

# REDUCTION OF THE TREATMENT GAP FOR PROBLEMATIC ALCOHOL USE IN BELGIUM





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Acknowledgements:	We thank all patients and care professionals who participated in the qualitative study and in the Delphi-rounds; also thanks to the librarians of the specialized libraries Caroline Godet (Infor-Drogues) and Marc Wauters (Vereniging voor alcohol- en andere drugproblemen).
Other reported interests:	All experts and stakeholders consulted within this report were selected because of their involvement in the topic of problematic alcohol use. Therefore, it is possible that they all have to a certain degree an unavoidable conflict of interest.
Layout:	Ine Verhulst
<b>Disclaimer:</b>	<ul style="list-style-type: none"><li>• <b>The external experts were consulted about a (preliminary) version of the scientific report. Their comments were discussed during meetings. They did not co-author the scientific report and did not necessarily agree with its content.</b></li><li>• <b>Subsequently, a (final) version was submitted to the validators. The validation of the report results from a consensus or a voting process between the validators. The validators did not co-author the scientific report and did not necessarily all three agree with its content.</b></li><li>• <b>Finally, this report has been approved by common assent by the Executive Board.</b></li><li>• <b>Only the KCE is responsible for errors or omissions that could persist. The policy recommendations are also under the full responsibility of the KCE.</b></li></ul>
Publication date:	19 January 2016 (2 <sup>nd</sup> print; 1 <sup>st</sup> print: 4 January 2016)
Domain:	Health Services Research (HSR)
MeSH:	Alcohol Drinking, Alcoholism, Alcohol-Related Disorders, Counseling, Early Medical Intervention, Primary Health Care
NLM Classification:	Alcoholism WM
Language:	English
Format:	Adobe® PDF™ (A4)
Legal depot:	D/2015/10.273/116
ISSN:	2466-6459
Copyright:	KCE reports are published under a “by/nc/nd” Creative Commons Licence <a href="http://kce.fgov.be/content/about-copyrights-for-kce-reports">http://kce.fgov.be/content/about-copyrights-for-kce-reports</a> .





How to refer to this document?

Mistiaen P, Kohn L, Mambourg F, Ketterer F, Tiedtke C, Lambrechts MC, Godderis L, Vanmeerbeek M, Eyssen M, Paulus D. Reduction of the treatment gap for problematic alcohol use in Belgium. Health Services Research (HSR) Brussels: Belgian Health Care Knowledge Centre (KCE). 2015. KCE Reports 258. D/2015/10.273/116.

This document is available on the website of the Belgian Health Care Knowledge Centre.



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## LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
AA	Alcoholics Anonymous
AOD	Alcohol and Other Drugs
AUD	Alcohol Use Disorder
AUP	Alcohol Use Problem
CI	Confidence Interval
CME	Continuing Medical Education
CRAFT	Community Reinforcement and Family Training
DSM-V	Diagnostic and Statistical Manual of Mental Disorders 5 <sup>th</sup> edition
ED	Emergency Department
GP	General Practitioner
INEBRIA	International Network on Brief Interventions for Alcohol and other Drugs
NICE	National Institute for Health and Clinical Excellence
OP	Occupational Physician
OR	Odds Ratio
SBI	Screening and Brief Intervention
SBIRT	Screening, Brief Intervention and Referral to Treatment
SES	Socio-Economic Status
WHO	World Health Organization



## ■ SCIENTIFIC REPORT

### 1 ABSTRACT

#### 1.1 Background

Alcohol consumption is a widespread phenomenon in western societies and it is a significant cause of morbidity and mortality. Problematic alcohol use affects an estimated 3.6% of the population between 15 and 64 years of age worldwide.<sup>1</sup> The Belgian health survey<sup>2</sup> found that 10% of the Belgian population has a problematic alcohol use.

However, only a small proportion of people with a problematic alcohol use seeks or receives treatment. A European study (including Belgium) found that only 8% of persons with an alcohol problem had consulted some form of professional assistance in the past year.<sup>3</sup> A Belgian study<sup>4</sup> found that 12.8% of persons with an alcohol use problem indicated they searched for help in the year after the problem started but 61% did so in later years with a mean delay of 18 years. So, many people who could profit from help/assistance do not seek or receive it and there is a long delay. It may be concluded that there is a large 'treatment gap'.

#### 1.2 Research aim

To analyse explanations for the treatment gap and to find ways and interventions, including facilitators and barriers in applying these, to improve the treatment rate of people with problematic alcohol use in Belgium.

#### 1.3 Methods

This study applied 3 research approaches:

- Review of the international and Belgian literature
  - Medline, EMBASE, Cochrane Library and Psycinfo and grey literature sources were searched in summer 2014 for review studies and for Belgian primary studies with date limit >2000 and written in English, Dutch, French or German
  - Literature was categorized into barriers/facilitators for seeking/starting treatment in individuals with problematic alcohol use, in care professionals and in society and into interventions for reducing the treatment in the mentioned three groups
  - Only descriptive analyses of the literature were applied



- Qualitative research by interviews with persons with an alcohol use problem (n=14), and interviews and focus groups with care professionals, and experts in the alcohol field (n=60)
  - To identify the factors on a personal, organisational and societal level that impede or facilitate the screening and advice given by professionals, initiation of treatment, and treatment-uptake by individuals with AUP;
  - To understand the complex interactions between those factors;
  - To identify the interventions/measures the surveyed individuals and professionals would consider effective in reducing the treatment gap from the point of view of the professionals and patients.
- Delphi study with persons with an alcohol use problem, care professionals, policy makers and experts (total across groups n= 35) in the alcohol field to check acceptability and priority of recommendations for improvement of the treatment
  - Two rounds by online questionnaire were planned and a face to face meeting afterwards with Delphi-participants to discuss results of previous rounds and to reach final agreement

## 1.4 Results

In the literature study 85 relevant reviews and 22 Belgian primary studies were included. It was found that individuals with AUP follow a long road before seeking help. Main barriers along the road are denial of the problem, belief that alcohol problems may improve on their own, desire to handle problems on their own, thinking that treatment is ineffective or uncomfortable, dislike of the prevalent group, fear of stigma, lack of financial resources and other. Next it was found that care professionals face also many barriers to initiate a kind of intervention; common mentioned barriers are lack of time and lack of knowledge and confidence. Also it appeared there is a societal/public stigma towards people with a problematic alcohol use, causing a barrier for affected persons to seek help.

