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Research Article

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Digital or In-Person Provision of Group Work in Alcohol Use Disorders? The Results of an Open-Label Study

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Abstract

Background: *The COVID-19 pandemic necessitated that treatment groups be provided digitally. This has created an opportunity to compare the digital provision of the Abstinence Preparation Group, a pre-habilitation intervention for people with alcohol dependence, with the pre-existing in-person provision, reported in 2016.*

Methods: *A mixed quantitative and qualitative approach was followed. People seeking treatment for alcohol dependence from a community Alcohol Use Disorder service in England were included. Quantitative data were collected retrospectively. A selection of people was also interviewed.*

Results: *Twenty-six (60.4%) completed the D-APG and of those, 17/26 (65.3%) achieved abstinence. Fourteen (54%) were completely abstinent at 1 month, 10 (38%) at 3 months and 8 (31%) at 6 months. Participants felt the group was more educational than therapeutic, with reduced interaction between participants. On the other hand, participants with anxiety or difficulties traveling appreciated the flexibility of the digital group. Both quantitative and qualitative results indicate that in-person APG is more effective, nevertheless, D-APG seems to be an alternative treatment option for certain people.*

Conclusions: *While the digital group offers a valid alternative for some people, in-person APG seems to be more effective for structured preparation before detoxification*

Keywords: Telemedicine, Digital, Group Work, Alcohol Use Disorders, Prehabilitation

Highlights

- Digital provision of groups in alcohol use disorder is an alternative for some people.
- There is a risk that digital groups become more educational and didactic rather than therapeutic.
- In-person theory-based groups such as the Abstinence Preparation Group are more effective than the digital version of the group.

1. Introduction

The COVID-19 pandemic necessitated major changes to service provision. New interventions or major modifications were made to well-established interventions to be compatible with social restrictions [1]. Those changes took place within a short period and with limited assessment of potential barriers or adverse impact on their effectiveness. Those changes and uncertainties were mostly relevant to psychological interventions either offered individually or in groups. There was also limited guidance on the management of risks and balance between efforts to engage and therapeutic boundaries. At the same time, COVID-19 restrictions provided an opportunity for innovations and new testing and learning [2]. The Abstinence Preparation Group is a theory-based therapy group for people with alcohol dependence. It is the only reported intervention that puts emphasis on the structured preparation received before medically assisted withdrawal (MAW) [3].

As a response to the COVID-19 pandemic and associated restrictions on travel, APG was delivered digitally (D-APG). The intervention follows the pre-habilitation paradigm in medicine and the Cognitive Behavior Therapy (CBT) treatment paradigm [4,5]. The intervention aims at empowering people to stabilize their drinking (partially controlled drinking), proceed, if possible, with gradual reduction (guided self-detox), and initiate positive lifestyle changes and changes to the immediate family environment [6]. Following completion of APG people progress to MAW (if required) and aftercare treatment and support as per the current National Institute for Health and Care Excellence [7]. Previous

APG evaluations indicated that the intervention is effective it is therapeutic rather than educational and combines generic group principles while it is theory-based it works according to theory it is acceptable by people and implementable within the National Health Service (NHS) [3,6,8-11]. APG was first introduced as part of a 3 stages alcohol dependence pathway within the National Health Service (NHS) in England in 2005 and at the current NHS Alcohol Use Disorder (AUD) Service in 2013 [8].

2. Methods

A mixed quantitative and qualitative approach was followed. All people presenting with alcohol dependence (AUDIT score >20) to a community NHS AUD Service in England, during the six-months period of January-June 2021 were included. Quantitative data were collected retrospectively using the Electronic Health Record system (TPP System One) and summarized using descriptive statistics [12]. Data included demographic characteristics, completion of the group, abstinence at the end of the group, and progress at 1-, 3- and 6 months post abstinence. Abstinence was defined as having no consumption of any alcohol during the preceding period. Outcome data were similar and compared with the previously reported data of 2016 [6]. A selection of participants who have attended D-APG as well as people with previous experience of attending APG in person, completed a semi-structured interview. The topic guide was based on a previously reported evaluation and focused on participants' subjective experiences, potential barriers and/or advantages, and aspects of theory-specific and generic group factors as per previous evaluations [9,10]. Every effort was made to follow the flow of the conversation and the participant's narrative. Interviews, completed over the telephone or in person, were audio recorded with consent and transcribed verbatim. Interviews lasted approximately 30 minutes (16-45 minutes). Interview transcripts were imported into NVivo software (Lumivero, Version 12 pro) and analyzed using a four-stage thematic approach [13].

