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Translating Research into Practice on Alcohol and Polysubstance Use Disorders
by Educating the Interprofessional Primary Care Team

Welcome to Weitzman Science to Practice: Alcohol Use Disorder!

We will begin the session shortly.

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Translating Research into Practice on Alcohol and Polysubstance Use Disorders by Educating the Interprofessional Primary Care Team

Welcome to Weitzman Science to Practice: Alcohol Use Disorder Fall 2025!

Session #2:

The Role of 12-Step Programs and Integrated Behavioral Health in Alcohol Use Disorder Treatment

December 4, 2025

Technology: Your Zoom window

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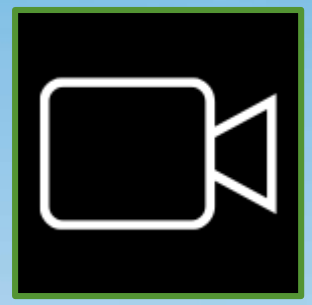

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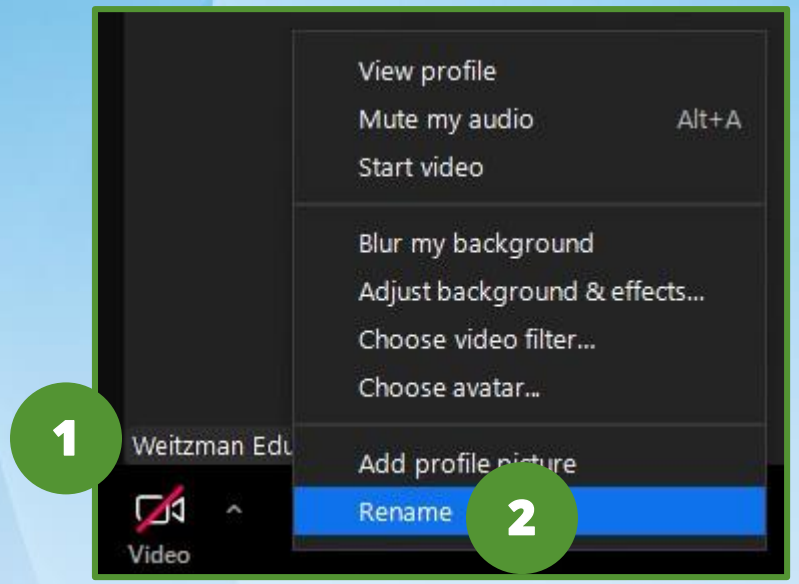
Technology: Your Zoom window, continued



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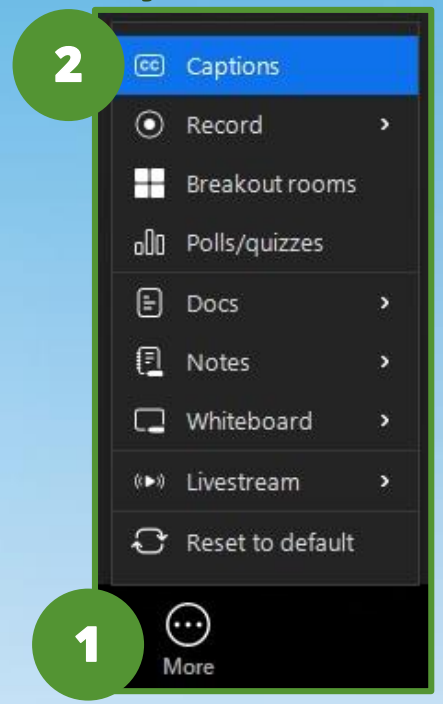

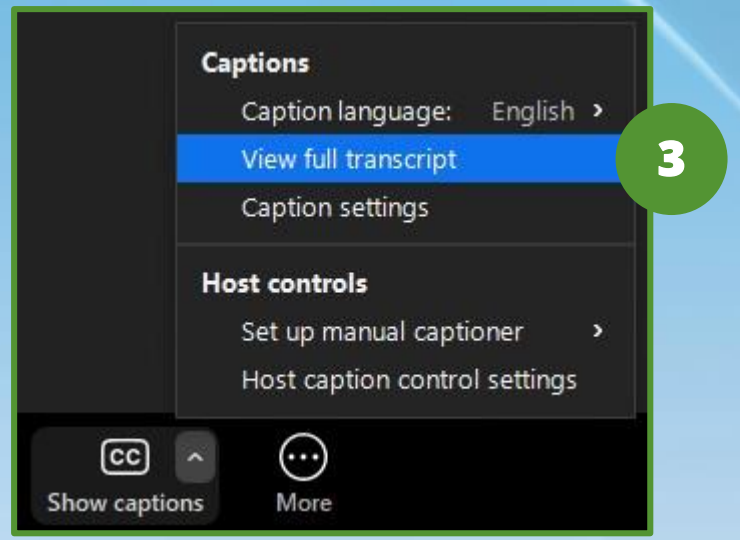

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In support of improving patient care, Moses Weitzman Health System is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

This series is intended for primary care providers (MDs, DOs, NPs, PAs) and behavioral health providers (psychiatrists, psychologists, social workers, therapists).

Please complete the survey and claim your post-session certificate on the WeP after today's session. **Please note: Pharmacists must claim credits within two weeks following today's session or we will not be able to award ACPE credits.**

You will be able to claim a comprehensive certificate on the WeP at the end of the series, December 18, 2025.