Several effective interventions targeted at easing patient barriers and help them to seek treatment or initiate behaviour change were found: Screening-brief interventions-referral to treatment (SBIRT) by health care professionals, internet based screening and awareness programs,

community reinforcement and family training, workplace interventions and stigma reducing interventions.

Also a large amount of research was found to overcome these impediments. Main intervention for patients is making them aware of their problem, e.g. by screening on alcohol use and motivational brief interventions. Main interventions for professionals is to train and to motivate them to screen and give brief interventions; however, all reviews stated as well that there was a lot of diversity in training formats and intensity, making it difficult to synthesize the results and to define the optimum duration and format of such initiatives. Interventions at a societal level are less clear

The qualitative study revealed that several barriers as well as facilitators are experienced by individuals with AUP and professionals. It appears that the treatment gap is a multiple phenomenon. Some elements are related to the individuals with an AUP, some others to the health professionals, and, more globally, in the socioeconomic context. Four main themes could be deduced from the interviews: individuals with AUP go through a long and stepped (however not always a linear) process before becoming aware of and recognising their problem; relatives (at home or in the social network) and colleagues (at work) play an important role along the persons' trajectory; professionals lack the time, knowledge, skills and proper attitudes and they pass the buck when it comes to tackling the AUP; and the origin and treatment of AUP are largely influenced by societal habits and views. It appeared that more information is needed among the general population about alcohol-related problems and healthcare professionals' knowledge on the topic, and the skills to manage it properly should be enhanced. In addition contextual and societal barriers have to be tackled.

The Delphi-study resulted in a general consensus on all proposals, based on the literature and the qualitative study. But it was stressed that it is necessary to implement the proposals simultaneously to enhance synergy.

## 1.5 Conclusion

The three research approaches confirmed each other and showed that the treatment gap for persons with problematic alcohol use is a multi-layered problem (individuals with AUP, their relatives, professionals, care system and general society). There are effective interventions to lower the treatment gap, but to obtain maximal effectiveness measures have to be taken at all levels in simultaneous way.



## 2 BACKGROUND AND PROBLEM DESCRIPTION

*Chapter Authors: Patriek Mistiaen & Laurence Kohn*

Alcohol consumption is a widespread phenomenon in our and other societies. In the European Union countries 89% of men and 82% of women aged 15–64 years are current drinkers<sup>5</sup> and the average daily consumption is around 3 standard drinks per day in most European countries<sup>6</sup>. In Belgium 82% of the population (15 year and older) uses alcohol and 14% consumes daily alcohol.<sup>2</sup>

Alcohol use is also a significant cause of morbidity and mortality. According to a recent WHO-report<sup>1</sup> the use of alcohol is a component cause of more than 200 disease and injury conditions in individuals, most notably alcohol dependence, liver cirrhosis, cancers and injuries. Mortality attributed to alcohol use is estimated at 1 in 7 deaths for men and 1 in 13 deaths for women.<sup>5</sup> Alcohol use disorders, are globally one of the most prevalent mental disorders, affecting an estimated 3.6% of the population between 15 and 64 years of age worldwide (men 6.3%; women 0.9%).<sup>1</sup>

The Belgian health survey<sup>2</sup> found that 10% of the Belgian population has a problematic alcohol use (based on the CAGE-criteria); the Flemish Association for Alcohol and other Drug Problems (VAD)<sup>7</sup> estimates that Belgium counts approximately 5 to 7% of the population that have a problematic drinking pattern (that is >4 standard units of alcohol per day for women or > 6 for men), and Rehm et al.<sup>8</sup> state that 5.4% of Belgian men and 1.9% of Belgian women aged 18–64 are affected with alcohol dependence. It is also a common problem in elderly: a study in 4825 Belgian 65+ aged people found that 10.4% were 'risky-drinkers', 4.6% 'heavy drinkers' and 5.5% 'problematic drinkers'.<sup>9</sup>

**It may be clear that problematic alcohol use is an extensive problem.**

Decreasing use of alcohol has positive health effects; treatment can reduce alcohol-related problems and alcohol-related mortality.<sup>10</sup> Moreover there are many recent evidence-based guidelines available for detecting, assessing and treating alcohol use disorders.<sup>10-12</sup> However, only a small proportion of people with a problematic alcohol use seeks or receives treatment. A

European study (including Belgium) found that only 8% of persons with an alcohol problem had consulted some form of professional assistance in the past year,<sup>3</sup> another study in six European countries showed that only 10% of the persons with an alcohol dependence received treatment for it.<sup>13</sup> Comparable figures come also from the USA.<sup>14, 15</sup>

A Belgian study<sup>4</sup> found that 12.8% of persons with an alcohol use problem indicated they searched for help in the year after the problem started but 61% did so in later years with a mean delay of 18 years. A recent Dutch study<sup>16</sup> found that 54% of persons with an alcohol problem did not receive/sought some kind of formal help within 4 years.

**So, many people who could profit from help/assistance do not seek or receive it and there is a long delay. It may be concluded that there is a large 'treatment gap'.**

This treatment gap is considered as the highest in all mental health services. Increasing treatment coverage to 40% of all people with alcohol dependence was estimated to reduce alcohol-attributable mortality by 13% for men and 9% for women.<sup>5</sup> Therefore, it is important to find ways to increase the treatment uptake. When people suffer from this problem it is then important to identify them, to refer them to the appropriate service in order to increase the uptake in the care system.

