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▶ Changing network support for drinking: Network Support Project 2-year follow-up.

Litt M.D., Kadden R.M., Kabela-Cormier E. et al. Request reprint

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Treatment services do not have to adopt, or ask patients to adopt, the belief system on which 12-step groups are founded in order to effectively encourage patients to tap in to the social support offered by these groups and improve their chances of sustained abstinence.

Abstract This account also draws on an earlier report on the same study. Media ads offering free treatment for drinking problems attracted 348 people to phone a US medical centre of whom 297 met the study's requirements and 210 joined the study. Nearly all met diagnostic criteria for dependence on alcohol, most were white and employed, half were in a live-in relationship, on average they said they drank about 16–17 UK units on three out of every four days, and had one prior treatment for alcohol dependence.

Participants were randomly allocated to one of three manualised treatments aiming to promote abstinence and offered over 12 weekly one-hour, one-to-one outpatient sessions. Most basic was **case management** during which practical, social or psychological barriers to abstinence were identified and patients directed to appropriate services. The main interest of the study was how an alternative **network support** therapy performed. Though derived from a 12-step based approach, 12-step philosophy was downplayed. Instead the emphasis was on using affiliation with Alcoholics Anonymous (AA) as a means of changing one's social support network, avoiding drinking friends, acquiring non-drinking friends, and enjoying activities other than drinking. The third treatment added **contingency management** to reinforce the network support option. It offered a prize draw opportunity to patients who provided proof signed by a third-party that they had completed recovery tasks set as part of network therapy, such as attending AA meetings, having coffee with a non-drinking friend, or signing up for a

further education. Patients were assured that whether they drank had no bearing on the availability of prizes. Patients were reinterviewed by researchers after treatment ended and then every three months for another two years.

All three treatments yielded sustained abstinence and substantial increases in non-drinking days. Contrary to expectations, drinking outcomes were best when network support was *not* incentivised by contingency management. When network therapy was implemented on its own, once treatment had ended the improvements were greater and more sustained than in either of the other two treatments. Towards the end of the follow-up, these patients avoided drinking on about 80% of days versus just over 60% for the other two treatments, and about 40% said they had been totally abstinent versus under 30%, statistically significant advantages. When supplemented by contingency management, during treatment patients did well, but the number of days they avoided drinking fell back after treatment ended. On abstinence yardsticks, case management patients did relatively poorly from the start, but by the final nine months they were doing as well as the contingency management patients whose gains had by then faded. On days they did drink, patients in all three treatments on average drank roughly the same amount, and there were no statistically significant differences in their experiences of negative alcohol-related consequences.

The study also assessed some of the 'mechanisms' through which the treatments might have affected drinking. Consistently the network support option led to the greatest and most sustained abstinence-supportive changes in the patient's social circle. By the end of the follow-up period, adding incentives to the network support option retarded these changes to the point where networks were no more supportive of abstinence than after the basic case management option, which did not even try to alter social networks. The standalone network support option also led to greater increases in patients' confidence that they could resist drinking ('self-efficacy'), and in their repertoire of strategies for doing so. Network support patients tended to add non-drinking contacts to their social networks rather than to eliminate drinkers.

Finally the study tested whether these mechanisms did indeed account for the advantage network support patients had in days without drinking. The resultant model suggested that network support improved on the other two options by more effectively (in each case, as measured after treatment had ended) increasing AA attendance, how many non-drinking friends the patient had, their confidence in resisting drinking, and their strategies for doing so.

For the authors their findings showed that a treatment focused on changing the drinker's social environment can result in long-term changes in their social networks which contribute to improved drinking outcomes. AA attendance and increasing the number of non-drinking friends were strong predictors of drinking outcomes, appearing to increase abstinence partly by reinforcing patients' confidence in their ability to resist drinking.

FINDINGS The messages of the study seem to be that:

1 An approach which systematically bolsters non-drinking contacts and support in a drinker's social circle can lead to greater and more sustained abstinence than typical counselling which does not include this component.

2 Incentivising this approach with material rewards may not only be ineffective, but actually counterproductive.

3 12-step philosophy can be de-emphasised during treatment, yet the non-drinking social support 12-step groups offers remains an effective ingredient.

Each is examined below.

1 The first of these messages appears out of line with Britain's UKATT trial, which found that for alcohol problems a network approach was *not* superior to a therapy based on motivational interviewing. Possible reasons for this discrepancy are many. For network therapies, the most fundamental is that in Britain the UKATT therapy focused on generating support from the client's *existing* family and friends, if possible directly involving them in therapy sessions. In contrast, the featured study's network treatment relied mainly on new contacts made via mutual aid groups, who perhaps could be relied on more to model and encourage abstinence, with fewer of the complications involved in also for example being a spouse, close friend or work colleague. In UKATT the attempt to involve these and other people was described as a "mixed blessing", attracting the highest number of "least useful" assessments in both therapist and client post-session feedback reports, though more often it was seen as among the most useful elements. This polarisation may derive from the attempt to involve people whose close and lasting/ permanent relationship with the patient carries with it the potential for seriously obstructing as well as facilitating progress. Another variant on this type of approach helps avoid such problems by selecting only patients with a suitable, supportive and willing partner.