Program logistics post-session

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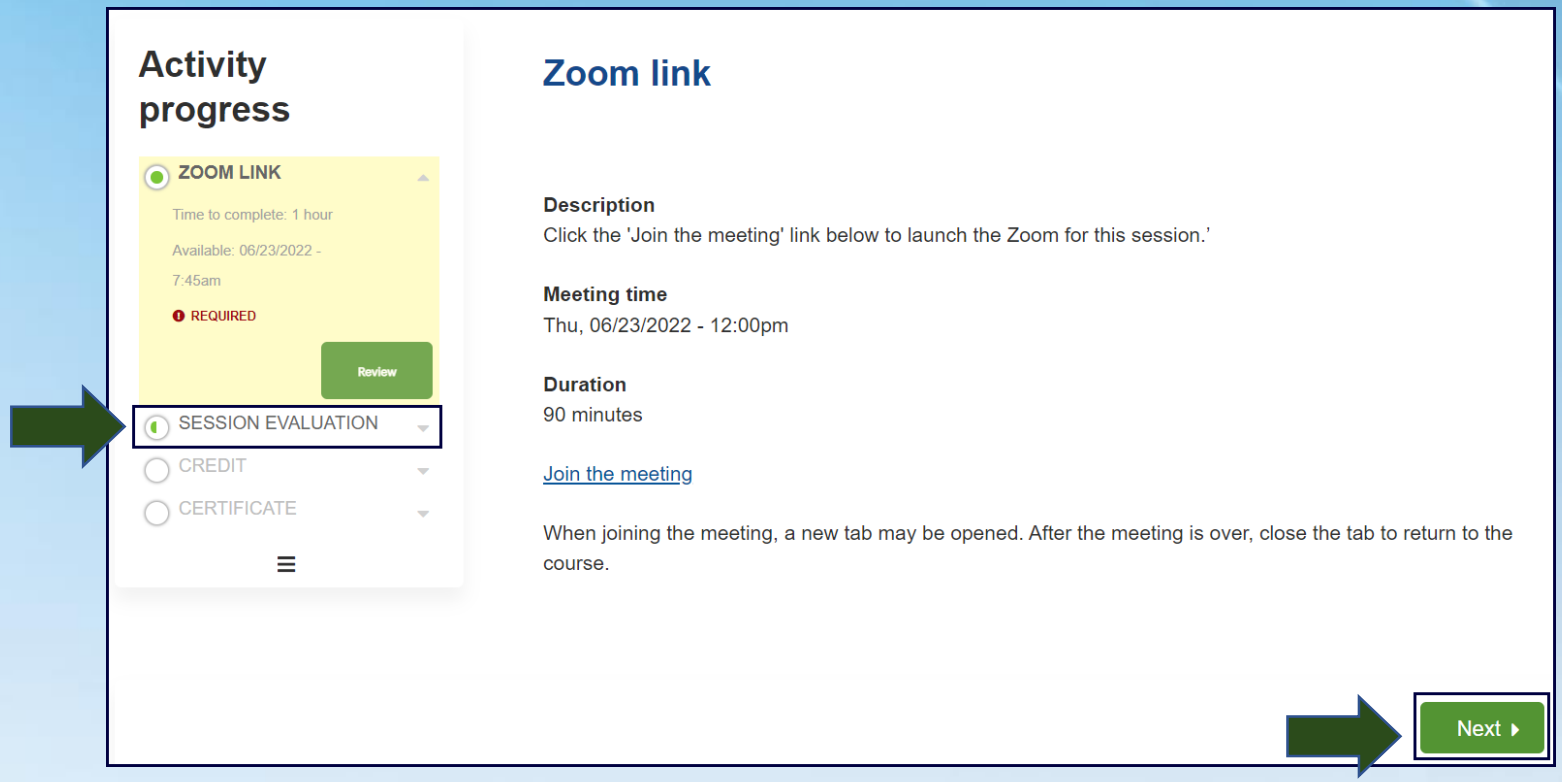

Program logistics post-session

Completing the session evaluation and claiming your CME/CE credit

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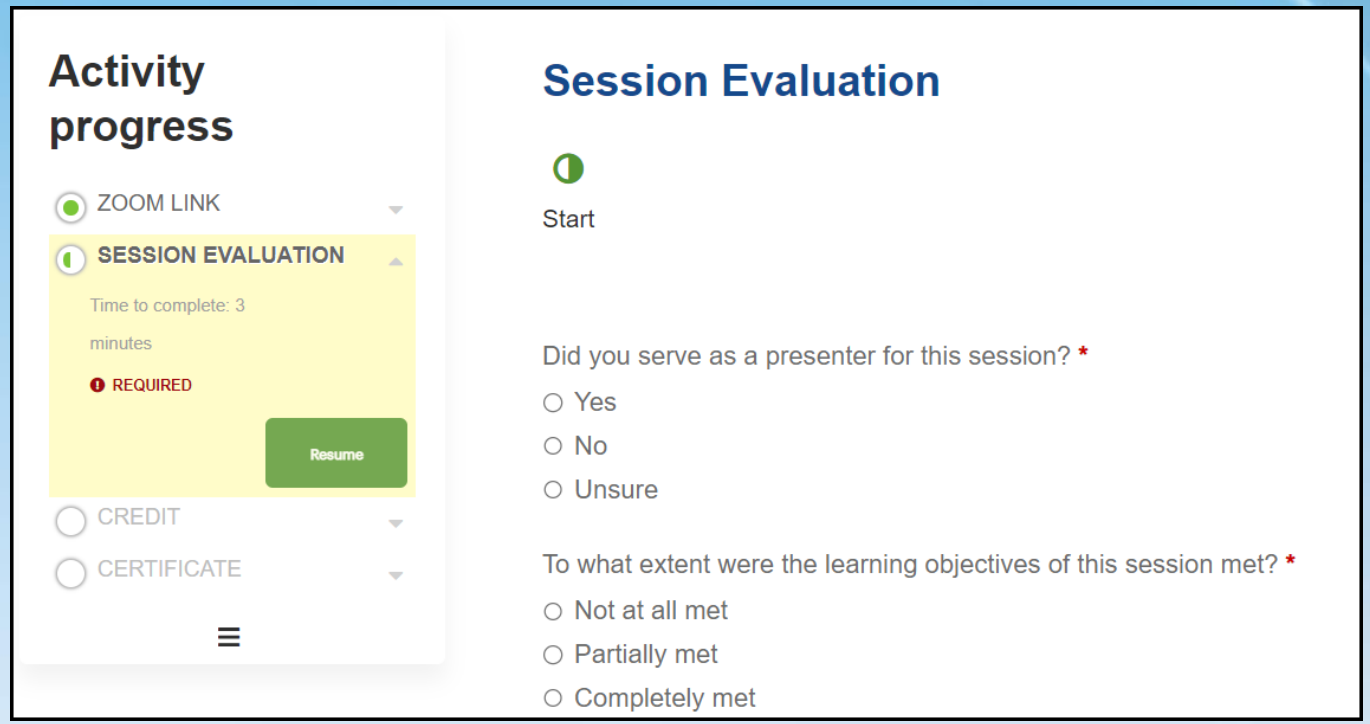

Accessing session recordings and materials

1. Return to the **Overview tab** of the live activity, *Weitzman Science to Practice: Alcohol Use Disorder – The Role of 12-Step Programs and Integrated Behavioral Health in Alcohol Use Disorder Treatment (December 4, 2025)*
2. Scroll down to the **Required Readings, Presentation Slides, and Session Recording** headers

You will then be able to click on **Required Readings, Session Recording, and Presentation Slides** listed below the headers to access the resources.

This Weitzman Science to Practice session has been made available by:

NIH R25 Alcohol and Other Substance Use Research Education Programs for Health Professionals

This project is supported by the National Institute on Alcohol Abuse and Alcoholism of the National Institutes of Health under Award Number R25AA031951 to translate research into practice on preventing, screening for, and treating alcohol use disorders in primary care. The content is solely the responsibility of the Weitzman Institute and does not necessarily represent the official views of the National Institutes of Health.

Disclosures

- With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the faculty listed above or other activity planners and any ineligible company in the past 24 months which would be considered a relevant financial relationship.
- The views expressed in this presentation are those of the faculty and may not reflect official policy of Moses Weitzman Health System.
- We are obligated to disclose any products which are off-label, unlabeled, experimental, and/or under investigation (not FDA approved) and any limitations on the information that are presented, such as data that are preliminary or that represent ongoing research, interim analyses, and/or unsupported opinion.

All Are Welcome

Weitzman Science to Practice Faculty

Aryn Phillips, PhD

Jack Todd Wahrenberger, MPH, MD

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Translating Research into Practice on Alcohol and Polysubstance Use Disorders
by Educating the Interprofessional Primary Care Team

Weitzman Science to Practice: Alcohol Use Disorder

The Role of 12-Step Programs and Integrated Behavioral Health in Alcohol Use Disorder Treatment

Aryn Phillips, PhD, and J. Todd Wahrenberger, MD, MPH

December 4, 2025

Learning objectives

By the end of the Science to Practice series, participants will be able to…

1. Apply best practices derived from peer-reviewed literature into practice within safety net settings.
2. Describe the steps involved in assessing peer-reviewed literature and their implications for determining validity.
3. Infer how peer-reviewed literature contributes to the evidence base behind clinical guidelines.