The treatment gap can be explained by several factors, related to patients as denial of individuals they have a problem or shame to admit it or being afraid that when seeking help they will be expected to refrain totally from drinking, related to caregivers as insufficient knowledge to detect problematic alcohol use or insufficient time to do so or don't see this as part of their jobs or insufficient knowledge of and experience with treatment options, or related to more societal factors as social acceptance of (excessive) alcohol use, taboo on mental health problems, inadequate insurance coverage of treatments or insufficient specialized manpower. More insight in these explanations is needed to be able to adequately improve the treatment uptake.



## Natural recovery

As mentioned above, only a small proportion of people with a problematic alcohol use seeks or receives treatment and there is a substantial treatment gap. However, there is evidence that most people with an alcohol problem are able to change their problematic behaviour without any kind of formal/professional help<sup>16-22</sup>; the percentages of people able to solve their problem on their own vary (from 25%<sup>21</sup> to 78%<sup>16</sup> partly depending on the severity level of the alcohol use problem in the studied population).

## 2.1 Research objective

This project aims to analyse explanations for the treatment gap and to find ways and interventions, including facilitators and barriers in applying these, to improve the treatment rate of people with problematic alcohol use in Belgium.

## 2.2 Definitions

This field of research is characterized by a wealth of terms and definitions to describe the problematic use of alcohol and, as well as what is considered treatment, and consequently what is considered treatment gap.

### 2.2.1 Problem

The most recent version of the Diagnostic and Statistical Manual of Mental Disorders DSM-5<sup>23</sup> use the term 'alcohol use disorder'. A person is considered to have an 'alcohol use disorder' if at least two of the eleven criteria below are met. The disorder is considered mild with 2-3 positive criteria, moderate with 4-5 and severe with  $\geq 6$ .

- Alcohol is taken in larger amounts or over a longer period than intended.
- Persistent desire or unsuccessful efforts to cut down or control alcohol use.
- A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
- Craving, or a strong desire or urge to use alcohol.
- Recurrent alcohol use resulting in a failure to fulfil major role obligations at work, school, or home.

- Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
- Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
- Recurrent alcohol use in situations in which it is physically hazardous.
- Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
  - A markedly diminished effect with continued use of the same amount of alcohol.
- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for alcohol.
  - Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms

However, there are many other definitions and terms used. In Belgium, the CAGE-questionnaire<sup>24</sup> is used in the National Health Survey.<sup>2</sup> A person is considered to have a 'problematic alcohol use' in case of two positive answers on the four questions below:

- Have you ever felt you should cut down on your drinking?
- Have people annoyed you by criticizing your drinking?
- Have you ever felt bad or guilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

Other terms frequently encountered are harmful drinking, risky drinking, heavy drinking, problematic drinking, hazardous drinking, alcohol misuse, alcohol abuse, alcohol overuse, alcoholism and alcohol dependence.

In this study, we did not apply strict terms or definitions to select the literature or applied in the qualitative part, in order to cover the problem as



comprehensive as possible. Throughout the report we mostly use the term **‘problematic alcohol use’**.

### 2.2.2 Treatment

In analogy of the mixed terminology of the problem, it is not always clear when an intervention is considered as ‘treatment’ for problematic alcohol use. Treatment (intervention) options vary from initial screening, brief interventions by applying motivational interviewing, giving advice, awareness programs, psychological approaches, peer support groups to pharmacological treatments (oversights of treatment options appropriate to different severity levels of problematic alcohol use and to the person’s stage of behaviour change can be found in among others.<sup>10-12, 25</sup> Also there is not always a clear distinction if an intervention is intended to treat the problematic alcohol use or if it is rather applied as an intervention to lead persons with problematic alcohol use to an appropriate treatment. This is especially the case with awareness programs and screening interventions that may have both effects: decrease of problematic alcohol use and leading to further treatment.

For this study we did not search for treatments of the problematic alcohol use itself but for interventions that are aimed to lead persons with problematic alcohol use to further treatment and to increase the treatment uptake.

### 2.2.3 Treatment gap

The treatment gap is the amount of persons with a problematic alcohol use that need or could benefit from a kind of treatment and do not receive it or have no access to it and aren’t able to solve the problem on their own.

## 2.3 Policy relevance

Problematic alcohol use is considered as a public health problem in Belgium. In 2013, the General Drug Policy Cell discussed and elaborated a national alcohol plan aimed to tackle this problematic use in Belgium. The treatment gap was one of the important issues in the discussion. The plan was not approved by the Inter-Ministerial Conference, but the issue will remain on the political agenda for the coming years and is a main concern for Directorate General Health Care and the Federal Public Service Health.

## 2.4 Research questions

### 2.4.1 First research question

What are the reasons for treatment gap?

- Is there a theoretical model that gives elements to highlight the low uptake of persons with problematic alcohol use in the care system?
- What barriers and facilitators do persons with an alcohol use problem experience to seek help?
- What are barriers and facilitators in (health) care professionals to detect, assess and intervene in persons with an alcohol use problem?
- What factors are there on a societal level that impede or facilitate to intervene for persons with an alcohol use problem?

### 2.4.2 Second research question

What interventions/measures are there that can enhance treatment uptake and how effective are these?

- as described in the literature
- or suggested by stakeholders

### 2.4.3 Third research question

What interventions/measures that can enhance treatment uptake are feasible in the Belgian context?

## 2.5 Methods

This study applied 3 research approaches:

- Review of the international and Belgian literature
- Qualitative research by interviews and focus groups with persons with an alcohol use problem, care professionals, policy makers and experts in the alcohol field
- Delphi rounds with persons with an alcohol use problem, care professionals, policy makers and experts in the alcohol field to check acceptability and priority of recommendations for improvement of the treatment

Each of the methods are extensively described in the following chapters.





