in Alcoholics Anonymous), to “drugs” (in Narcotics Anonymous), to “sex” (in Sexaholics Anonymous), or “gambling” (in Gamblers Anonymous). While there are a wide variety of alterations to the goal of the

process (each addressing a behavior that is defined as “out of control” by the participant), the model itself remains unchanged. And, for the purposes of this study, all references to the 12-Step model will be in reference to the alcohol/drug abuse characterized by Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). According to *How It Works*, (Williams, 2014, p. 58) a descriptive chapter of the AA program’s textbook, the program abides by the following 12 steps:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

The program encourages new participants to find a *sponsor* (referring to a more experienced member with typically at least one-year of sobriety) who will help newcomers work through these twelve steps and any resulting conflicts. The process of working through the twelve steps is unique to the individual and the relationship they have with their sponsor and the program at large. And it is to be noted that there is some flexibility around the use of the word “God” –which can be substituted for the idea of a “higher power”. The program is self-sustaining (relying upon donations from members) and typically meets for an hour in community spaces such as churches and community centers. In urban areas there is typically greater access and availability so that, if needed, a participant could attend numerous group meetings per day. Each group is run slightly differently, abiding by a unique set of “home” group rules, though a typical group would involve descriptive readings from the textbook followed by open sharing –in which self-identified “addicts” share past experiences, insights and inspirations, and current thoughts and emotions over the course of an hour. In this way the program encourages groups to support each other and draw strength from identifying with one another’s experiences. Groups sometimes include a key speaker who shares their story of addiction and recovery, using the majority of the group time, and most allow time at the end for others

to share and reflect at the end of their story. Group sizes can range from a small group to hundreds –small groups fostering intimacy and relatability, and large groups serving as both a platform for guest speakers and a means through which local 12-step goers can see and greet each other as a community (Mäkelä, 1996). At the end of each group, there is always time saved for “a burning desire” –someone who is struggling with sobriety and feels a “burning” need to share with other members.

The structure of governance among 12-step programs is widely diverse among group practices. As a result, a specific 12-step fellowship’s beliefs on a particular issue can be widely varied between groups. And, while one group might support an ideal, another might adamantly oppose it (White, 2011). However, the program itself is distinguishable by its belief in a spiritual awakening as a result of working these 12 steps. The 12-step model defines addiction as an all-consuming disease characterized by 3 distinct elements: “physical (compulsion and loss of control over decisions about using), mental (obsession with use), and spiritual (self-centeredness). For [12-Step] members, every aspect of recovery is based on sweeping all drugs/alcohol from their lives. This decision “is not tangential; it is the very essence of the program” (White, 2011). The program assumes that upon completion of these 12-steps, members will have begun a transformation. And, motivated by the discomfort of living substance free, this transformation will lead to connection with their higher power (Williams, 2014).

As mentioned above, the program does tend to be highly decentralized. However, because of these diverse practices, its fundamental abstinence principle is sometimes subject to interpretation depending on the group and its members. While some groups may look favorably upon other treatment options, a notable issue within the program

overall is the tendency to believe that the 12-step model is the only viable recovery option. As the 12-Step AA book states: “rarely have we seen a person fail who has thoroughly followed our path. Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves...They are naturally incapable of grasping and developing a manner of living which demands rigorous honesty. Their chances are less than average” (Willams, 2014, pg.58). This language, taken directly from the AA text, is dismissive of recovery outside the 12-step model and can leave participants feeling conflicted. However, there are various instances in which the program has proven itself an invaluable asset to other modalities of treatment.

Role of harm reduction models in recovery

Acknowledging that these biases exist within the 12-Step program, it is important to understand that attitudes are shifting in favor of leniency toward alternative treatment modalities. According to research, 12-step program attitudes are beginning to slowly shift toward further acceptance of alternative treatment modalities or in some cases are at least being reevaluated. More modern definitions of recovery are now beginning to include those engaged in medication-assisted treatment (White, Campbell, Shea, Hoffman, Crissman & Dupont, 2013). The mention here, of medication-assisted treatment, falls under the category of harm reduction. “As an intervention strategy, harm reduction is considered a policy or program directed toward decreasing the adverse health, social, and economic consequences of drug use without requiring abstinence from drug use. While this approach can include abstinence, harm reduction services are generally low threshold

in that abstinence is not required to obtain services and multiple barriers to service access are removed” (Lee, Engstrom, & Peterson, 2011).