At a deeper level, in mutual aid groups the members are the vehicles of their own recovery and that of other members. The more active this participation, the greater are the benefits (1 2). In contrast, the UKATT therapy *was* a therapy; it required certain actions of the patient and a degree of participation, but in the context of something being done to rather than by them. The background notes deal with the issues of whether mutual aid groups are available and supported in the UK, and other differences between the featured study and UKATT which could account for the difference in outcomes.

2 *How* incentivising network support with material rewards made it less effective seems reasonably clear; *why*, less so. Especially towards the end of the two-year follow-up period, incentives weakened the network support option's positive influences on how many non-drinking friends the patient had, their confidence in resisting drinking ('self-efficacy'), and their strategies for doing so. Since all these partly accounted for impacts on abstinence, this too was weakened. A possible reason is that external incentives to engage in social network activities distracted patients from or diluted the impact of the rewards inherent in such activities, like praise and recognition for efforts to stop drinking. The study's authors highlighted the influence of post-treatment self-efficacy. It seemed as if during treatment patients relied on (or at least, saw themselves as relying on) the incentives to keep them on track. When these ended, they were left without the strong belief in their own ability which in other patients had been built up by the experience of resisting drinking without the need for incentives. The potential for material rewards to undermine 'intrinsic' motivation for engaging in, completing, or doing well at a task is well established. Though studies are few, such an effect has also been observed in substance use treatment, during which readiness to change, motivation, or confidence in one's ability to resist substance use were held back by contingency management relative to other therapies. The most relevant of these studies found that supplementing motivational and coping skills therapy with rewards halved what without the rewards was a substantial increase in confidence in ability to refrain from smoking cannabis. Such effects are however by no means inevitable. The meaning the patient attaches to the

incentives is probably critical and can be influenced by how these are integrated in to accompanying therapy. The background notes explore this important issue further.

3 The implication that 12-step philosophy can be de-emphasised during treatment is potentially important for people who find it hard to embrace this philosophy, but would benefit from repeated and extended contact with committed abstainers. For the relatively secular UK, the 'higher power' steps and references to God seem the least appreciated and most off-putting of the 12 steps, the more so in one study among drinkers in treatment (the majority held these views) than drug users. In this study almost half the drinkers said the 12 steps would deter them from attending AA/ NA meetings. Focusing instead on the social network/support offered by mutual aid groups is also in line with findings from across health and mental health sectors (for example, among the elderly) of the adverse impacts of loneliness and the positive impacts of social support networks. The social support element was also highlighted by England's National Treatment Agency for Substance Misuse in its recommendations for effective commissioning for recovery.

However, it cannot be assumed that 12-step philosophy played no part in the featured study's outcomes. It seems unlikely that these beliefs *remained* de-emphasised while patients participated in Alcoholics Anonymous meetings. Potentially, fostering commitment to AA philosophy was one way AA attendance and non-drinking friends helped sustain abstinence, bolstered patients' confidence they could resist drinking, and extended their repertoire of strategies for doing so − all ways network support exerted a greater impact than the other treatments. Evidence has been found for many ways in which mutual aid supports abstinence. Social support is one, but may itself be sustained, justified and even mandated by 12-step traditions and philosophy, much in the way that the social support gained from (for example) joining sports clubs or churches may be sustained, justified and mandated by the traditions of the sport or religious beliefs involving obligations to others and communal worship. The background notes explore these issues further, concluding that 12-step groups mainly work through mechanisms common to other therapies, among which is social support, and in particular social support for abstinence. However, this particular form of support may have been highlighted because the research has generally adopted abstinence as its key outcome measure.

Despite some methodological limitations (of which the main one was that the patients had not sought treatment in the normal way ▶ background notes), the study offers a way for services in countries like the UK to tap in to the social support offered by mutual aid groups without having to ask patients to adopt the belief system or objectives on which 12-step groups are founded. Historically the perfectionist ideal of abstinence, though it originated in the UK, took root in the USA but was sidelined and even ridiculed in Britain, which was more comfortable (and still is) with a pragmatic approach embracing controlled drinking. The consequences seemed apparent in a study published in 2000, which found that only a small minority of alcohol treatment clients in the UK attend AA. Practical tactics for increasing mutual aid uptake include emphasising the concrete benefits and mutual support available through AA rather than the spiritual aspects, escorting patients to 'taster' meetings during treatment (with the escort perhaps being a former patient now attending AA), arranging an introductory meeting at the treatment

service, and inviting AA members to address patients. Patients who attend AA during treatment are more likely to continue attending in the aftercare phase.

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