Opening Poll

- Which of the following have you *personally* recommended to a patient? (Choose all that apply)
  - AA / NA / 12-step groups
  - SMART Recovery
  - CBT-based therapy
  - Integrated behavioral care
  - Medications for AUD (naltrexone, acamprosate, disulfiram)

Alcoholics Anonymous – History and Clinical Context

Key dates and figures:

- **1935 – Founding:** Bill Wilson ("Bill W.") and Dr. Bob Smith meet in Akron, OH; *Alcoholics Anonymous* begins as a mutual-help fellowship.
- **1939 – The Big Book:** lays out the Twelve Steps—an experiential, spiritual, and behavioral framework.
- **1950s – Expansion:** chapters across the U.S. and abroad; Twelve Traditions codify group autonomy, anonymity, and non-professional status.
- **Today:** ~2 million members, 180+ countries; numerous spin-offs (NA, Al-Anon, SMART's secular counterpart).

The 12 Steps of Alcoholics Anonymous

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.

What Happens at an AA Meeting?

Purpose:
Peer-led mutual-help meeting focused on maintaining sobriety; not formal treatment.

Structure:

- **Opening readings:** AA preamble, 12 Steps/Traditions, brief literature selections
- **Format:** Speaker meeting (member shares their story) *or* discussion meeting (members share on a topic)
- **Sharing:** Individuals speak about drinking history, recovery progress, setbacks, coping strategies
  - No cross-talk, advice-giving, or feedback from others
- **Sponsorship:** Members announce availability; newcomers may seek a sponsor
- **Sobriety recognition:** Chips/tokens for milestones
- **Closing:** Readings/prayer + informal fellowship

Clinical relevance:

- Provides **sober social network**, **accountability**, and **identity transformation**
- Encourages **daily structure** and **ongoing recovery behaviors**
- Complements MAT, outpatient therapy, and TSF
- Appropriate for all severity levels; abstinence-focused

AA's Legacy for Modern Treatment

- **Template for community recovery:** All modern peer models—Celebrate Recovery, SMART, Women for Sobriety—either extend or react to the AA model.
- **Integration with professional care:** The 12-Step Facilitation (TSF) trials in Project MATCH and the Cochrane review show that clinician-delivered linkage to AA improves abstinence and reduces cost.
- **Common misconceptions:** AA ≠ religion; it's spiritually open and behaviorally structured.
- **Equity note:** Access and comfort vary—women, LGBTQ+, or trauma survivors may prefer parallel or modified meetings.

What is 12-Step Facilitation (TSF)?

Twelve-Step Facilitation (TSF) is a **structured, clinician-delivered, evidence-based treatment** designed to help people initiate and sustain involvement in Alcoholics Anonymous (AA) or other 12-step fellowships.

Key Features:

- Manualized, time-limited therapy (typically 12–24 sessions)
- Focuses on acceptance, surrender, and active engagement in recovery community
- Integrates education, motivational strategies, and behavioral planning
- Emphasizes abstinence and long-term recovery support

Goal:
Increase AA participation → increase abstinence → improve long-term outcomes.

What Happens in TSF Sessions?

Core Components:

- Explanation of AUD as a chronic illness
- Introduction to AA principles, Steps, and Traditions
- Identification of triggers, high-risk situations, and coping strategies
- Exploration of barriers to attending meetings or getting a sponsor
- Encouragement of early step-work and community connection
- “Homework”: attend meetings, obtain a sponsor, begin AA tasks

Mechanisms of Change:

- Connection to sober peers
- Accountability & structure
- Internalization of recovery identity
- Ongoing behavioral reinforcement for abstinence

How TSF Differs From AA

TSF (Treatment)	AA (Fellowship)
Clinician-led therapy	Peer-run community
Evidence-based manual	No clinical manual
Time-limited sessions	Ongoing, indefinite
Assignments: meetings, sponsor, stepwork	Voluntary participation
Focus: initiating change	Focus: sustaining sobriety
Billable treatment	Free, no membership

Bottom Line:
TSF = clinical intervention
AA = mutual-help support system
TSF is the bridge that helps people successfully engage with AA and build long-term recovery.

Cognitive Behavioral Therapy (CBT) for AUD

What CBT Is:
A structured, skills-based, evidence-based therapy focused on identifying and modifying thoughts, emotions, and behaviors that drive drinking.

Core Components:

- Functional analysis of drinking patterns
- Identify high-risk situations, triggers, and automatic thoughts
- Build coping skills (urge surfing, refusal skills, alternative behaviors)
- Problem-solving and stress management
- Behavioral activation
- Relapse prevention planning

Mechanism of Action:
Improves self-monitoring, enhances coping capacity, reduces conditioned responses, and strengthens behavioral strategies for maintaining abstinence or reduced use.

How CBT Works Clinically

Session Structure:

- Collaborative agenda setting
- Review of drinking behavior and between-session “practice”
- Cognitive restructuring
- Skills training and rehearsal
- Behavioral experiments
- Relapse prevention check-in

Clinical Strengths:

- Effective for mild–severe AUD
- Fits well with MAT and primary care integration
- Targets co-occurring anxiety, depression, PTSD
- Highly teachable + adaptable across settings
- Strong evidence base, especially for coping-skill deficits

Bottom Line:
CBT teaches **how** to change drinking behavior through new skills and strategies.

Motivational Enhancement Therapy (MET) for AUD

What MET Is:

A brief, structured, MI-based therapy designed to increase a patient's **intrinsic motivation**, resolve ambivalence, and strengthen commitment to behavior change.

Core Components:

- Personalized feedback about drinking risks and patterns
- Exploration of ambivalence and discrepancy
- Eliciting change talk
- Reinforcing autonomy + self-efficacy
- Collaborative, non-confrontational style
- Development of individualized change plan

Format:

Typically 4–6 sessions (assessment + 3–4 motivational sessions).

How MET Works Clinically

Mechanism of Action:

- Enhances internal motivation
- Strengthens commitment language
- Shifts decisional balance
- Reduces resistance
- Increases treatment engagement and follow-through

Best Use Cases:

- Early-stage AUD
- Ambivalence about change
- Patients resistant to directive therapies
- Young adults / mandated populations
- Pre-treatment engagement before CBT, IOP, MAT, or TSF

Bottom Line:
MET helps patients decide **why** to change; CBT helps them learn **how** to change.

Mechanisms of Change

AA Concept	MET / CBT Parallel	Clinical Translation
Step 1 *– Admitting powerlessness*	MET's "developing discrepancy" — accepting ambivalence and limits	Patient articulates cost of continued use
Step 2–3 *– Turning toward a higher power / decision to change*	Self-efficacy and commitment language	Strengthens intrinsic motivation
Steps 4–9 *– Inventory, confession, amends*	CBT's cognitive restructuring + behavioral experiments	Re-evaluating core beliefs, repairing relationships
Steps 10–12 *– Maintenance, service, sponsorship*	Relapse prevention and social reinforcement	Creates sustainable recovery community

What is a Systematic Review?