There are two distinct examples of medication-assisted treatment that will be highlighted in this work: Methadone Maintenance Treatment (MMT) and Buprenorphine. These two drugs are part of a harm reduction practice called opioid replacement therapy (ORT). MMT is a comprehensive long-term program centered upon the regulated distribution of a synthetic opioid agonist as an alternative to active drug abuse. As a condition of accessing this medication, clients take part in counseling, case management, and various other medical and psychosocial services. MMT became a federally endorsed program in the United States (U.S.) in 1971. As opposed to MMT, Buprenorphine is a relatively new treatment that became approved for medical use in the U.S. in 1981. This partial agonist opioid is considered safer and less stigmatized than MMT and can be prescribed by a qualified physician. These two medication-assisted treatments have been largely successful at curbing drug abuse, however both can often place patients at odds with the 12-step model of recovery.

Harm reduction is a broad category. And while ORT is certainly a highlight of harm reduction as it relates to adolescent substance abuse, there are many other treatment modalities -ranging from needle exchange programs and safe injection sites to the distribution of other drugs (such as Naltrexone and Naloxone), and brief interventions. One of the most prominent forms of harm reduction in recent years has been the use of electronic cigarettes for smoking cessation. Like other harm reduction practices, electronic cigarettes are a means of delivering the addictive drug (in this case nicotine) in a safer way that mitigates associated risks (such as lung cancer, coronary heart disease,

and stroke) for an approximated 50 million American smokers (Polosa, 2013). What makes such harm reduction approaches unique is their acknowledgement of the benefits people derive from their substance of choice. While 12-step models and various other modalities tend to denounce any recognition of the benefits associated with substance abuse, harm reduction strategies recognize that people find benefits associated with drug use. Thus, rather than deny them, such practices aim to allow people to continuously derive benefits from their chosen substance but through a safer delivery system (Polosa, 2013). This is where the two programs fundamentally differ. The 12-step model strives toward a goal of abstinence that forbids the use of most mind-altering substances; though there are occasional exceptions (or willful disregard) for drugs such as nicotine and caffeine. The model aims for participants to have a spiritual awakening, as a result of working through the twelve steps, which will lead to the participant ultimately refraining from any substance use whatsoever. Harm reduction strategies, on the other hand, acknowledge an individual's choice to use substances and aim to mitigate the negative impacts of those choices –though many will simultaneously encourage abstinence as a long-term goal. Thus, the two programs have different aims with regard to long-term outcomes.

Method

While there is not a lot of literature directly comparing 12-step spiritually-based programs with harm reduction strategies, there is a wealth of knowledge on each topic individually as related to adolescent substance abuse. The literature presented evaluates treatment outcomes for 12-step models and harm reduction methods of treatment. A majority of the literature is adolescent focused –discussing material relevant to those

between the period of puberty and young adulthood. Evaluating a comparison between these two treatment modalities will contribute to the field by providing insights into the effectiveness of the two most popular drug/alcohol treatment strategies available today. Due to a lack of data directly comparing the two models against each other where adolescence is concerned, research assessing youth participation in, or the general effectiveness of, harm reduction strategies and 12-Step meetings was evaluated as a means of comparison. For example, data evaluating positive/negative outcomes of youth participation in Narcotics Anonymous (NA) meetings was compared against outcomes evaluating youth participation in Methadone Maintenance Treatment (MMT) to assess how the two might work in conjunction with or in opposition to each other. Several works evaluated research concerning participants dual enrolled in harm reduction-based programs and participating in 12-step meetings.

A majority of the data is adolescent focused, however there are exceptions made for useful information directly relevant to program outcomes. Information and research was collected from journal articles, books, and dissertations through the Portland State University Library database as well as through Google Scholar. Within these databases, research was used from the fields of psychology, social work, public health, and other areas relevant to adolescent drug use. These specific fields of research were chosen so that the material would be representative of a wide range of mental health perspectives.

These sources are peer reviewed, relevant to the topic at hand, and present research findings that can support evaluations made in this work. A systematic review was used to analyze this data in which research was organized nominally and then carefully evaluated so that each work would be comparative of another. The review was

then organized into a narrative and presented through an introduction, key concepts, methods, findings, and a discussion section. The discussion includes a summary of the study's interpretations, limitations/strengths, future research recommendations, and a conclusion.

Findings

AA and NA meetings remain the most commonly sought form of treatment for substance abuse problems among adults and adolescents alike. This is likely due to the program's wide availability, the opportunity for social networking, and the fact that attendance is free of cost. The 12-step model is associated with improved outcomes for both mandated and non-mandated program attendants and has been shown to initiate behavior change –often moving participants along the stages of change from pre-contemplation to contemplation. In this sense, the program works to reinforce harm minimization goals emphasized by Medication-Assisted Treatment, Needle Exchange Programs, Brief Interventions, and many other practices.