3. Results

During the six-month period, 64 people were offered D-APG. Of those, 48/64 (75%) started the intervention, and 26/64 (40.6%) were considered completers as they have attended at least 4 sessions and have covered the missing session material in other ways [3]. Demographics are summarized in Table 1.

D-APG group	Mean	Minimum	Maximum
Age (n=64)	46.2	21	76
		N	%
Sex (n=64)	Female	29	45.3
	Male	35	54.7
Marital Status (n=64)	Single - Living Alone	23	35.9
	Married/Civil Partner	17	26.6
	Cohabiting	9	14.1
	Single - Living with Family	12	18.8
	Divorced	1	1.6
	Common Law Partnership	1	1.6
	Widowed	1	1.6

Table 1: Demographic Characteristics

Out of the 26 completers, there was a similar number of males and females (M=14, F=12). The mean AUDIT score was 32.15 There was no difference between completers and non- completers as far as AUDIT score was concerned. Seventeen completers (17/26; 65.3%) achieved abstinence: the majority (n=13; 76.5%) achieved abstinence by guided self-detox, four by MAW (two by unplanned hospital and two by planned inpatient). At the 1-month follow-up (one month after achieving abstinence +/- 1 week), 14/17 participants were abstinent while 3 experienced one lapse. The abstinence rate was 32.6% (14/43) of those who started D-APG and 54% (14/26) of those who completed D-APG.

At 3-month follow-up (+/- 1 week), 10 participants remained abstinent while five experienced one lapse and two relapsed. The abstinence rate was 23.3% (10/43) of those who started D-APG and 38% (10/26) of those who completed D-APG. At the 6-month follow-up (+/- 1 month), eight remained abstinent, three experienced one lapse, and five relapsed. The abstinence rate was 18.6% (8/43) of those who started D-APG and 31% (8/26) of those who completed D-APG. Table 2 compares APG 2016 with D-APG.

	2016 APG Face to Face	D-APG Group
Started APG	94% of Accepted	43% of Accepted
Completed	77% of Starters	60% of Starters
Abstinence	84% of Completers 51% Guided Self-Detox	69.2% of Completers 76.5% Guided Self-Detox
Abstinent 1 Month	44% of Starters 56% of Completers	32.6% of Starters 54% of Completers
Abstinent 3 Months	38% of Starters 48% of Completers	23.3% of Starters 38% of Completers
Abstinent 6 Months	39% of Starters 50% of Completers	18.6% of Starters 31% of Completers

Table 2: Comparison Between APG (2016) and D-APG

3.1. Qualitative Analysis

Semi-structured interviews were conducted by MDP and lasted approximately 30 minutes (16-45 minutes). Eighteen participants who attended at least 4 sessions were invited to take part. Seven agreed to take part. Those interviewed attended 5 sessions on average (min=4; max=8), and three had previous experience attending the APG in person. Demographics of the sample are summarized in table 3.

	N
Gender	
Female	5
Male	2
Age	
20-29	1
30-39	2
40-49	2
50-59	2
Marital Status	
Single Living with Family	3
Single Living Alone	1
Single Living with Friend	1
Married/Civil Partner	2

Table 3: Demographic Characteristics of Interviewed People

Most participants reported a positive experience within the group setting and in their relationships with peers. Most highlighted the importance of meeting others with a shared experience of addiction and being able to relate. This had a positive effect in reducing the sense of loneliness and pressure in a supportive and non-judgmental environment.

Female (003): '[…] it was a little bit difficult, but when I went it was so good to be in a group [...] feeling "oh that other people like myself". […] It's a relief to feel that there are other people who understand that I can share and that was really good.'

