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Television-supported self-help for problem drinkers: A randomized pragmatic trial

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ABSTRACT

Objectives: To test the effectiveness of a television-supported self-help intervention for problem drinking.
Methods: Dutch television viewers (N=181) drinking in excess of the guidelines for low-risk alcohol use were randomly assigned either to the *Drinking Less* TV self-help course (consisting of five televised sessions supplemented by a self-help manual and a self-help website) or to a waitlisted control group. To ensure trial integrity, intervention delivery was mimicked beforehand by sending intervention participants weekly DVDs in advance of the actual telecasts in 2006. Pre-post assessments were carried out on both groups, as well as a 3-month follow-up assessment on the intervention group to study effect maintenance. The primary outcome measure was low-risk drinking.
Results: The intervention group was more successful than the waitlist group in achieving low-risk drinking at post-intervention (OR=9.4); the effects were maintained in the intervention group at 3-month follow-up.
Conclusions: The low-threshold television-based course *Drinking Less* appears effective in reducing problem drinking.

1. Introduction

Numerous publications in recent decades have highlighted the need for brief, low-threshold interventions to reach out to problem drinkers (Institute of Medicine, 1990; Anderson & Baumberg, 2006; Kaner et al., 2007). This concern is indeed warranted, given the wide prevalence of problem drinking, its consequences in terms of morbidity and mortality (Murray & Lopez, 1996; World Health Organization (WHO), 2004), and the associated economic costs (Klingemann & Gmel, 2001; Smit et al., 2006).

Brief interventions have meanwhile been thoroughly investigated and shown effective in both primary care settings (Ballesteros, Duffy, Querejeta, Arino, & Gonzalez-Pinto, 2004; Kaner et al., 2007) and the general population (Moyer, Finney, Swearingen, & Vergun, 2002; Apodaca & Miller, 2003). Most brief interventions in primary care are delivered with some form of therapeutic guidance, whereas those aimed at the public are often without personal therapeutic support (Cuijpers & Riper, 2007). In primary care settings, the dissemination of brief interventions is still hampered by factors like the limited number of professionals who administer them, the difficulty of reaching problem drinkers, and the high costs of implementation (Kaner, Lock, McAvoy, Heather, & Gilvarry, 1999; Moyer & Finney, 2005; Raistrick, Heather, & Godfrey, 2006). This has prompted a search for broad-scale dissemination channels for brief interventions outside primary care.

Television and the Internet are media that could potentially enable low-threshold, low-cost dissemination. The applicability of the Internet for providing mental health interventions has developed strongly since the turn of the millennium, and a corresponding evidence base has been built (Kypri et al., 2004; Riper et al., 2008). Radio and television, by contrast, have largely evolved along different lines. Approaches have often been limited to brief, stand-alone mass communication strategies to warn about social and health risks of problem drinking, and these have had little success in effecting behavioral change (Austin & Husted, 1998; Cuijpers, Scholten, & Conijn, 2005).

Yet television does have a potential for health promotion interventions extending far beyond the genre of brief mass media campaigns. It can be used to deliver more in-depth programs on overcoming psychological or behavioral problems and targeting specific groups (Austin & Husted, 1998; Park, Yi, Joo, & You, 2001). It could be a powerful medium to bring self-help interventions to large audiences. Awareness has also been raised of the impact of alcohol use in non-alcohol-related TV series (Blair, Yue, Singh, & Bernhardt, 2005), particularly soap operas (Breen, 2007). Multi-media interventions using combinations of broadcasts and self-help manuals have been found more effective than single strategies used alone (Jason, Salina, McMahon, Hedeker, & Stockton, 1997).

Gradually, television is now being used more widely to promote healthy lifestyles and behavioral change, such as smoking cessation (Jason et al., 1997), physical exercise (Hopman-Rock, Borghouts, & Leurs, 2005) and coping with emotional problems (Barker, Pistrang, Shapiro, Davies, & Shaw, 1993). Television series have also been

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developed to promote low-risk alcohol consumption by adults (Bennett, Smith, Nugent, & Panter, 1991; Teleac/NOT, 2006), but little is known yet about their effectiveness. The series evaluated by Bennett et al. (1991), entitled *Pssst…. the Really Useful Guide to Alcohol*, consisted of six 30-minute installments broadcast by the BBC in 1989. Viewers of the series were compared with matched controls, and results showed improvement in alcohol-related knowledge, but not in attitude or in actual alcohol consumption.

This article reports on the effectiveness of *Drinking Less? Do It Yourself!* (Teleac/NOT, 2006), a five-week Dutch television self-help intervention designed to reduce problem drinking. To our knowledge, this is the first randomized controlled trial of a television-based self-help intervention for problem drinking in the general population. We hypothesized a beneficial posttreatment effect in terms of lower alcohol consumption as compared to the waitlisted control condition.