It is important to note that, according to the National Treatment Center Study, some 59.7% of publicly funded drug/alcohol treatment programs (and 75.6% of those privately funded) now utilize the 12-steps as their primary orientation. Other programs, which may draw from cognitive-behavioral and eclectic approaches, also tend to incorporate the 12-steps (Lee, Engstrom, & Peterson, 2011). Thus, there are currently many programs across the nation demonstrating compatibility between harm reduction strategies and 12-step models.

12-Step model as a benefit to harm reduction strategies

Participation in 12-Step meetings has been shown by existing research to significantly improve the likelihood of long-term abstinence in adolescents. In a study of substance abusing adolescents admitted to residential treatment, pro-social behaviors were found to be positively correlated with 12-step meeting attendance and participation (Pagano, 2013; Kelly, 2013). Such pro-social behaviors and their emotional associations (such as feeling “selfless”, “caring for others”, and “accepting others”) have a positive impact on adolescents co-participating in harm reduction treatment strategies such as Opioid Replacement Therapy (ORT) (Pagano, 2013). This is due to the application and relevance of these behaviors in relapse prevention strategies taught by harm reduction models. These shifts in behavior and attitude also support participant engagement in similarly associated activities such as the group attendance and counseling required by Methadone Maintenance Treatment (MMT). The 12-Step model encourages such behavioral changes specifically through the practice of encouraging participants to take on responsibilities through service positions. Being accountable and relied upon for such service positions has long lasting positive impacts that encourage responsibility and emphasize skills that reinforce strategies to mitigate harm. Such service positions include:

- 1.) Finding and maintaining meeting locations
- 2.) Arranging programs and meeting schedules
- 3.) Providing literature and coffee
- 4.) Collecting and organizing donations
- 5.) Resolving group problems
- 6.) Helping those in need
- 7.) Maintaining contact with the larger 12-step community

Another key role that 12-step meetings play in supporting harm reduction strategies is the immense social support network provided to participants upon entry. Many adolescents entering the program, whether attending by court mandate or by choice, find themselves isolated from their social matrix –typically preceding, or as a consequence of, their substance abuse. However, among 12-step participants, “there is an assumption of mutual and automatic trust stemming from the simple identification of being an alcoholic [or addict]”(Mäkelä, 1996). With isolation being an important contributing factor toward substance abuse, it is worthwhile to note the connection that 12-step meetings offer new participants. To foster this connection further, there are 12-step meetings that serve particular populations. For example, there are men or women only groups, special groups for the lesbian, gay, bisexual, and transgender (LGBT) community, groups for newcomers, and young people’s groups –aimed at serving younger members who might otherwise be disenchanted by significant age differences between themselves and the group majority. By fostering social connection (through service positions and an “assumption of mutual trust”) and relatability (through celebratory sobriety tokens and unified engagement in recreational activities outside of conventional 12-step meetings) the 12-step model supports skills that will be necessary for adolescents to benefit from harm reduction strategies (Mäkelä, 1996). Additionally, by functioning as a free program with young peoples meetings, the 12-step model compensates for a found “lack of specialized treatment programs, poor health care coverage, and inconsistent quality in adolescent treatment services,” and in this way works to function as a support system for adolescents and young adults who might not otherwise be able to fully benefit from other treatment services (Winters, Tanner-Smith, Bresani, & Meyers, 2014, pg. 200).

12-Step model as a complication to harm reduction strategies

The most important difference between harm reduction strategies and the 12-step model is that the latter views addiction as a disease while harm reduction strategies present as a public health alternative to moral and disease models of addiction. As a result, while there may be commonalities, the two modalities have notably different outcome goals. 12-step models strive to push participants toward their defined version of abstinence through a spiritual awakening. And, while abstinence may be included as a goal of harm reduction strategies, they typically emphasize the importance of a helping relationship in which the professional/organization strives to reduce the negative consequences associated with continued use –though typically without requiring abstinence. Because of this difference in outcome goals, participants (especially adolescents and young adults) may find themselves conflicted between two seemingly opposing ideologies. And, while it is often that drug beginning the recovery process say they want to be abstinent, individual meanings seem to have widely diverse applications (Neale, 2011). According to research, the term “abstinence” itself has widely varying interpretations. Additionally, while abstinence may be defined in various ways, “recovery” is even more widely variant –and a harm reductionist concept of recovery is conceptually very different from 12-step “recovery”. Thus, a conflict of interest presents itself.

