



BRIEF REPORT

The Introduction of Self Help Group Facilitator in an Alcohol Unit: Preliminary Results

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Abstract

The main outcome of Alcohol Use Disorders (AUDs) treatment is the achievement of abstinence.

Pharmacological and psychosocial activities are strictly imbricated, however the results at one year are still unsatisfactory.

To date, the most effective tool for maintaining abstinence is attendance at Self-Mutual-Help Groups (SHGs).

Despite that, to date few patients attend Self-Help Groups (SHGs). For this reason we have decided to introduce the Self-Help Group Facilitator (SHGF) to our service.

After the introducing of SHGF, more patients have attended the SHGs. Moreover, there was an overall reduction in alcohol consumption.

It is suggestive to image how a social health operator in collaboration with SHGs can improve clinical progress, at lower cost.

Keywords

Alcohol Use Disorders, Self-Help Group Associations, Self-Help Groups Facilitator, Caregiver

lyzes find abstinence from 25 to 43%. Percentages that vary in relation to the intensity of the treatment and the length of the follow-up [2-6]. The abstinence rate decreases significantly over time.

It is well known that Self-Mutual-Help Groups (SHGs) are key in promoting long-term sobriety.

Anonymous Alcoholics (AA) in the United States of America have played an important role since 1935. In Europe Vladimir Hudolin has introduced alcoholics in treatment clubs.

In a paper of 1969 Hudolin affirmed: "During the patient's treatment he forms part of the Club of treated alcoholics, which works within the framework of the Institute.... Simultaneously the patient work in local clubs, in which they will become members after their treatment is finished. The final purpose of such work is to aim that the club should become an auto-psychotherapeutic group in which the alcoholic will exert maximum activity for the benefit of his own treatment" [7].

Scientific evidence has shown the effectiveness of the SHGs even if it is not associated with pharmacological and psychotherapeutic treatments. In addition, a lot of studies have proven the long-term efficacy of this tool both in relation to drug therapy and psychotherapy [8-19].

These positive results have also been reported in patients with psychiatric comorbidity [15].

Recently a Cochrane Systematic Review (27 studies containing 10.565 participants; 21 RCTs/quasi-RCTs,

Introduction

The main outcome of Alcohol Use Disorders (AUDs) treatment is the achievement of abstinence.

Follow-up of untreated or treated patients in non-accredited structures found an average abstinence of one year of 21% [1].

Pharmacological and psychosocial activities are strictly imbricated, however the results at one year are still unsatisfactory. After formal treatment, meta-an-



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5 non-randomized, and 1 purely economic study) evidenced that manualized AA interventions are more effective than other established treatments such as cognitive behavioral therapy, for increasing abstinence. Probably the AA frequency allows a better cost-benefit ratio [20].

Despite these results, to date few patients attend self-help groups. In 2018, the Italian Health Minister's Report to Parliament stated that only 4.8% of patients attend them [21].

In real practice it is very difficult to access patients to groups.

The reasons are many, however the most significant are the following: distrust on the part of patients and healthcare professionals and lack of time to devote to describing self-help groups.

It is good to underline how a constructive relationship with the family or friend of the AUD patient who decides to support the patient (Informal Caregiver - IC) is also crucial. Sometimes this contact is missing. Family members often no longer have resources available [22].

For this reasons, according to the initial activity of Hudolin [7], we favored the establishment of SHGs within our Institute and we have decided to introduce the Self-Help Group Facilitator (SHGF) to our service. This figure can be carried out by a healthcare professional with experience in an alcoholic unit and with a proven knowledge of SHGs.

SHGs activity is as follows: Explore possible barriers, describe the different ones "empathically" associations, break down negative myths, inform about positive aspects and results, give courage and monitor frequency.

In our service the role is played by a socio-health operator. This operator also moderates the groups for IC (ICGs) monthly.

Methods

In our Addiction Unit, the SHGF was introduced in June 2019. The patients were inserted from January 2020 to June 2019. All AUD patients are affected by compensated Alcohol related Liver Disease (ALD) and have been divided into two groups. The observational study was conducted retrospectively. Group A: 40 patients (12 females and 28 males) immediately after the first medical visit met the SHGF. During the visit (average duration 45'-60') the groups (AA and alcoholics in treatment clubs) are described and the advantages discussed. In addition, the SHGF meets the patient's family or friends and asks to participate in the ICGs. These groups discuss possible problems or progress and therapeutic adherence.

Group A was compared with Group B made up of 40 patients (15 females, 25 males) traditionally accepted in the same period of time.

Patients in group B were only given the telephone number or email of the associations with general information on the activity carried out.

All patients signed informed consent and consent to scientifically process data anonymously. These consents are kept in the medical records.