Female (006): '[…] I ended up coming away really sad, really, really sad, and worrying about other people instead of looking after myself.'

Most people appreciated the flexibility of the digital group, rather than having to travel. People unable to drive, and those suffering from anxiety, often had to rely on friends or family members to attend the face-to-face group. Nevertheless, a few participants suggested that they would have liked the option of attending in person, especially after a few meetings when they felt more settled in the group.

Female (007): 'I didn't have to travel and could … could do it if I was at work... As opposed to just taking an hour out for a virtual meeting.'

Female (002): 'It was stressful to have to get to the hospital every

week. In fact, if I didn't have my family helping me get there, I'm not sure I would have […].'
Female (004): '… I think I would have missed more groups because if I was having a bad day with my anxiety, I wouldn't leave the house. […]'
Female (006): 'I probably would have been reluctant to go to a face-to-face anyway. But I would have done once I kind of knew the people in that group.'
Female (002): 'I like the fact that virtually I didn't have to show myself […]. I participate in the group but I'm not gonna be bumping into any of these people because I don't see them.'

Some felt that the relationship and bonding with the other group members was compromised by having to interact over the screen. D-APG felt at times more like an educational group, with a lack of interaction within participants, and facilitators perceived as teachers.

Female (003): 'It was probably easier when you are face to face cause you sort of go around the room you can see everybody, you probably have a little chat whilst you are waiting…; so you probably feel closer to the people or know more about them or have that extra little camaraderie, whilst you don't so much when you are suddenly on Teams.'
Male (001): 'I found it […] hard over like Teams to actually connect with anyone. And it is just kind of like you are all sitting there like a class, waiting for a teacher.'

4. Discussion

Quantitative data suggested that D-APG was worse in all outcome measures compared to the previous in-person implementation, reported in 2016, for both starting and completing the intervention as well as a reduction in abstinence rates following completion at 1-, 3- and 6-months post abstinence. The exception was the percentage of participants achieving abstinence with guided self-detox while attending the group, which was higher, and the rate of abstinence at 1 month which was similar.
Interviews confirmed the positive impact of the generic group effect such as peer support and learning from each other, similar to previous evaluations. Those who had previous experience with the in-person APG felt that this effect was compromised with the D-APG. The group felt at times more like an educational group, with a lack of interaction among participants, and facilitators perceived like teachers. On the contrary, others appreciated the flexibility of the digital group mostly those with anxiety, indicating that the digital group could be an alternative. These less favorable recovery outcomes could be attributed to the social circumstances during the pandemic, which might have compromised the opportunities for recovery activities in the community, barriers to attending relapse prevention interventions and peer support, or even potentially reduced effectiveness of those interventions due to digital provision (similarly to D-APG). Taking though into consideration the reports from qualitative interviews about (a) the change of the overall style of the sessions to educational rather than therapeutic, (b) the reduced interaction between participants, as well as (c) the reduced rate of completion of the group and finally (d) the reduced rate of abstinence at completion it could be argued that both the nature and the efficacy of the group has been compromised by digital provision.

A major limitation of the qualitative analysis is that interviews were conducted over a year after the attendance of D-APG. For the same reason, it was decided to interview people who had attended at least 4 D-APG to make sure they had enough exposure and recollection of the intervention. Furthermore, compared to the previous evaluation, there was more flexibility in defining completers mostly due to COVID-19 restrictions and the groups compared were therefore not identical.

5. Conclusions

While D-APG offered a valid alternative for some participants, in-person APG seems to be more effective and to that effect should be the preferred option. To improve the efficacy of D-APG emphasis should be given to the therapeutic nature of the group and interaction between members of the group should be encouraged.

Authors Contribution
Maria Del Picolo collected and analyzed both quantitative and qualitative data and contributed to writing up; Sai Bo Cheung collected data; Christos Kouimtsidis conceived the project, developed the protocol, and wrote up the manuscript.

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Compliance, Ethical Standards, and Ethical Approval

The project was part of a wider evaluation of services during the COVID-19 period, hence no ethics approval was required. All data are managed and stored in compliance with the Surrey and Borders Partnership Clinical Governance local policy, available at request.

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