This conflict is also evidenced by the designation of a participant as an “addict”. For example, within 12-step groups, members are socially pressured/obligated to introduce themselves as “addicts” whereas this distinction is not specified within harm reduction strategies such as ORT. Because the 12-step model is very specific, noting in

its third tradition that “the only requirement for... membership is a desire to stop [using],” a participant will never be expelled from a group due to a lack of abstinence (Williams, 2014, pg. 564) However, the fact that a desire to stop using is required for membership is itself contrary to harm reduction strategies –which serve people regardless of their intent, aiming to tap into intrinsic (rather than extrinsic) motivation.

“The stigma associated with drug use has been repeatedly identified as a barrier to accessing health-care services” and this trend has translated into the treatment world itself (Macneil & Pauly, 2011, pg. 31). In a survey of 322 patients co-participating in 12-step groups and MMT, it was found that one-quarter (25%) reported negative experiences related to their MMT patient status and, among the others, only 34% even disclosed their MMT status –and might therefore have sought to avoid conflict by hiding their participation in a harm reduction model (White, Campbell, Shea, Hoffman, Crissman, & Dupont, 2013, pg. 294). Because of the prevailing stigmas and discrimination against ORT and other medication-assisted, or non-12-step, treatment options, many adolescents co-participating in both modalities report difficulties participating in 12-step programs due to their involvement in harm reduction programs. As stated earlier, in its text (just prior to listing the 12-step of recovery), the 12-step book describes those “who do not recover” as people who are “born that way,” “constitutionally incapable of being honest,” and naturally incapable of...honesty,” with “chances that are less than average” (Williams, 2014 pg.58). This wording provides a means through which 12-step members are able to engage in negative attitudes and stigmas toward alternative treatment modalities –especially harm reduction strategies, which do not place the same type of importance on abstinence. This bias has been a primary and ongoing source of incompatibility between

the two modalities. The skepticism is also prevalent on the medical side of treatment; with many treatment providers reporting difficulties concerning the compatibility of the two modalities (Lee, Engstrom, & Peterson, 2011 pg. 1156).

Discussion

These findings have significant implications on multiple levels. For example, noting the negative impacts of 12-step programs upon harm reductions strategies, it will be important going forward (on a macro scale) that attitudes within the 12-step program shift toward a more favorable outlook on alternative (specifically harm-reductionist) treatment modalities. This shift would be characterized by more favorable attitudes and serve to mitigate negative attitudes toward such practices as medication-assisted treatment. With regard to outcome –noting that the two modalities have contrasting outcome goals—it will be important for youth, and the professionals working with them, to determine their intended outcome based on what is both reasonable and attainable and find ways to customize their participation in both modalities to compliment this intended outcome. On a smaller (micro) scale, this research suggests that the 12-step definition of total abstinence may not be an immediately realistic goal for many substance-abusing youth. Thus, rather than alienating them through required participation in modalities, such as 12-step, that aim towards such outcomes, professionals determining youth outcomes (judges, counselors, family members) might instead get feedback from multiple sources (including the youth themselves) to evaluate what an attainable goal might look like and therefore recommend, for example, that they focus on one modality (such as harm reduction) while attaining reasonable benefits from another –such as the social support network provided through 12-step participation. Policy-wise, this might suggest

that, rather than the current tendency to immediately implement both modalities wherever substance abuse is called into question as an addressable issue, (as is commonly practiced today) professionals and youth work together toward defining both desired and attainable goals and utilize the program best suited to their need.

With regard to positive outcomes, it is important that professionals (who may disregard 12-step recovery) recognize the immense social support provided to new participants as benefit, unique in itself, that youth might seek solely for its own purposes. Additionally, pro-social behaviors, associated with 12-step attendance, may be directly beneficial in their application toward alternative treatment modalities such as harm reduction. Thus, participation in 12-step meetings might serve as an intermediate socialization tool that prepares youth for more meaningful engagement in professional treatment.

These findings, overall, suggest that there are means through which the negative effects of dual participation (in both harm reduction and 12-step recovery) might be mitigated, and means through which benefits might be derived with specific intent from one program and applied toward another. It should be noted that this literature review was limited by time restraints and might therefore have lacked a more in-depth analysis of the consequences associated with co-participation in these two varying recovery modalities. However, while this limitation may have reduced the amount of material presented, the author's personal experience with both harm reduction strategies and 12-step recovery served as an essential asset in the analysis of both programs and their impact upon one another. Going forward there will need to be more in-depth research

assessing the means through which 12-step participation affects and engagement in harm reduction strategies such as ORT for adolescent youth as a special population.