AUDs were diagnosed with the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5th Edition Criteria [23].

Monthly drinking variables were derived from the Timeline Follow-Back [24] that provided information of daily number of standard drinks. To define standard drinks, a conversion card was provided. The conversion of recorded standard drinks to grams was performed by a statistical programmer with the following Italian-specific factor: 12 grams. At screening patients reported their daily drinking over the previous month (28 consecutive days). At subsequent visits, they reported drinking since the previous visit [25].

The certainly of abstinence is given by the random evaluation of urinary ethylglucuronide.

Greater psychiatric comorbidity is present in overlapping percentages (Group A: 25%, Group B: 20%).

All patients underwent psychotherapy.

Being patients with liver disease, they did not undergo adverse/anticraving therapy with hepatotoxic or potentially hepatotoxic drugs. Only a minority part was subjected to acamprosate therapy (15% in the reference group and 17.5% in the control group).

Follow up was carried out until October 2020 (5-9 months).

The potential outcomes to be calculated are many. At present, the following outcomes have been assessed: Frequency at SHGs, frequency at ICGs and abstinence or reduction of alcohol consumption over 50%.

In consideration of the short follow-up period, the cases that achieved complete abstinence were added to those with a significant reduction in consumption (> 50%).

Statistical analysis: Fisher exact test calculator for a 2 × 2 contingency table.

Results

The results are summarized in [Table 1](#) and [Table 2](#).

The number of patients who had access to the groups is significantly greater in group A (70% vs. 10%, < 0.00001) as is the number of patients who have had an active and collaborative IC (60% vs. 5%, < 0.00001) ([Table 1](#)).

In group A there was an overall reduction in alcohol consumption compared to group B (70% vs. 45%, < 0.0411) ([Table 2](#)).

Table 1: SHGF: Self-Help Group Facilitator, Self-Help Groups Frequency (SHGF Freq), Informal Caregiver Groups Frequency (ICG Freq), Total Abstinence (Abs), < 50% (consumption reduction of over 50%), Cons (no changes in consumption).

	Cases	SHG Freq	ICG Freq	Abs	< 50%	Abs + < 50%	Cons	Cons + < 50%
Group A (SHGF)	40	28 (a)	24 (c)	17	11	28 (e)	12	23
Group B No SHGF	40	4 (b)	2(d)	16	2	18 (f)	22	24

a-b: < 0.00001

c-d: < 0.00001

e-f: < 0.0411

Table 2: Self-help mutual groups frequency and/or informal caregiver groups frequency and alcohol consumption abstinence or significant consumption unchanged reduction consumption (SHMGs: Self-help mutual groups, ICGs: Informal caregivers groups).

	Cases	abstinence or significant reduction consumption	consumption unchanged
SHMGs + ICGs frequency	19a	18/19 (94.7%)	1/19 (5.2%)
SHMGs or ICGs frequency	18b	12/18 (66.6%)	6/18 (33.3%)
No frequency	43c	16/43 (37.2%)	27/43 (62.7%)

a-c: 0.0002

a-b: 0.0422

b-c: 0.0496

In cases where there is a simultaneous attendance at SHMGs and ICGs, the reduction in consumption increases in a highly significant way compared to those who attend only one of the two (< 0.0422) or those who do not attend any group (< 0.0002) (Table 2).

Conclusions

It emerges as a figure dedicated to managing the relationship with SHGs can be crucial to increase the number of patients attending SHGs. If a stable collaboration between family (through ICGs) and alcohol unit is added to this aspect, the result can be even better.

Moreover, it can be assumed that with this type of activity there is a favorable cost-benefit ratio.

In the group of patients received by the SHGF there is also a significant reduction in alcohol consumption. Not foreseeing abstinence as a final result even in the most difficult patients is incorrect and also the trust of patients and families is betrayed. However, those with a total abstinence have also been added those with a significant reduction in consumption, that is, over 50%. The reduction in consumption, in fact, can have a meaning as a bridge to abstinence or in some selected clinical and environmental conditions.

In addition, Roereche and Rehm [26] found that reducing 14 to 11 alcoholic beverages per day reduces mortality risk by about 10 times, as does reducing 3 to 0 alcoholic beverages per day.

These results will certainly have to be reconfirmed on a larger patient population, and on a longer follow-up period, however the introduction in the addiction units of the SHGF can help better manage difficult patients and can represent a decisive boundary between service, family and community. This would create a true network between patient, family, associations and ad-

diction units with undoubted clinical and socio-health advantages.

It is suggestive to imagine how in the alcoholological/addiction unit a socio-health operator can significantly improve clinical performance, moreover at lower costs.

Disclosure

The author has no conflicts of interest to disclose.

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