Systematic review defined

- A review of the research literature using systematic, explicit, accountable methods.
  - Identifies and describes relevant research, critically appraises research in a systematic way, and synthesizes findings into a conclusion.
  - Thoroughly explains methods.
- One type of evidence synthesis.

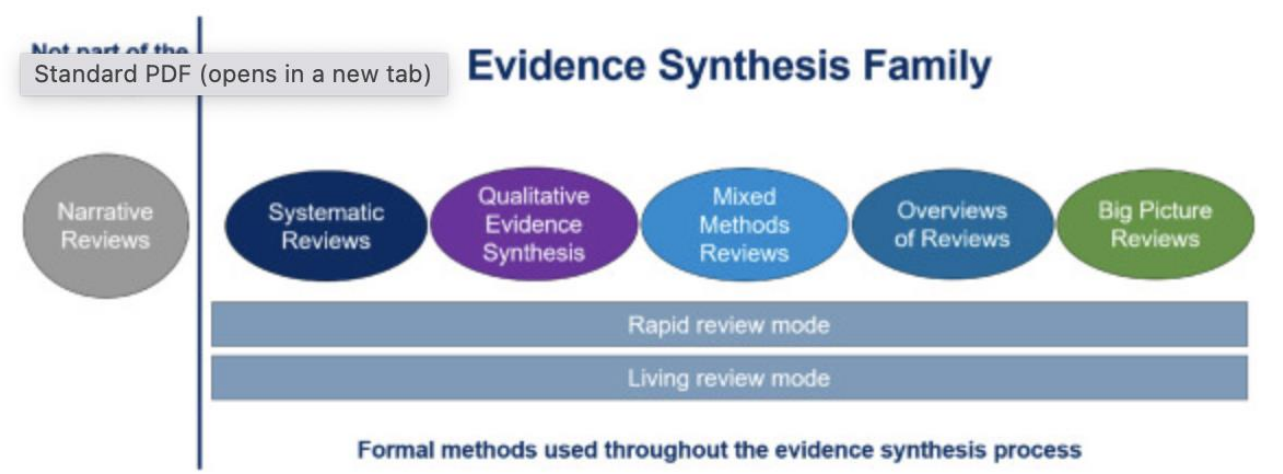


Image source: Nussbaumer-Streit et al., 2025

Sources: Gough et al., 2017; Nussbaumer-Streit et al., 2025.

Steps in a systematic review

1. Identify the research question and determine the inclusion eligibility criteria.
2. Search for research.
3. Screen and select studies for inclusion.
4. Abstract data from studies and assess risk of bias.
5. Summarize the data.
6. Assess the certainty of the evidence & present conclusions.

Source: Brignardello-Peterson et al., 2024.

Risk of bias?

- Tools for assessing bias in each included study, depending on study type.

Cochrane Risk of Bias Tool for Randomized Trials

- Bias from randomization process
- Bias from deviations from intended interventions
- Bias due to missing outcome data
- Bias in measurement of the outcome
- Bias in selection of the reported result

Cochrane Risk of Bias in Non-Randomized studies of Interventions

- Bias due to confounding
- Bias in selection of participants into study
- Bias in classification of interventions
- Bias from deviations from intended interventions
- Bias due to missing outcome data
- Bias in measurement of the outcome
- Bias in selection of the reported result

Sources: Higgins et al., 2024; Sterne et al., 2024.

Risk of bias?

- When identified, bias should be incorporated into analyses.

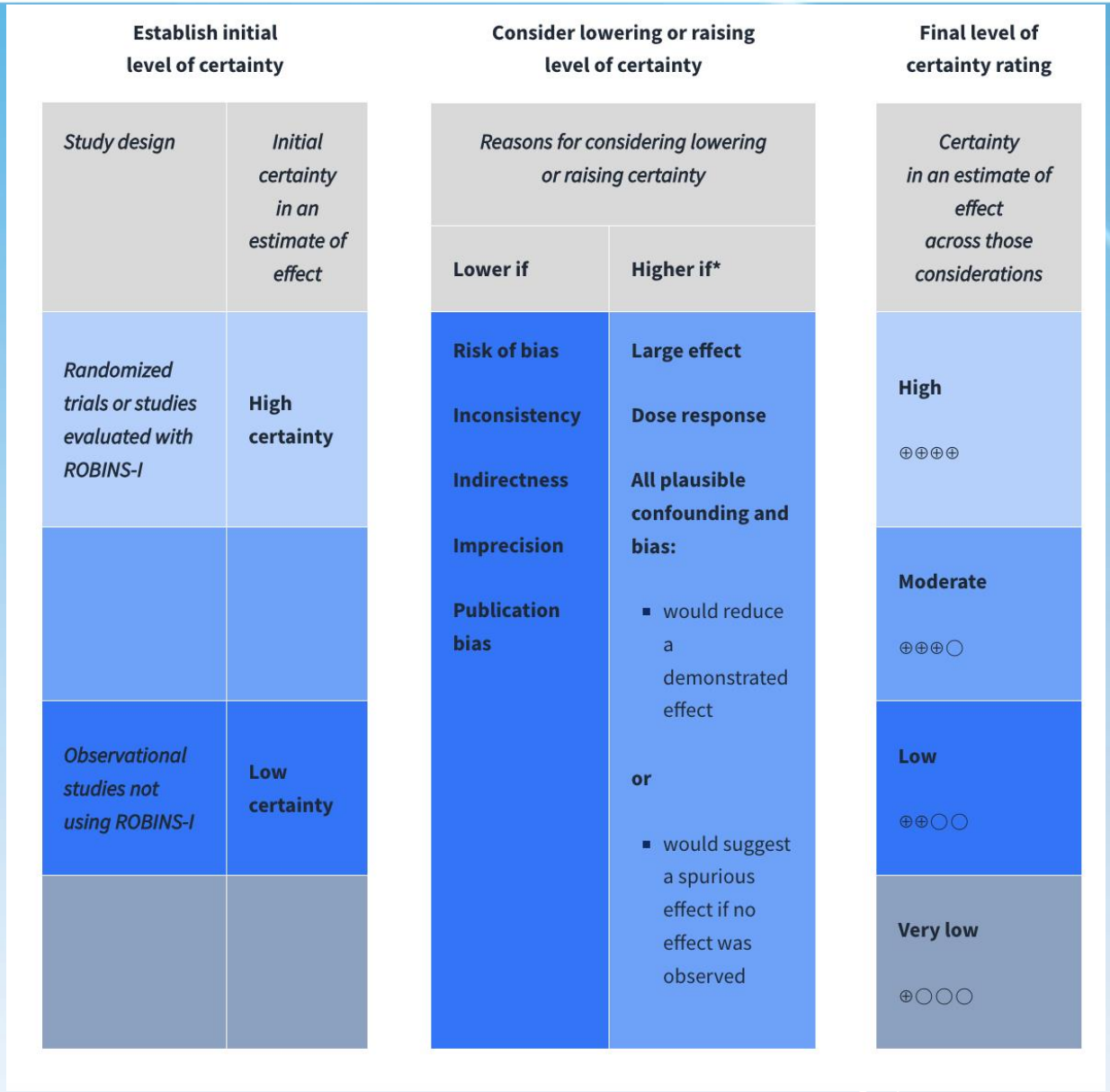
- Possible methods.
  - Restricting primary analyses to studies at low risk.
  - Presenting analyses stratified by risk.
  - Presenting results from all studies and providing narrative discussion about the bias risks.
  - Adjusting effect estimates for bias.