### 3 LITERATURE REVIEW: BARRIERS, FACILITATORS AND INTERVENTIONS

*Chapter Authors: Patriek Mistiaen, Françoise Mambourg, Laurence Kohn & Marijke Eyssen*

As stated in the general introduction many persons with a problematic alcohol use do not receive treatment.

Treatment coverage of the population with alcohol dependency is estimated around 10% only.<sup>3, 8</sup> The [USA National Survey on Drug Use and Health](#) states that “among the persons aged 12 or older who needed treatment for an alcohol use problem in 2011, only 8.5 percent of the people received alcohol use treatment at a specialty facility”.<sup>15</sup>

The **treatment gap** can be explained by several factors, related to **patients** as denial of patients who have a problem or shame to admit it or being afraid that when seeking help they will be expected to refrain totally from drinking, related to **caregivers** as insufficient knowledge to detect problematic alcohol use or insufficient time to do so or don't see this as part of their jobs or insufficient knowledge of and experience with treatment options, or related to more **societal** factors as social acceptance of (excessive) alcohol use, taboo on mental health problems, inadequate insurance coverage of treatments or insufficient specialized manpower. More insight in these explanations is needed to be able to adequately improve the treatment uptake. Also more insight is needed in the array of interventions that may help to reduce this treatment gap and into the effectivity of those interventions.

In this chapter results from the literature review are presented.

#### 3.1 Method

As a first step in the project we did a ‘scoping review’ to get insight in what is already known.

A scoping review can be best described as ‘summarizing a range of evidence in order to convey the breadth and depth of a field’.<sup>26</sup> Some key differences with a systematic review include formulating broad research aims (i.e., no focused questions with narrow parameters), developing and refining in- and exclusion criteria for papers during the review process (i.e. post hoc instead of a priori).

We did not aim to find ALL evidence, neither to end with definite conclusions and recommendations, but only to get a firm grasp on the matter and to feed the qualitative research part that follows.

We set such aims, because of the enormous amount of literature in the field of alcohol and other drugs (AOD) and because the large variation in language in this field. It is therefore not feasible to develop a single, definitive search strategy encapsulating all the relevant complexity and inconsistency in language/terminology without retrieving an unmanageable number of redundant records.

Instead of aiming to identify the relevant literature using a single search, we have adopted (as was also done in a review of NICE)<sup>27</sup> an emergent approach, which attempts to identify evidence that will inform understanding of the problem area. This evidence is then explored in order to inform further retrieval by the identification of useful search terms and keywords/index terms, in other data sources and by checking cited and citing publications. The process is cyclic with searching continuing until no new useful ideas/evidence were identified and within the limited time to do the literature review.



### 3.1.1 Searches

First, Medline, EMBASE, Cochrane Library and Psycinfo were searched and restricted to reviews, systematic reviews, meta-analyses or practice guidelines. The search strategies (appendix 1) were based on this initial Pubmed-search string:

((("help seeking" OR denial OR blame OR shame OR stigma OR "treatment refusal" OR "treatment gap" OR "treatment coverage" OR "treatment uptake" OR "brief intervention" OR "brief interventions" OR "SBIRT")) AND (("National Institute on Alcohol Abuse and Alcoholism (U.S.)"[Mesh] OR "Alcohol-Induced Disorders"[Mesh] OR "Alcohol-Related Disorders"[Mesh] OR "Alcohol Drinking"[Mesh] OR "Alcoholism"[Mesh]))

As a second step, the titles/abstracts of the obtained references were screened independently by two reviewers to see if the reference concerned:

- a theoretical model about help seeking (help avoiding) behavior in patients with alcohol use disorder  
OR
- a review of (qualitative) research in (adult) patients why or why not they searched for help and/or what obstacles or facilitators they encountered along the way or about interventions to overcome those barriers  
OR
- a theoretical model about behavior of health care professionals concerning detecting or treatment initiating for patients with alcohol use disorder  
OR
- a review of (qualitative) research in health care professionals why or why not they screened and/or initiated treatment for persons with alcohol use disorder and/or what obstacles or facilitators they encountered along the way or about interventions to overcome those barriers  
OR
- a review of societal factors that influence help seeking behavior of patients or screening/treatment behavior of care professionals

Exclusion criteria were studies on binge drinking, studies in adolescents, studies in patients with a major primary psychiatric diagnosis and alcohol use problems as a secondary diagnosis and studies in persons where the main problem was cocaine or other drug use disorder.

Next, full texts were obtained of the references, of which title/abstracts fulfilled above criteria, and full-texts were then again assessed on those criteria independently by two reviewers.

In the third step, we searched for publications that cited one of the references that were included in step 2. The references obtained this way, were then assessed with the same criteria as in step 2, with the exception that we did no longer restrict to review articles. To find citing articles we used Google scholar, assessed through 'Harzing's Publish or Perish' ([http://www.harzing.com/pop.htm?source=pop\\_4.6.4.5271#about](http://www.harzing.com/pop.htm?source=pop_4.6.4.5271#about)), since this contains both citing scientific articles as well as citing grey documents.

In step 4, grey literature was searched on the websites of a selection of (international) alcohol/addiction (research) organizations for publications on our topic. The choice for databases/websites was partially based on the document of Ali et al.<sup>28</sup> concerning finding grey literature on drugs, alcohol and HIV research; furthermore we restricted to western countries and that have a for us easy understandable language (Dutch, English or French). Searching and screening on inclusion criteria was done simultaneously by a single reviewer.

