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▶ Translating effective web-based self-help for problem drinking into the real world.

Riper H., Kramer J., Conijn B. et al. Request reprint

Alcoholism: Clinical and Experimental Research: 2009, 33(8), p. 1401–1408.

Combining a randomised trial with a 'real-world' test, studies of the Dutch *Drinking Less* programme have gone further than any others to establish the beneficial impacts of web-based alcohol self-help interventions.

Abstract The study was a 'real-world' test of a promising Dutch internet-based self-help intervention for problem drinking. A previous randomised trial employing the methodological safeguards possible in tightly controlled research (particularly the recruitment of a comparison group not given access to the intervention) had established that the intervention reduced drinking. At issue in the featured study was whether similar drinking reductions would be seen when the intervention was made freely available to the general public. If they were, then the assumption could be made that these too were caused by having access to the intervention.

Drinking Less is an on-line, interactive programme with no personal therapist input. Aimed at risky drinkers among the general adult population, the intervention is based on principles derived from motivational interviewing, cognitive-behavioural therapies and self-control training. Its home page (▶ *right*) offers links to alcohol-related

information, treatment services, a discussion forum, and the *Drinking Less* self-help programme, the core of the intervention. Over a recommended six weeks (though this is entirely up to the user) the programme guides visitors in preparing to change their drinking, setting goals , implementing change, and finally sustaining it, preferably by drinking within recommended limits.

The earlier trial had found that six months later, at least 17% of adult problem drinkers randomly allocated to this intervention had reduced their drinking to within Dutch guidelines, compared to just 5% allocated to an on-line alcohol education brochure. Before the study, both groups had averaged about 55 UK units a week. At follow-up, the *Drinking Less* group had cut consumption to about 36 UK units a week, but the brochure group had barely changed.

The featured study monitored what happened when over 10 months spanning 2007 and 2008 the web site was advertised to the Dutch public. During this time round 27,500 people visited the site, of whom 1625 signed up for the self-help programme, accessing it on average 23 times. Typically they were well educated, employed, middle-aged men. On average they drank about 50 UK units a week, and nearly all who completed the on-line AUDIT screening questionnaire scored in a range indicative of alcohol abuse or dependence.

During the first seven of the 10 months, 378 of site visitors who signed up to the *Drinking Less* programme also agreed to participate in research to assess its impact. On average they drank roughly the same amount (95% exceeded Dutch guidelines) as all 1625 who signed up and were also similar in age, sex, employment, and motivation to change. Despite some statistically significant differences, they were also broadly similar to participants in the earlier randomised trial. Over 8 in 10 had never received professional help for their drinking. A few weeks later a survey suggested that after signing up, nearly 9 in 10 went on to use the programme, though generally only a few times.

Of the 378 in the baseline sample, 153 responded to an on-line follow-up survey six months later. Before signing up to the programme, just 4% had confined their drinking within Dutch guidelines; six month later, 39% did so. They had also nearly halved their average consumption from 50 UK units to 27. On the 'fail-safe' assumption that the intervention had no impact on people who were not followed up, still the drinking reductions were statistically significant; from 5%, the proportion drinking within guidelines rose to 19%, and consumption fell from 51 UK units to 42.

Next the analysts compared these results with those from the six-month follow-up in the randomised trial. Based only on respondents to the follow-up surveys, and adjusting for differences between the samples, in the 'real-world' test over twice as many (unadjusted figures 36% v. 19%) people moved to drinking within Dutch guidelines. When the assumption was made that in both trials the intervention had no impact on people not followed up, the figures still favoured the 'real-world' test (15% v. 10%), but the difference was no longer statistically significant.

The researchers concluded that the featured study had shown that the benefits established by the randomised controlled trial would be sustained when the intervention

was made routinely and generally available to the public. The expected throughput of 3000 *Drinking Less* programme users a year would amount to nearly 3% of the country's problem drinkers who would otherwise not have received professional help. Probably because they require the drinker to take the initiative and visit the site, such interventions reach people who, compared to the totality of problem drinkers, are more likely to be women, employed, highly educated, and motivated to change their drinking. Given its low cost per user, this type of intervention seems to have a worthwhile place in a public health approach to reducing alcohol-related problems.

FINDINGS Though only a minority of site visitors may sign up for web-based alcohol programmes, nevertheless the numbers engaged can be very large, and the risk-reductions seem of the order typical in studies of brief advice to drinkers identified in health care settings. In these settings screening programmes typically identify people who are not actually seeking help for drinking problems – 'pushing' them towards intervention and change – while web sites 'pull' in people already curious or concerned about their drinking. As such these two gateways can play complementary roles in improving public health and offering change opportunities to people who would not present to alcohol treatment services. However, in Britain and elsewhere, both tactics reach only small fractions of the population who drinking excessively, leaving the bulk of the public health work to be done by interventions which drinkers generally cannot avoid and do not have seek out, such as price increases and availability restrictions.