References

- Centers for Disease Control and Prevention. (2016, December 16). Understanding the Epidemic. Retrieved from <https://www.cdc.gov/drugoverdose/epidemic>
- Heyman, G. (2009). *Addiction: A disorder of choice*. Cambridge, MA: Harvard University Press.
- Hilarski, C. (2005) *Addiction, assessment, and treatment with adolescents, adults, and families* (2005). Binghamton, NY: Haworth Social Work Practice Press, Binghamton, NY.
- Kelly, J. (2013). Alcoholics Anonymous science update: Introduction to the special issue. *Substance Abuse.*, 34(1), 1.
- Kelly, J. (2013). Emerging adults' treatment outcomes in relation to 12-step mutual-help attendance and active involvement. *Drug and Alcohol Dependence.*, 129(1), 151.
- Kelly, J. F., & Urbanoski, K. (2012). Youth recovery contexts: The incremental effects of outcomes. *Alcoholism: Clinical and Experimental Research*, 36(7), 1219-1229.
- Lee, H.S., Engstrom, M., & Peterson, S.R. (2011). Harm reduction and 12 steps: complementary, oppositional, or something in-between? *Substance Use & Misuse*, 46 (9), 1151-1161. doi:10.3109/10826084.2010.548435
- MacArthur, G. (2014). Interventions to prevent HIV and hepatitis C in people who inject drugs: A review of reviews to assess evidence of effectiveness. *International Journal of Drug Policy*, 25(1), 34.
- Macneil, J., & Pauly, B. (2011). Needle exchange as a safe haven in an unsafe world. *Drug and alcohol review*, 30(1), 26-32.

- Mäkelä, K., Alcoholics Anonymous, & World Health Organization. (1996). *Alcoholics Anonymous as a mutual-help movement: A study in eight societies*. Madison, WI: University of Wisconsin Press.
- Mignon, S. (2014). *Substance abuse treatment options, challenges, and effectiveness*. New York: Springer Publishing Company.
- Mistral, W. (2016). Reducing alcohol-related harm among young people. In W. Mistral (Ed.), *Integrated approaches to drug and alcohol problems: Action on addiction*; pp. 152-165). New York: Routledge/Taylor & Francis Group.
- Neale, J. (2011). What is the role of harm reduction when drug users say they want abstinence. *International Journal of Drug Policy*, 22(3), 189.
- Pagano, M. (2013). Assessing youth participation in AA- related helping: Validity of the Service to Others in Sobriety (SOS) questionnaire in an adolescent sample. *American Journal on Addictions*, 22(1), 60.
- Patton, R., Deluca, P., Kaner, E., Newbury-Birch, D., Phillips, T., & Drummond, C. (n.d.). Alcohol screening and brief intervention for adolescents: The how, what and where of reducing alcohol consumption and related harm among young people. *Alcohol and Alcoholism*, 49(2), 207-212.
- Polosa, R. (2013). A fresh look at tobacco harm reduction: The case for the electronic cigarette. *Harm Reduction Journal*. 10(1), 19.
- Understanding the Epidemic. (2016, December 16). Retrieved February 20, 2017, from <https://www.cdc.gov/drugoverdose/epidemic/>
- White W. (2011) Narcotics Anonymous and pharmacotherapeutic treatment of opioid addiction in the United States. Philadelphia: Philadelphia Department of

- Behavioral Health and Intellectual disability Services and the Great Lakes
Addiction Technology Transfer Center. Retrieved from
<http://atforum.com/documents/2011NAandMedication-assistedTreatment.pdf>
- White, W., Campbell, M., Shea, C., Hoffman, H., Crissman, B., & Dupont, R. (2013).
Coparticipation in 12-step mutual aid groups and methadone maintenance
treatment: A survey of 322 patients. *Journal of Groups in Addiction &
Recovery*, 8(4), 294-308.
- William, B. (2014). *Alcoholics Anonymous* (Deluxe ed.). New York: Jeremy P.
Tarcher/Penguin.
- Winters, K., Tanner-Smith, E., Bresani, E., & Meyers, K. (2014). Current advances in the
treatment of adolescent drug use. *Adolescent Health, Medicine and
Therapeutics.*, 5, 199-210.