Following websites were checked:

- Australia:
  - [National Drug and Alcohol Research Centre](#)
  - [The National Centre for Education and Training on Addiction](#)
- Belgium:
  - [FOD, cel drugs](#)
  - [Biblio-Drogues](#)
  - [la Fédération Wallonne des institutions pour toxicomanes](#)
  - [La Fédération Bruxelloise des Institutions pour Toxicomanes](#)
  - [Eurotox ASBL, Observatoire Socio-Épidémiologique Alcool-Drogues, Fédération Wallonie-Bruxelles](#)
  - [Vereniging voor Alcohol- en andere Drugproblemen](#)



- [Wetenschappelijk Instituut Volksgezondheid](#)
- Canada:
  - [The Canadian Centre on Substance Abuse](#)
  - [Centre for Addiction and Mental Health](#)
- Europe:
  - [The European Monitoring Centre for Drugs and Drug Addiction](#)
  - [Optimizing delivery of health care interventions project](#)
  - [Amphora, Alcohol Public Health Research Alliance](#)
  - [Phepa, Primary Health Care European Project on Alcohol](#)
- France:
  - [L'Association Nationale de Prévention en Alcoologie et Addictologie](#)
  - [Alcool Assistance](#)
  - [Société Française d'Alcoologie](#)
- International:
  - [International Society for the Study of Drug Policy](#)
  - [SALIS, Substance Abuse Librarians & Information Specialists](#)
  - [inebria international network on brief interventions for alcohol and drugs](#)
- Netherlands:
  - [Trimbos instituut](#)
  - [IVO, wetenschappelijk bureau voor onderzoek, expertise en advies op gebied van leefwijzen en verslaving](#)
- UK:
  - [The National Addiction Centre](#)
  - [National Treatment Agency for Substance Misuse](#)
  - [King's College, Addictions Department, the Section of Alcohol Research](#)
  - [Alcohol Research UK](#)
  - [Drug and Alcohol Findings](#)
- USA:

- [The National Institute on Alcohol Abuse and Alcoholism \(NIAAA\), Alcohol and Alcohol Problems Science Database](#)
- [Centers for Disease Control and Prevention, Alcohol and Public Health](#)
- [The Substance Abuse and Mental Health Services Administration](#)
- [the National Institute on Drug Abuse](#)
- [Library Alcohol & Drug Abuse Institute, University of Washington](#)
- [The Drug Policy Alliance](#)

Additionally, two repositories ([www.openaire.eu](http://www.openaire.eu) and [www.oaister.org](http://www.oaister.org)) were searched with 'alcohol AND barrier'.

Step 5 was the search in two Belgian catalogues specialized in alcohol and drugs (<http://www.biblio-droques.be/>; <http://vad-koha.ossllabs.biz/>); search strategies for these were developed in cooperation with the librarians of these catalogues.

As step 6, the 2014 conference of the International Network on Brief Interventions for Alcohol and other Drugs (INEBRIA) was attended and relevant abstracts were selected.

Step 7 concerned requests to Belgian experts in the field of alcohol, which were present at the initial stakeholders meeting of this project, to complement the literature.

In step 8, all obtained relevant documents in previous steps were screened on important references that were missed earlier.

All searches were done in September 2014.

In the applied approach searching and selecting is combined, and due to the nature of the data sources and the selection procedure, it is not possible to give an overview of all references that were seen but excluded. Also this approach requires serendipity in finding things and is inevitably also influenced by subjectivity of the selector. This causes that the method is not exactly reproducible, and we can not definitely state we found all relevant material.



### 3.1.2 Selection

All documents that were obtained, were then merged into one database, containing 443 documents. Since these documents now contained many different type of study methodologies, these were then initially categorized on research aim (barriers in patients, barriers in professionals, interventions for patients, interventions for professionals, etc..) and type of study (review, questionnaire, trial, etc.). Also references with an origin in Belgium, or containing data from Belgium were labelled.

In order to handle the large amount of references within a restricted time frame, we first checked for each research question the category 'reviews' (207 were labelled as such) if there was a (one or more) methodological well performed review (*minimal criteria here for were: (1) search sources documented in publication, (2) at least 2 literature sources searched (3) and at least MEDLINE/pubmed, (4) search strategy documented in publication or obtainable from authors, (5) selection criteria documented in publication*). In this way, we could reduce the 207 reviews to 105 'well-documented' reviews, still too large to handle. Therefore, a second reviewer went through these references with some additional criteria (language is English, Dutch, French or German, publication date is 2000 or younger, document has to be alcohol specific or at least give separate results when more drugs were studied, research population belongs to western countries, exclusion of cost-effectiveness studies and exclusion of studies concerning patients with major psychiatric disorder). In this way the number of reviews was reduced to 85, of which 9 concerned patient barriers, 64 interventions for patients, 8 barriers in professionals, 15 interventions for professionals, 4 barriers in society and 2 interventions at societal level (categories not mutual exclusive, some reviews discussed both barriers and interventions, or both patients and professionals).

With regard to the reviews about interventions for patients, 47 concerned 'Screening-Brief Interventions-Referral to Treatment (SBIRT)'-interventions, and therefore we further restricted this subcategory to the 7 meta-reviews only.

With regard to the reviews about interventions for professionals, we made a further selection to reviews specifically related to the alcohol field and presenting outcome data on either number of patients screened, number of patients given brief interventions or frequency of raising the issue of alcohol consumption.

Inclusion flow is depicted in Figure 1.

The reviews as selected above were the base for each of the research questions.

Additionally, we used references of other research design types, as trials, surveys or qualitative studies, to **illustrate** the findings of the reviews and/or to have more insight into the amount of factors. The selection of these references was not systematically nor exhaustive, but only those that illustrated best the issues at stake.

Finally, for each of the research questions we looked at Belgian empirical data.

### 3.1.3 Data extraction & synthesis

We performed data-extraction on the selected reviews for each questions. Reviews were assessed on their risk of bias with the Amstar instrument. Data were gathered about applied data sources and search period, number and type of included studies and country of origin, characteristics of population, interventions, outcomes and effects, as sought in the reviews and as analysed.

Data-extraction was done in Excel by one reviewer and checked by a second.

Since our base were reviews, we only synthesized findings in a descriptive way and did not attempt to pool results in a mathematically way.