With its combination of a randomised trial and a 'real-world' test, the featured research programme has gone further than any other in establishing the beneficial impacts of web-based alcohol interventions. However, largely because many site users do not complete research surveys, it remains impossible to be sure that the results seen in such studies will be replicated across the entire usership of the sites. Details below.

Strengths and limitations of the featured study

The featured study's combination of a randomised trial with all its methodological safeguards, and a 'real-world' trial approximating normal conditions, affords what seems to be the best indication to date of the contribution web-based self-help interventions could make to reducing heavy drinking and associated health risks. However, its twin pillars are weakened by the fact that many people either did not join the studies or did not supply follow-up data; those who did may not have been typical of all the people who might access such sites. In the randomised trial, 40% of the baseline sample did not complete the six-month follow-up survey, and in the featured study, nearly 60%. Though on the measures taken by the study the respondents generally seemed typical of the baseline sample, clearly something was sufficiently different to cause them to respond while the others did not. In both studies this problem was catered for by assuming that non-responders were also non-changers. Though this almost certainly underestimated the impact of the intervention, still in both there remained significant and worthwhile improvements.

What could not be catered for in either study was the degree to which people who join such studies differ from the much greater number who would use the web sites, but decline participation in research. This problem was especially apparent in the featured study, in which it seems that around 6% of site visitors signed up for the self-help

programme. Of these, perhaps a third or slightly more of the people who signed up for the programme during the relevant period also agreed to participate in the research. In some important ways (including amount drunk and motivation to change) they seemed similar to the bulk of programme sign-ups, though the researchers suspect they were more likely to have engaged with the programme.

Opening more doors to change for more people

A review of computer-based alcohol services for the general public has rehearsed the advantages: immediate, convenient access for people (the majority in developed nations) connected to the internet; consequently able to capitalise on what may be fleeting resolve; anonymous services sidestep the embarrassment or stigma which might deter help-seeking; such services are available to people unwilling or less able to talk about their problems to a stranger; generally they are free and entail no travel costs or lost income due to time off work; very low operating cost per user if widely accessed; easily updated. In consumption terms, the drinking problems of web site users are comparable to those of drinkers who seek treatment, yet few have received professional help, perhaps partly because their higher socioeconomic status and greater resources have enabled them to restrict the consequential damage. People who actually engage with web-based assessments of their drinking problems have more severe problems than those who just visit and leave. Including the randomised trial which paved the way for the featured study, the review found eight studies which evaluated the effectiveness of computer-based interventions for the general public. In all but one the users significantly improved on at least one of the alcohol-related measures recorded by the studies.

A particular role for alcohol self-help sites may be to offer an easy, quick and accessible way to for drinkers to actualise their desire to tackle their problems, especially when that desire is allied with the resources to implement and sustain improvements without face-to-face or comprehensive assistance. After conducting the Project MATCH trial, some of the world's leading alcohol treatment researchers argued that "access to treatment may be as important as the type of treatment available". The implication is that in cultures which accept 'treatment' as a route to resolving unhealthy and/or undesirable drinking, having convincing-looking and accessible 'treatment doors' to go through may be more important than what lies behind those doors, as long as this fulfils the expectations of the client or patient. This is likely to be especially the case for people who retain a stake in conventional society in the form of marriages, jobs, families, and a reputation to lose. These populations – the kind the featured study suggests are attracted to self-help alcohol therapy web sites – have more of the 'recovery capital' resources needed to themselves do most of the work in curbing their drinking.

The British Down Your Drink site

The best known British alcohol self-help web site is the Down Your Drink site run by a team based at University College London, an initiative originally funded by the Alcohol Education and Research Council and now by the Medical Research Council's National Prevention Research Initiative. In 2007 this was revised to offer set programmes from a one-hour brief intervention to several weeks, but also to generally give the user greater control over the use they made of the site. The approach remained based on principles and techniques derived from motivational interviewing and cognitive-behavioural

therapies.

The previous version had been structured as six consecutive modules to be accessed weekly. An analysis of data provided by the first 10,000 people who registered at the site after piloting ended in September 2003 revealed that most were in their 30s and 40s, half were women, nearly two-thirds were married or living with a partner, just 4% were unemployed, and most reported occupations from higher socioeconomic strata. As an earlier study commented, site users were predominantly middle class, middle aged, white and European. Six in 10 either did not start the programme, or completed just the first week. About 17% completed the six weeks. Of these, 57% returned an outcome questionnaire. Compared to their pre-programme status, on average they were now at substantially lower risk, and functioning better and living much improved lives. The sample had been recruited over about 27 months, a registration rate of about 4500 a year. By way of comparison, in England during 2008/09, around 100,000 adults were treated for their alcohol problems at conventional services. User profile and site usage had been similar during the earlier pilot phase. Results from surveys sent to pilot programme completers indicated that three quarters had never previously sought help for their drinking.

Thanks for their comments on this entry in draft to Heleen Riper of the Trimbos Institute in the Netherlands. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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