- Performers of systematic reviews should also consider funding sources and potential conflicts of interest when reviewing studies.

Source: Boutron et al., 2024.

Certainty?

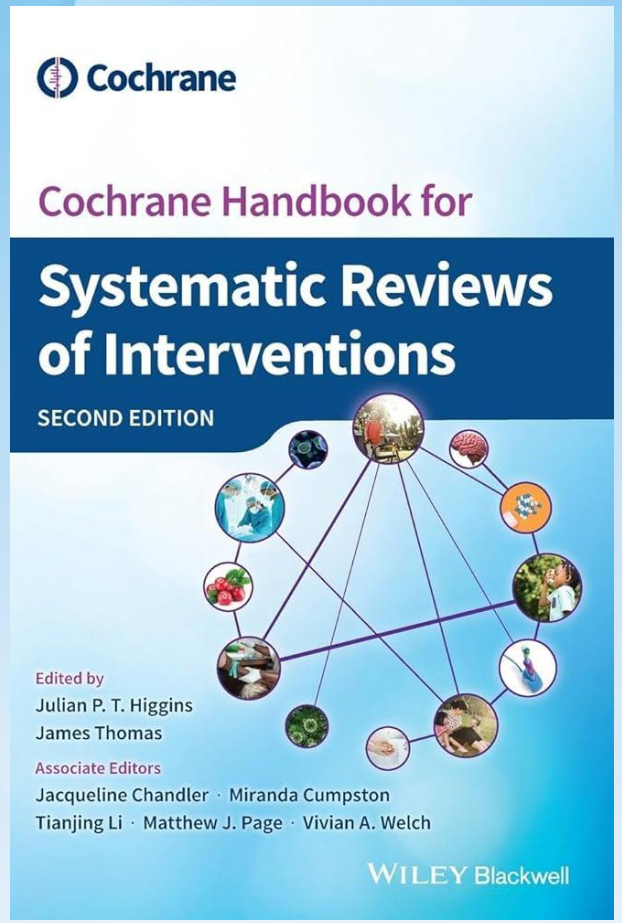
- The extent to which one is confident that an estimate of an effect is close to the quantity of interest.
- Grading of Recommendation Assessment, Development and Evaluation (GRADE) approach.



Sources: Atkins et al., 2004; Guyatt et al., 2008; Schünemann et al., 2024.

Image source: Schünemann et al., 2024.

Cochrane reviews



Great resources:

- www.cochrane.org/authors/handbooks-and-manuals/handbook/current
- systematicreviewtools.com

Case Studies

Case 1: JS — Early Severe AUD

Background:

JS, a 21-year-old college student, presented to my office with his father seeking help for escalating alcohol use. His family has a strong history of addiction and recovery, and they were increasingly alarmed by his behavior. In the prior year, JS withdrew from college following two hospitalizations related to binge drinking and a DUI charge. His family organized an intervention and asked for guidance on treatment options. JS has no significant medical comorbidity. During our visit, JS acknowledged the severity of his drinking and stated he “couldn’t keep going like this” and needed to make a change.

Alcoholics Anonymous and other 12-Step Programs for Alcohol Use Disorder

John F. Kelly, Keith Humphreys, & Marica Ferri

Cochrane Database Syst. Rev.

March 2020

Objective

- Evaluate whether peer-led Alcoholics Anonymous (AA) or professionally delivered treatments that facilitate AA involvement (12-Step Facilitation, TSF) achieve important outcomes.
  - Outcomes: abstinence, reduced drinking intensity, reduced alcohol-related consequences, alcohol addiction severity, and health cost offsets.
- TSF – interventions that have adapted some methods from AA but are also designed to link individuals to community AA groups.

Methods – Study inclusion criteria

- Any studies that compared AA or TSF with other interventions, 12-Step Program variants, or no treatment on the outcomes of interest.
  - RCTs, quasi-RCTs, or non-randomized studies.
- Studies on adults (age 18+) with AUD, alcohol abuse, or alcohol dependence.
  - Excluded studies in which participants were coerced to attend AA.
- No language, year, or publication status restrictions.

Methods – Search and selection

- Searched:
  - Cochrane drugs and alcohol group specialized register, Cochrane central register of controlled trials, MEDLINE PubMed, Embase Ovid, CINAHL EBSCO, PsycINFO EBSCO, WHO international clinical trial registry platform, clinicaltrials.gov, and reference lists of included studies, systematic reviews, and meta-analyses.
- 2 authors independently reviewed titles and abstracts and articles that met eligibility criteria underwent full text review.

Methods – Data abstraction and risk of bias assessment

- For included studies, 2 authors abstracted relevant elements, including study design, sample characteristics, description of experimental and control interventions, outcomes, study fundings, and potential conflicts of interest.
- Used Cochrane's risk of bias tools for randomized clinical trials and non-randomized studies.

Methods – Measures of treatment effects & certainty assessment

- Summarized effects, pooled data using meta-analyses when possible.
- Summarize results according to:
  - Study design: RCT/quasi-RCT vs. non-randomized.
  - Manualization/clinical fidelity of intervention.
  - Type of intervention to which AA/TSF was compared.
- Assessed certainty using GRADE approach.