Table 1 – Inclusion Flow

DATABASES SEARCH		Medline =219; EMBASE = 89; Cochrane = 57; Psychinfo = 45 TOTAL = 412			
			Duplicates: -96		
	316		Exclusion on TIAB: -213	Ex Population: 45 Ex Topic: 145 Ex design:23	
	103		Not obtainable: -2		
	101		Exclusion on full text: -23	Ex Population: 2 Ex topic: 8 Ex design: 13	
	78				
EXTRA SEARCHES : Special libraries: 31 / Websites: 66 / Inebria: 13 / Expert meeting: 1 / Citing_cited search: 253 TOTAL: +365					
	443				
		-236	Further selection to reviews		
	207				
		-52	Further criteria (>2000; western countries; English/Dutch/French/German; no cost-effectiveness)		
	153				
		-70	Further criteria (≥2 databases, at least Pubmed, search strategy presented)		
	85				
Categorized to research question					
Patient barriers	Pat barriers intervention	Prof barriers	Prof barriers intervention	Societal barriers	Societal barriers intervention
9	64	8	15	3	2
	SBIRT: 47	Non SBIRT:17			
	SBIRT meta review: 7		With strict outcome: 5		



## 3.2 Results

Results are presented by research question; for each of the research questions the main findings are showed at the beginning, followed by an in more depth description. Also for each question, results based on the reviews are firstly presented, followed by illustrations from primary research and then data from Belgian empirical studies.

### 3.2.1 Patient barriers and facilitators

#### MAIN FINDINGS Patient barriers:

- Denial of the problem or insufficient recognition of it is stated in 3 reviews as the main barrier for patients to initiate treatment seeking
- Denial of the problem was found to be present in 70-80 % of the patients with AUD in large scale studies in USA and Europe
- Next to denial, there are other personal and treatment related barriers that exist when patients have passed the problem recognition phase. Examples of person related barriers are feeling embarrassed they have a problem or no time available or inadequate insurance coverage; examples of treatment related barriers are being unaware of what treatments are available or not believing that treatment would really help
- Two reviews found that stigma exists on several levels; in the persons themselves, in professionals and in society towards patients with an alcohol problem and all three may act as a barrier for patients to seek help
- Two Belgian empirical studies also mention stigma as a barrier
- The studied reviews did not present the magnitude/frequency of these barriers
- Facilitators to start seeking help mentioned in the reviews are help/support of family, friends and colleagues and a good relationship between patient and health care professional

- Based on 4 reviews, it seems that most patients find it acceptable that health care professionals discuss alcohol intake as part of the initial assessment in a consultation or at ED-visit; however acceptability is lower in risky drinkers.
- There are some Belgian empirical data showing that screening for alcohol use is acceptable to patients.

#### 3.2.1.1 Reviews

Nine reviews<sup>29-37</sup> fulfilled our inclusion criteria concerning barriers and facilitators in patients.


**Table 2 – barriers in patients; characteristics of reviews**

Reference	Methodology	Population characteristics	Research topic	Critical appraisal of review quality
<b>Council_2004</b>	N data sources: 5 Searched period: 1990-2001 N included studies: unclear Funding: the Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA), and by Research Triangle Institute	All substance users Studies origin: unclear	Health Services Utilization by Individuals with Substance Abuse and Mental Disorders	Amstar: 1 Synthesis: descriptive
<b>Johnson_2011</b>	N data sources: 6 Searched period: 1997-2008 N included studies: 47 Funding: National Institute for Health and Clinical Excellence (NICE)	Patients and professionals (most primary care)  Studies origin: (primary studies) Canada 1x Denmark 2x Finland 7x Germany 1x New Zealand 1x Sweden 2x UK 19x USA 9x	Barriers and facilitators to implementing screening and brief intervention for alcohol misuse	Amstar: 2 Synthesis: descriptive
<b>Kulesza_2013</b>	N data sources: 2 Searched period: 1990-2011 N included studies: 28 Funding: training grant	mixed, mostly on patients with substance abuse, only 4 about AUDs alone  Studies origin: Asia 2x Canada 2x Europe 2x USA 22x	Substance Use Related Stigma	Amstar: 2 Synthesis: descriptive
<b>Leong_2014</b>	N data sources: 3 Searched period: 1980-2014 N included studies: 17	GP patients  Studies origin: Australia 2x	Patient beliefs and attitudes towards the acceptability of receiving alcohol use enquiry from general practitioners	Amstar: 3 Synthesis: descriptive



	Funding: Royal Australian College of General Practitioners	Canada 2x Europe 1x Finland 3x Sweden 2x UK 6x USA 1x		
<b>Littlejohn_2006</b>	N data sources: 7 Searched period: 1987-2005 N included studies: 18 Funding: no funding	non-dependent, hazardous, or harmful alcohol drinking in primary care settings.  Studies origin: not clear from review	Does socio-economic status influence the acceptability of, attendance for, and outcome of, screening and brief interventions for alcohol misuse	Amstar: 3 Synthesis: descriptive
<b>McKellar_2012</b>	N data sources: 2 Searched period: 1990-2011 N included studies: 18 Funding: not stated	patients with AUD only  Studies origin: not specified	low-intensity interventions for stepped care	Amstar: 4 Synthesis: descriptive
<b>Pedersen_2011</b>	N data sources: 6 Searched period: up to 2010 N included studies: 33 Funding: no funding	emergency and surgical patients  Studies origin: Australia 2x Denmark 1x Finland 1x Germany 1x Spain 3x Sweden 2x Switzerland 1x UK 6x USA 16x	Will emergency and surgical patients participate in and complete alcohol interventions?	Amstar: 6 Synthesis: quantitative
<b>Schomerus_2011</b>	N data sources: 5 Searched period: up to 2010 N included studies: 17 Funding: Glaxo SmithKline and Lundbec	General population  Studies origin: Brazil 1x Ethiopia 1x Europe 7x New Zealand 3x North America 5x	The stigma of alcohol dependence compared with other mental disorders	Amstar: 2 Synthesis: descriptive





<b>Tsogia_2001</b>	N data sources: 2 Searched period: 1990-2001 N included studies: 19 Funding: not stated	problem drinkers and/or drug misusers;  Studies origin: Can 2x IRL 1x NL 1x UK 1x USA 13x	Entering treatment for substance misuse	Amstar: 1 Synthesis: descriptive
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First, the individual reviews are discussed alphabetically below and secondly the reviews are put together and summarized according to factor considered.

