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Al-Anon Intensive Referral (AIR): A Formative Evaluation for Implementation

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Acknowledgments

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Concerned others

- **Millions of concerned others** (COs; i.e. families and friends) **are affected** by substance use disorders of a close relative or friend
- **COs suffer in many domains**
  - Quality of life
  - Health
  - Mental health
  - Relationships
  - Physical violence
  - Healthcare costs
- COs need **knowledge and skills to cope** with their problems

Orford et al, 2013; Timko et al, 2013, 2019; Casswell et al, 2011; Karriker-Jaffe et al, 2018; Birkeland et al, 2018; Ray et al, 2007, 2009; Weisner et al, 2010; Dawson et al, 2007; Hussaarts et al, 2012

Al-Anon

- **What is Al-Anon?**
  - **12-step mutual-help program** for people concerned about another's drinking (i.e., concerned others)
  - **Widely available**
- **Benefits of Al-Anon participation:**
  - Wellbeing
  - Coping
  - Improved relationships
  - Mental health/wellness
- ***However*... Al-Anon is underutilized**

O'Farrell & Clements, 2012; Timko et al, 2013; Al-Anon Family Groups, 2012; Gorman & Rooney, 1979; McGregor, 1990; O'Farrell & Fals-Stewart, 2003; Cutter and Cutter, 1987; Dittrich and Trapold, 1984; Keinz et al, 1995; Miller et al, 1999

Al-Anon Intensive Referral (AIR)

- **A short intervention to facilitate Al-Anon engagement**
  - Based on prior "intensive referral" studies
  - 4 sessions over ~2 months (education, motivational interviewing, etc.)
  - Delivered by trained AIR coaches
- **Currently being tested in a randomized controlled trial***
- **Implementation question**: What are the **barriers, facilitators, and recommendations for implementing AIR** and using it in routine practice at substance use disorder (SUD) treatment programs?

*NIAAA R01 AA024136-01A1 (Christine Timko & Michael Cucciare)

Study design and sample

- **Qualitative formative evaluation**
  - Hybrid Type 1 effectiveness-implementation trial (Curran et al, 2012)
- **Purposive sample**
  - 10 SUD treatment programs
    - 8 in the trial + 2 naïve (no prior knowledge of AIR)
    - 6 in Arkansas + 2 in California + 2 in Nebraska
    - 6 community + 4 Veterans Affairs (VA)
    - 8 residential + 2 intensive outpatient (IOP)
  - 31 key informants
    - 10 Clinical directors
    - 21 Staff (counselors, psychologists, case managers, etc.)

Data collection and analysis

- **Semi-structured interviews**
  - Based on CFIR →
  - Phone (~30 min) or on-site (~60min)
- **Thematic analyses**
  - Deductive + inductive
  - Barriers, facilitators, recommendations

Consolidated Framework for Implementation Research (CFIR)*

1. **Intervention characteristics**
   Evidence, cost, adaptability, trialability, etc.
2. **Outer setting**
   Patient needs, policies, peer pressure, etc.
3. **Inner setting**
   Organizational structures, culture, climate, readiness, etc.
4. **Characteristics of individuals**
   Knowledge and beliefs, self-efficacy, personal attributes, etc.
5. **Process**
   Key people, planning, engaging, executing, monitoring, etc.

*Damschroder et al, 2009

Facilitators

+**Recognized unmet need for COs**

+**Positive perception of AIR**
- Al-Anon generally viewed favorably
- AIR face validity, adaptability/fit

+**Organizational culture**
- 12-step philosophy (from encouraging attendance to hosting meetings)
- Culture of innovation ("early adopters," EBP-focused)

Facilitators

+**Staff readiness**
- Generally would be receptive to delivering AIR
- Generally trained in MI

+**Organizational capacity**
- Family education groups (community sites)
- Client follow-up calls
- Physical resources generally not an issue (e.g. rooms)
- Staff time
  - However…

Barriers

- **Organizational capacity**
  - Staff time; also turnover
  - Limited interactions with COs (e.g. lack of family groups)

- **AIR model**
  - Time horizon (1-mo residential programs)
  - Focus on AUD/Al-Anon

- **VA policy**
  - VA has limited resources for non-veteran populations (COs)
  - Competing priorities (dictated externally)
  - (Possible) legal issues (cannot be seen to "represent" Al-Anon)

Barriers

- **CO-client relationship issues**
  - Some clients have no COs ("burnt bridges", homelessness)
  - Some clients may not want CO involved
  - But client consent may be necessary (release of information)

- **CO readiness**
  - Lack of knowledge about addiction, Al-Anon, self-care, etc.
  - Disengaged, lack of motivation ("not my problem")

- **CO access barriers**
  - Time for AIR sessions or Al-Anon meetings (travel, scheduling/work)
  - Distances/transportation to Al-Anon meetings (rural)

Recommendations

- **Identify and engage key people**
  - Senior leaders (clinic directors)
  - Find staff with best fit (clinical role, CO/client perceptions, etc…)

- **Training and resources**
  - Train staff on Al-Anon, AIR, MI (refresher)
  - Resources – share AIR materials, brochures etc…

Recommendations

- **Integrate AIR into ongoing operations**
  - In/with family group or follow-up calls
  - As part of intake process (if family present)
  - Make part of job description, evaluate in performance reviews
- **Adapt AIR**
  - Expand to more programs (e.g. Nar-Anon, Celebrate Recovery)
  - Pursue COs with highest readiness

Conclusions

- **Strong potential** for AIR implementation and use
- **Different levels of capacity and readiness**
  - Full implementation by leveraging existing capacity
  - Partial implementation (e.g. case-by-case)
- **Adaptation to local context recommended**
  - To improve fit and feasibility
  - But could also undermine its effectiveness (fidelity)
    - Need to rigorously assess any adaptations in future studies

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Thank you!

Any questions?

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