Results – Studies included

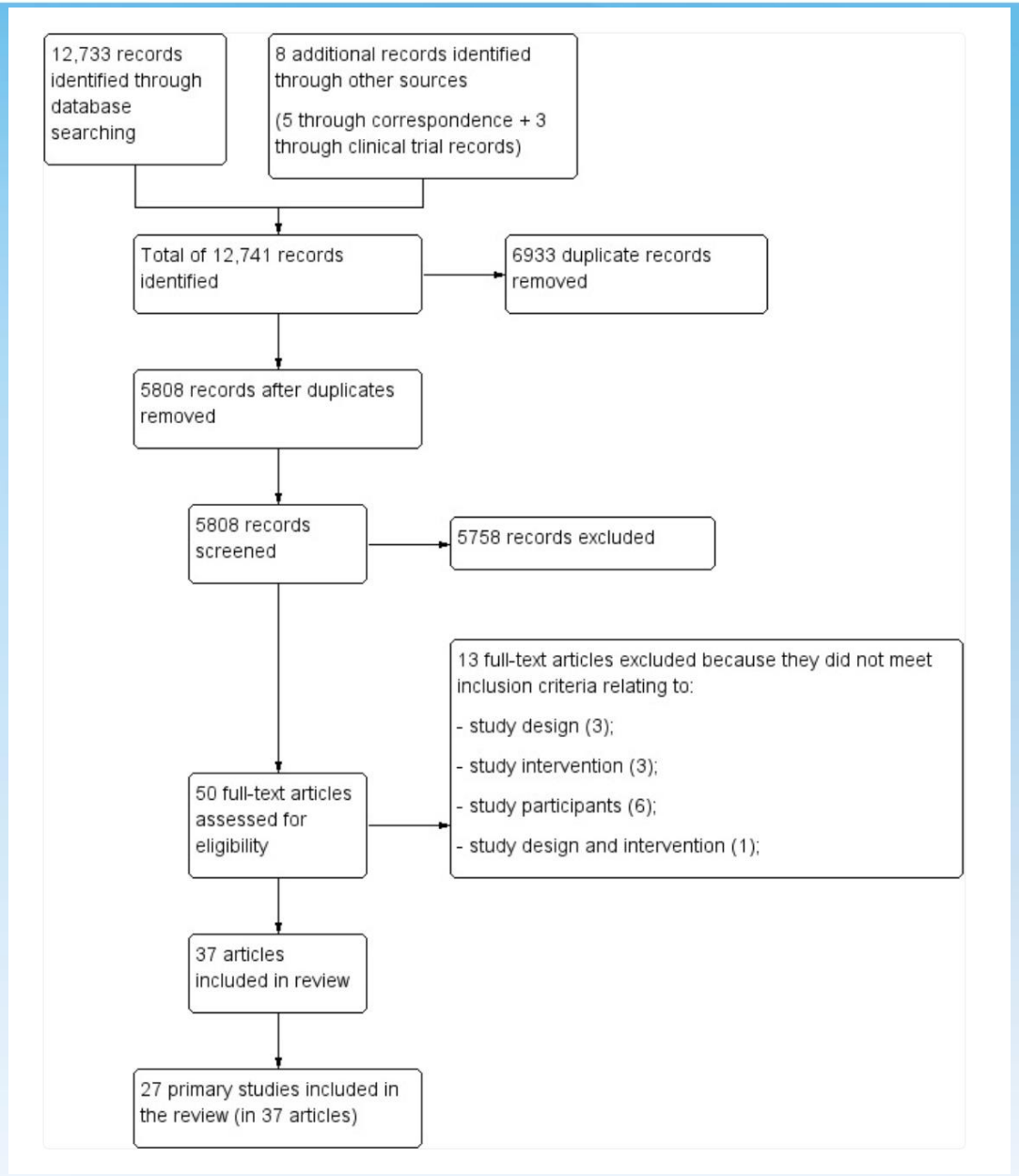


Image source: Kelly et al, 2020.

Results – Studies included

Included studies by study design, degree of manualization, and theoretical orientation

Study	Design	Degree of manualization	Treatment comparison
Blondell 2001	Non-randomized	Part/non-manualized	Different theoretical orientation
Blondell 2011	RCT	Part/non-manualized	Different theoretical orientation
Bogenschutz 2014	RCT	Part/non-manualized	Different theoretical orientation
Bowen 2014	RCT	Part/non-manualized	Different theoretical orientation
Brooks 2003	Quasi-RCT	Manualized	Different theoretical orientation
Brown 2002	RCT	Manualized	Different theoretical orientation
Davis 2002	RCT	Manualized	Different theoretical orientation
Grant 2017	Non-randomized	Part/non-manualized	TSF variant
Herman 2000	RCT	Part/non-manualized	Different theoretical orientation
Humphreys 1996	Non-randomized & Economic	Part/non-manualized	Different theoretical orientation
Kahler 2004	RCT	Manualized	TSF variant
Kaskutas 2009	Quasi-RCT	Part/non-manualized	TSF variant
Kelly 2017	RCT	Manualized	Different theoretical orientation
Litt 2007	RCT	Manualized	Different theoretical orientation
Litt 2016	RCT	Manualized	Different theoretical orientation
Lydecker 2010	Quasi-RCT	Manualized	Different theoretical orientation
Manning 2012	RCT	Part/non-manualized	TSF variant
MATCH 1997a	RCT	Manualized	Different theoretical orientation
McCrady 1996	RCT	Manualized	Different theoretical orientation
Mundt 2012	Economic	Part/non-manualized	TSF variant
Ouimette 1997	Non-randomized	Part/non-manualized	Different theoretical orientation & TSF variant
Timko 2006	RCT	Manualized	TSF variant
Timko 2011	Quasi-RCT	Manualized	TSF variant
Vederhus 2014	Quasi-RCT	Manualized	TSF variant
Walitzer 2009	RCT	Manualized	Different theoretical orientation & TSF variant
Walitzer 2015	RCT	Manualized	Different theoretical orientation
Zemore 2018	Non-randomized	Part/non-manualized	Different theoretical orientation

Image source: Kelly et al, 2020.

Results – Risk of bias

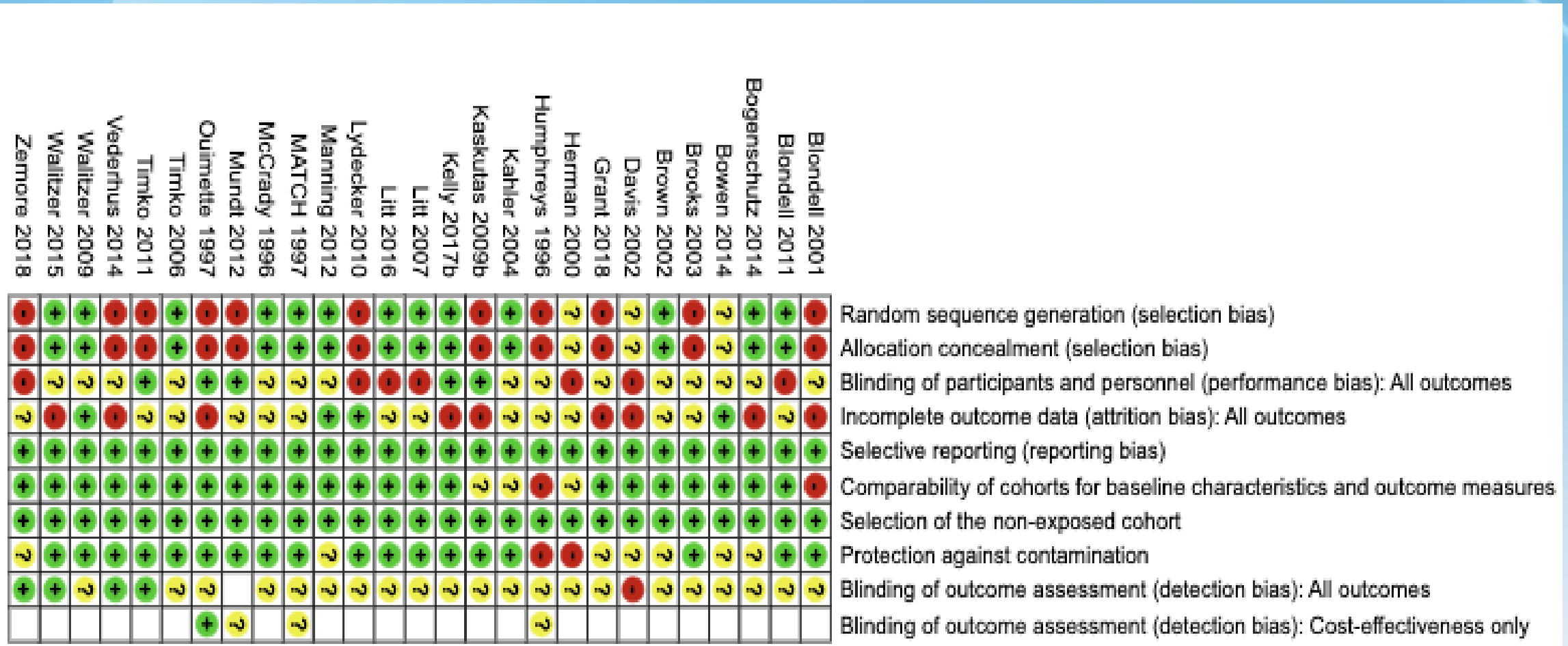


Image source: Kelly et al, 2020.