In the Council review,<sup>29</sup> the health services utilization by individuals with substance abuse is studied in the context of the USA insurance system (end of the XX century). These are the barriers facilitators and influencing factors they found for patients:

- Barriers :
  - Demographic factors as race/ethnicity and rural residence
  - Homeless persons
  - No employment, no insurance coverage
  - Deny that patient need treatment
  - Financial barriers
  - Older persons
  - Lack of capacity in treatment programs
  - Restrictive costs of treatment
- Facilitators :
  - Providing social services for mothers
  - Being employed
  - Pressure from colleagues
  - Physical consequences of abuse
  - Attention to disorder by health care professionals

- Influencing factors :
  - Age at first use of alcohol (the earlier the use the greater is the likelihood for substance abuse)
  - Men are more likely to need treatment than women.
  - Need increases with age up to the mid-30s and then declines
  - race and ethnicity : no influence
  - The influence of predisposing factors—such as level of educational attainment, income, and employment status—on treatment need is still being evaluated.

Johnson et al.<sup>30</sup> identified barriers and facilitators to intervention implementation at organizational, provider and patient level. The publication is mainly on barriers and facilitators in professionals to start screening and give brief interventions (see paragraph 3.2.3). With regard to factors at patient level, they state some particular patient characteristics are associated with a higher likelihood to be approached by professionals to discuss their drinking, namely, being male, being unemployed and (in USA) from black or Hispanic origin. A good rapport between patient and professional was found to be a facilitator to discuss an eventual drinking problem. Finally they found that the majority of patients expressed positive attitudes toward screening and discussing drinking.

Kulesza et al.<sup>31</sup> have conducted a review investigating the relationship between stigma experienced by individuals who use drugs. They discerned 4 types of stigma: public, perceived, enacted, and self-stigma. *Public stigma* has been defined as the endorsement by the public of prejudice against a specific stigmatized group, which manifests in discrimination towards



individuals belonging to that group. *Perceived stigma* refers to a process whereby stigmatized individuals think that most people believe common negative stereotypes about individuals belonging to the same stigmatized category as they do. *Enacted stigma*, was described as a direct experience of discrimination and rejection from members of the larger society. Finally, *self-stigma* was defined as negative thoughts, feelings, and diminished self-image resulting from identification with the stigmatized group and anticipation of rejection from the larger society. They found that alcohol users are more stigmatized than people who use other drugs. Inconclusive results on the relationship between stigma and demographic variables; alcohol/drug use severity or self-efficacy. Also they found that those with higher level of perceived public stigma towards individuals who use drugs were less likely to have a history of past year treatment utilization. So different types of stigma may act as barriers to seek help.

Leong et al.<sup>32</sup> studied patient beliefs and attitudes towards the acceptability of receiving alcohol use enquiry from general practitioners. Participants in the included studies resembled a community general practice population and they excluded studies in which participants had specifically alcohol use disorder. Based on 15 quantitative and 2 qualitative studies, they suggested that although alcohol discussions are less acceptable than those on other health promotion topics, overall patients were positive towards alcohol discussions with their GPs, be it with striking variations in estimates between studies. Only few patients held categorically negative views to GP alcohol enquiry; risky drinkers were half as likely to have wanted advice. There was some evidence that patients preferred alcohol discussion to be held with GPs or practice nurses over other health professionals. Furthermore they found as facilitators to discuss alcohol use if the topic was brought up by the patient, it was perceived by the patient to have been related to the reason they came, if it is linked to a current health problem and if the consultation time was perceived as sufficient.

Littlejohn<sup>33</sup> studied if the socio-economic-status (SES) of a patient influenced acceptability of, attendance for, and outcome of, screening and brief interventions for alcohol misuse. Twelve studies provided data on numbers of positively screened potential participants who declined to participate in brief intervention research. On average 38% (SD 21.41, 95% CI 25.89–50.15) of potential participants declined to participate following screening. There was no clear relationship of SES.

McKellar et al.<sup>34</sup> reviewed low-intensity interventions that can be tailored to address many of the perceived barriers that hinder individuals with AUDs from seeking help. This systematic review of interventions contains nevertheless a narrative description of some kinds of barriers:

- Individuals' perceptions of negative concomitants of treatment:
  - including stigma
  - dislike of the prevalent group format
  - emphasis on spirituality in treatment
  - self-help groups
  - lack of privacy ,
  - concern that treatment is ineffective
  - disinterest in abstinence goals
- Other common individuals 'reasons involve:
  - a desire for autonomy and/or a wish to "handle problems more on their own"
  - the belief that their alcohol problems are not serious or may improve on their own
- Practical considerations:
  - need for childcare
  - the problem of arranging transportation
  - traveling long distances to care
  - the cost of treatment and lack of adequate insurance
  - high time commitment for standard alcohol treatment
  - interference with responsibilities to family or work.

Pedersen et al.<sup>35</sup> performed a systematic review to assess first acceptance of screening among emergency department and surgical patients and secondly the acceptance of interventions for those positively screened for alcohol use disorders. The median screening acceptance rate and intervention acceptance rate for emergency patients were respectively 83% (range 31-98%) (based on 18 studies) and 67% (21-96%) (based on 23 studies). For surgical patients they were respectively 65% (47-83%) (based on 2 studies) and 99% (54-100%) (based on 5 studies).