2. Method

2.1. Recruitment

Study participants were recruited through advertisements in national newspapers referring interested people to a trial-related website containing additional information. After giving informed consent, candidates were invited by e-mail to respond to web-based questionnaires. Inclusion criteria were (1) alcohol consumption exceeding the limits specified by the pertinent Dutch guideline for low-risk drinking (Posma & Koeten, 1998); (2) age 18 or older, (3) access to a DVD or video player and Internet, and (4) an e-mail address. Exclusion criteria were (1) current professional help for alcohol problems, (2) current participation in a self-help group such as Alcoholics Anonymous, (3) current intake of alcohol medication, and (4) current involvement in another study on problem drinking. In accordance with the low-risk guideline, men were selected who were drinking more than 21 units per week or 6 units or more at least one day a week over the past month. Women were selected who were drinking either more than 14 units per week or 4 units or more at least one day a week. One unit represents 10 g of ethanol.

2.2. Intervention

The *Drinking Less? Do It Yourself!* intervention is a cognitive-behavioral self-help intervention to reduce alcohol consumption. The core component consists of five 25-minute televised sessions (Teleac/NOT, 2006) featuring a trained addiction coach and two real-life problem-drinking course participants (a man aged 53 and a woman aged 47) who report on their progress with the course. The coach gives them and the general public advice about low-risk drinking and about how to take the next step in cutting back. After each course week, the coach gives the two participants feedback, noting what went well but pointing out pitfalls in how they were pursuing their action plan to reduce drinking.

The series advises the use of additional supportive materials, consisting of a self-help manual (Lemmers, Kramer, Conijn, Riper, & van Emst, 2006) and a related self-help website called Drinking Less (www.MinderDrinken.nl). The television sessions, manual and website correspond closely. They guide the participants through 4 stages. In the first stage, the focus is on a review of current alcohol consumption and assessment of the benefits, drawbacks, and hazards of that level of drinking. Participants are given tools to evaluate their alcohol consumption and to clarify (a) the units of alcohol now consumed, (b) their balance of pros and cons of drinking, (c) their risk of alcohol-related problems, and (d) their motivation to change their drinking habits. They are also encouraged to keep an alcohol diary. The second stage involves goal setting for future moderation. Participants receive information and exercises to help them decide on goals for drinking, such as a maximum number of drinks per day and per week and a reasonable time frame for reaching the goals. The third stage is directed at achieving these goals. A key task is preparedness for future situations in which drinking is hard to resist (because of social pressure or drinking habits). Participants are encouraged to describe their potential risk situations and devise ways to cope with them. The final stage is consolidation and relapse prevention. It teaches participants to deal with relapse and prevent it in the future. They analyze relapse situations and plan ways to handle these better. The beneficial effects of social support are discussed, and participants are encouraged to find someone like a friend or family member to support them in sticking to their goals.

The Drinking Less website offers some extras that supplement the information and exercises from the self-help manual and the televised installments. It provides graphical feedback on risk situations and on progress made (based on the alcohol diary); it also offers a user forum where participants can exchange experiences and get support from peers.

2.3. Procedure

The trial was conducted before the actual broadcasting started on Dutch nationwide television, to ensure that the control group had no access to the intervention during the trial. We mimicked the television series beforehand by sending one session per week to the intervention group on DVD. The self-help manual (Lemmers et al., 2006) and the web address of the interactive Drinking Less website (www.minderdrinken.nl) were enclosed with the first installment. The waitlisted group received all course materials after the T1 assessment, as the nationwide telecast began. Both groups were allowed access to other forms of treatment during the study.

2.4. Primary outcome measure

The primary outcome measure was problem drinking, defined as alcohol consumption exceeding the guideline—an average of more than 21 or 14 standard units (male/female) per week or 6 or 4 units or more (m/f) at least 1 day per week over the previous month. Units per week were measured using the Dutch version of Weekly Recall (WR) (Cahalan, Cisin, & Crossley, 1969; Lemmens, Knibbe, & Tan, 1988). Respondents reported retrospectively on their daily alcohol consumption over 7 days prior to the questioning. The frequency of days with 6 or 4 units was assessed using a question from the Dutch version of the Quantity-Frequency Variability Index (QFV) (Lemmens, Tan, & Knibbe, 1992): "How many times in the past four weeks did you drink 6 or more (male)/4 or more (female) alcoholic drinks on a single day." To ensure standardized responses on the alcohol consumption measures, the course provided an overview of standard units for various beverages, each unit containing 10 g of ethanol.

2.5. Secondary outcome measures

Secondary outcome measures were mean weekly alcohol consumption as assessed with WR and alcohol-related problems assessed with the 6-item version of Problem Index, a validated Dutch questionnaire for problem drinking (Cornel, Knibbe, van Zutphen, & Drop, 1994; Candel, 2001), on which a score of 3 or higher reflects significant problems related to alcohol use.

2.6. Other baseline data

Sociodemographic data on participants were obtained at baseline, and the validated Dutch version of the Readiness to Change Questionnaire was used to assess their willingness to change their alcohol consumption (RCQ-D), (Rollnick, Heather, Gold, & Hall, 1992; Defuentes-Merillas, Dejong, & Schippers, 2002).