Results – Main findings

RCT/Quasi-RCT, manualized, comparison to treatment w/ different orientation

- Abstinence: no evidence of difference between AA/TSF and other treatment at end point but advantage for AA/TSF at all other follow up points. Certainty HIGH.
- Drinks per drinking day: AA/TSF showed advantage at 36 month follow up. Certainty MODERATE.
- Alcohol-related consequences: no evidence of difference between AA/TSF at intervention in meta-analysis. One study found benefit of AA/TSF. Certainty MODERATE.

Results – Main findings

RCT/Quasi-RCT, manualized, comparison to TSF variant

- Abstinence: no evidence of difference between AA/TSF and TSF variant. Certainty MODERATE.
- Percent days abstinent: most studies found no evidence of difference, one found advantage for AA/TSF. Certainty MODERATE.
- Drinks per drinking day: no evidence of difference. Certainty MODERATE.
- Alcohol addiction severity: some evidence of advantage of more intensive AA/TSF vs. less intensive. Certainty MODERATE.

Results – Main findings

RCT/Quasi-RCT, non-manualized, comparison to TSF variant

- Abstinence: one study found advantage of more intensive AA/TSF vs. less intensive, one study no evidence of difference. Certainty MODERATE.

Economic analysis studies

- Evidence for health care cost savings. Certainty MODERATE.

Discussion

- AA/TSF has an advantage over other treatment modalities (e.g. CBT, MET) in terms of abstinence and is at least as effective as other modalities in terms of reducing:
  - Drinks per drinking day.
  - Alcohol-related consequences.
  - Addiction severity.
  - Also may avert health care costs.

- More intensive AA/TSF interventions may be more effective than less intensive interventions.

Strengths and limitations

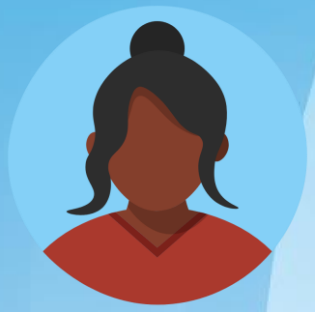
- Strengths: very rigorously and transparently conducted systematic review according to Cochrane guidelines.
- Limitations:
  - No use of bias assessment in analyses.
  - Limited discussion of publication biases.
  - Limited representation of studies from other countries.

Cochrane 12-Step Study – Clinical Takeaways

- 12 Step Facilitation is not just a referral – it's an active linkage process
- AA participation enhances recovery capital – social, spiritual and behavioral.
- Cost offsets matter: This is one of the few interventions that saves health system dollars
- We still need trauma informed sensitivity – AA is powerful but no universally safe for every patient.

Follow-up Poll

- What outcome matters most in your work with AUD? (Choose one)
  - Abstinence
  - Reduced drinking / harm reduction
  - Stable housing
  - Fewer hospitalizations
  - Engagement / trust
  - All of the above



Case Studies

Case 2: DB — SMI and AUD

Background:

- **DB is a 42-year-old woman with schizoaffective disorder, severe alcohol use disorder, and chronic homelessness. Over the past six months she has been living unsheltered on the streets and intermittently engaging with our Street Outreach and Street Medicine teams.**
- She has undergone multiple inpatient detox admissions without sustained engagement afterward, and has repeatedly failed short stays in SROs and congregate, low-barrier shelters due to behavioral dysregulation and rapid relapse.
- Last month, she was enrolled onto an ACT team and admitted into Mercy of Care, our low-barrier transitional program for individuals with SMI and chronic homelessness. During her stay, we are using a harm-reduction approach with MI, CBT, and ACT-based psychosocial interventions to support stabilization, engagement, and readiness for change.

Integrated behavioral interventions for adults with alcohol use disorder: A systematic review

Hagar Hallihan, Manassawee Srimoragot, Jun Ma, Rosie Hanneke, Sangeun Lee, Kathleen Rospenda, Anne M. Fink

Drug and Alcohol Dependence

October, 2024

Objective

- Understand effects of integrated behavioral interventions designed to treat AUD in adults on alcohol-related outcomes compared with usual care or single intervention.
- Integrated interventions = combination of two or more behavioral interventions
  - E.g. cognitive behavioral therapy (CBT), motivational enhancement therapy (MET), TSF.
  - Focused on interventions that included theory-based behavior change components specifically designed for adults with AUD.
- Outcomes = abstinence, reduced consumption, decreased use frequency, fewer days drinking, alleviation of AUD symptoms.

Methods – Study inclusion criteria

- Limited to randomized clinical trials (RCTs)
- Adults (age 18+) with low, moderate, or high risk for AUD and had at least two other mental health conditions.
- No restrictions on setting or length of follow up.
- No restriction on language or year of publication, but articles must be available in English.

Methods – Search and selection

- Searched:
  - MEDLINE PubMed, Embase, and APA PsycInfo (Proquest).
  - Forward and backwards citation search of all included studies.
- 2 authors reviewed titles and abstracts and articles that met eligibility criteria underwent full text review.

Methods – Data abstraction & risk of bias assessment

- For included studies, authors abstracted study design, eligibility criteria, study duration, baseline participant characteristics, study retention, characteristics of treatment and control groups, treatment duration, and primary & secondary AUD outcomes.
  - Determined meta-analyses were not appropriate for any outcomes.
- Used Cochrane's risk of bias tool for randomized clinical trials.

Results – Studies Included

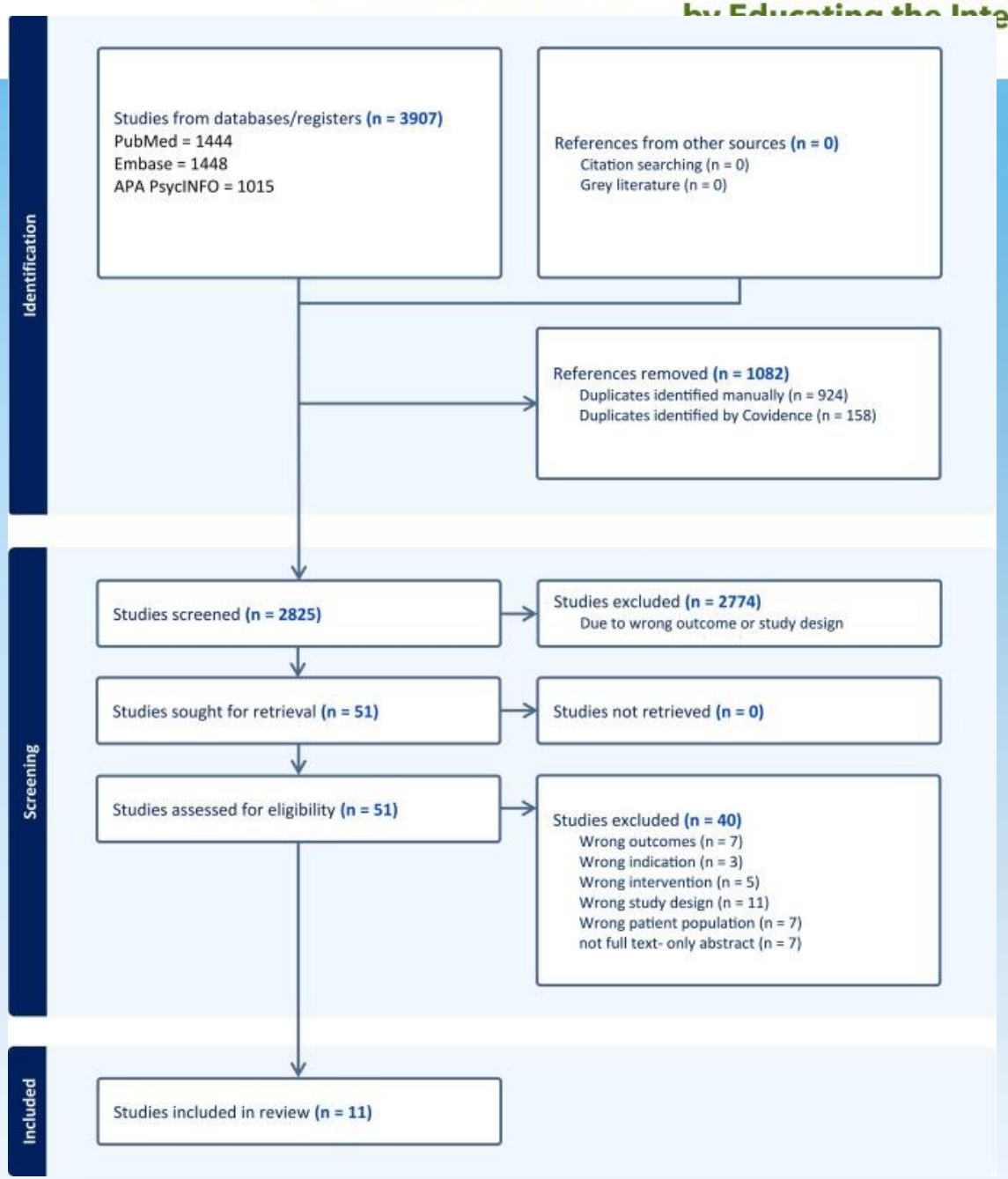


Image source: Hallihan et al., 2024.

Results – Studies Included

- Studies assessed variety of interventions as integrated intervention. Only one study analyzed TSF.
- Duration ranged 5 to 24 weeks with follow up often at 3, 6, and 12 months.
- # of sessions ranged 5 to 26, with an average of 16 sessions.
- All interventions delivered by trained interventionists
- Study participant mental health conditions included depression, anxiety, mood disorder, psychosis, other substance use disorders, post traumatic stress, and intimate partner violence.
- Participants were predominantly white and male.

Results – Risk of Bias

Cochrane risk of bias assessment.

	Study	Random sequence generation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessment	Incomplete outcome data	Selective reporting	Other bias
1.	Baker et al. (2010)	/	/	/	x	?	?	?
2.	Barrowclough et al. (2010)	/	/	/	?	?	?	?
3.	Brown et al. (2006)	/	?	?	?	?	?	?
4.	Chermack et al. (2019)	/	/	?	/	?	?	?
5.	Drapkin et al. (2008)	?	?	x	?	?	?	?
6.	Gouzoulis-Mayfrank et al. (2015)	/	?	/	?	?	?	?
7.	Kay-Lambkin et al. (2009)	/	/	/	/	?	?	?
8.	McGovern et al. (2011)	/	?	?	x	?	?	?
9.	Satyanarayana et al. (2016)	?	/	/	/	?	?	?
10.	Sorsdahl et al. (2015)	?	/	?	/	?	?	?
11.	Stapinski et al. (2021)	/	/	?	/	?	?	?

Note: /, low risk; X, high risk;?, Unclear

Image source: Hallihan et al., 2024.

Results – Main Findings

Integrated intervention compared to usual care

- 4 studies assessed.
- Found evidence that integrated care linked with reduction in % days of alcohol use & alcohol use in grams, increase in days abstinent.

Integrated intervention compared to single intervention

- 7 studies assessed.
- Found evidence that integrated care linked with higher abstinence rate, decrease in number of drinking days, and alcohol composite scores.

Discussion

- Integrated interventions are effective in reducing alcohol use, decreasing heavy drinking, and promoting abstinence.
- Lack of effects observed may be due to small sample sizes.

Strengths and Limitations

- Strengths: reliance on RCTs.
- Limitations:
  - No assessment of certainty.
  - No use of bias assessment in analyses.
  - No discussion of publication biases or possible conflicts of interest.
  - Limited search.
  - Limited generalizability.

Integrated Behavioral Interventions – Clinical Takeaways

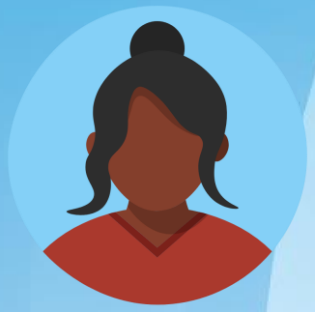
- These studies validate what community health center teams already do – blending MI, CBT, and depression/PTSD work
- Integrated programs outperform usual care because they address why the person drinks, not just that they drink.
- Deliver by nurses, therapists or counselors in team-based setting mirrors our real-world staffing.

Case Studies - Continued

Case 1: JS — Early Severe AUD

Follow up:

- Dropped out of college due to escalating heavy alcohol use.
- Experienced two alcohol-related hospitalizations and a DUI.
- Family-led interventions increased motivation for treatment.
- No medical or psychiatric comorbidities.
- Began MI/CBT with therapist, then referred to 12-Step Facilitation.
- Returned to school; attends weekly AA meeting on campus.
- **Sustained abstinence for 1 year.**



Case Studies - Continued

Case 2: DB — SMI and AUD

Follow up:

- 42-year-old woman with **schizoaffective disorder** and **alcohol dependence**.
- **Recurrent homelessness**; street homeless for the past 6 months.
- Engaged intermittently with **street outreach** and **street medicine** teams.
- Multiple prior **detoxes**; unable to maintain stability in SRO housing or congregate low-barrier shelters.
- Recently enrolled on an **ACT team**.
- Entered **Mercy of Care**, a low-barrier SMI-focused shelter, last month.
- Current clinical approach: **MI, CBT, and ACT** integrated.
- Now staying indoors **5 out of 7 nights** as winter approaches.

Putting both cases together

Domain	Case 1 (AUD only, TSF/AA)	Case 2 (SMI + AUD, Integrated)
Primary modality	TSF → AA linkage	MI + CBT + trauma/PTSD modules (+ AA optional)
Abstinence	Sustained > 1 year	Marked reduction, partial abstinence
Mental health change	N/A	Improved mood stability, fewer relapses
System impact	↓ ED visits, low cost	↓ hospital days, ↑ team coordination costs
Take-home	12-Step = durable scaffold	Integrated care = necessary for complexity

Questions?

Feel free to unmute or put your questions in the chat!

Works cited and future reading

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