Schomerus et al.<sup>36</sup> reviewed, based on 17 general population studies, the magnitude of public stigma on alcohol dependence compared with other mental disorders. In comparison with depression and schizophrenia, they found that:

- Alcoholism was less commonly regarded a mental illness
- Alcohol-dependent patients are held much more responsible for their condition
- With regard to unpredictability and being dangerous, alcohol dependent persons were ranked similarly
- Alcohol is seen as a same dangerous conditions
- Alcohol-dependent people evoked more irritation, anger and repulsion
- Alcoholism being rejected most
- Alcoholism was named most frequently (by 78%) in studies addressing acceptance of structural discrimination

They suggest that public stigma may impede the seeking of help for alcoholism.

Tsogia et al.<sup>37</sup> performed a research on the reasons for or against entering treatment for alcohol and drug misuse. They included 18 studies applying a quantitative method, 3 studies applying a qualitative approach and 1 review. Tsogia et al.<sup>37</sup> divided factors that contribute to/hinder treatment entry into five areas, and some subareas. They come to following conclusions:

1. Demographic, health and substance factors:

- demographic:
  - Overall, contradictory evidence exists in the literature for the effect of age on treatment entry
  - In relation to gender, most studies have not found it to be an important variable in entering treatment
  - Overall, demographic variables have been examined by a few studies, and does not allow for conclusive evidence to be drawn.

- health:
  - there seems to be surprisingly little evidence for health issues constituting a significant reason to enter treatment
- substance:
  - evidence to support the hypothesis that substance related issues are important for treatment entry is limited

2. Intrapsychic:

- problem recognition:
  - There seems to be high consensus in most studies that issues around problem awareness, cognitive appraisal, and attitudes towards treatment are important and can affect treatment entry
  - The evidence does not appear conclusive on the issue of expectations from treatment including effectiveness
- psychological distress:
  - Few studies have examined the relevance and impact of psychological distress on treatment entry, and the evidence remains inconclusive

3. Social:

- negative consequences:
  - Negative social consequences as a result of substance misuse have been shown to be a significant reason for treatment entry in a number of studies
  - Negative social consequences (i.e. what one will lose socially if he or she enters treatment) can also be perceived as barriers to entering treatment
  - There is evidence that often the social consequences of entering treatment, and mostly social embarrassment and the fear of stigmatization by society, outweigh the consequences of continuing one's substance misuse, and constitute a main reason for not entering treatment



- Social pressure:
  - experiencing social pressure to enter treatment and having more social resources seems to be associated with treatment entry by most studies.
- Coercion:
  - Societal and legal coercion have been seen as having a powerful influence on treatment entry for substance misuse
- Social predisposing variables:
  - the number of years that an individual has been in education was not associated with treatment entry
  - marital status has not been found to be related to treatment entry for either alcohol or drugs
  - being employed could also act as a barrier for treatment entry, since the time spent in treatment might cause disruption in one's job.
  - socio-economic variables have not been found to be strongly associated with treatment entry
  - financial difficulties in supporting treatment entry were found to be a commonly reported reason for not entering treatment, but not the most important one
- 4. Life events
  - although there is some indication that certain types of life events may contribute to entering treatment, there are still important gaps in our systematic investigation and knowledge in this area
- 5. Prior treatment experience:
  - individuals' reasons for the treatment experience being influential in their decision to re-enter treatment have not been extensively explored by most studies, and therefore research does not seem to be conclusive in this area

### Summary

Of the reviews described above, four reviews<sup>29, 30, 34, 37</sup> studied a variety of factors that hinder or facilitate patients to seek/help for their alcohol use problems; two reviews<sup>31, 36</sup> were focused only on a single factor, namely stigma, and three reviews<sup>32, 33, 35</sup> looked specifically at the acceptability for patients to be screened for or to discuss alcohol use by a health care professional and the influencing factors on this.

With regard to barriers and facilitators, the reviews used different systems to categorize the factors, causing difficulty to compare them easily with each other. However, in an attempt to bring barriers/facilitators together, we choose for a categorization scheme, developed by Rubio-Valera et al.<sup>38</sup> that is applicable to both factors in patients and in professionals. Rubio Valera et al. make a distinction between personal factors (intrapersonal and interpersonal), institutional factors, community factors and public policy that may affect health care professionals' preventative actions; these can now be 'translated' to factors that may affect patients' actions/behaviours to seek help/treatment.

#### *Intrapersonal factors*

Psychological barriers encountered by the patient to seek help described in reviews, are: deny that they have a problem,<sup>29, 34, 37</sup> belief that alcohol problems may improve on their own or desire to handle problems on their own.<sup>34</sup> Attitudes toward treatment as concern that treatment is ineffective or uncomfortable (disinterest in abstinence goals) or may interact with responsibilities to family or work are also cited as barriers.<sup>34</sup> On the other hand, problem recognition is the most influential factor for entering treatment. When alcohol abuse causes undesirable personal states, physical consequences or damage, they can act as facilitator for treatment entry.<sup>37</sup> Also crisis situations as certain types of life events (mainly negative)<sup>37</sup> seems to be a facilitator for screening acceptance and subsequent intake in care.



### ***Factors acting in interaction with non-professionals***

When patients interact with non-professionals, dislike of the prevalent group<sup>34</sup> as fear of stigma<sup>31, 34, 36</sup> are cited as psychological barriers to seek help. On treatment level, lack of privacy in self-help groups may also be found as a barrier for some individuals.<sup>34</sup> On the other hand, influence and sometimes pressure from family, colleagues, and social environment as fear of negative social consequences may act as influencing or facilitating factors for seeking help.<sup>34, 37</sup> Having more social resources is also cited as a facilitating factor.<sup>37</sup>

### ***Factors acting in interaction with health care professionals***

Firstly, it's important to note that patients have mainly a positive attitude towards alcohol discussions with their GPs, although with variations in estimate between studies.<sup>32</sup> Based on our findings, the "best scenario" for seeking help may be described as an interaction between a patient having a health problem linked to alcohol or bringing up himself the topic and/or perceiving to have sufficient time therefore, and a GP or a practice nurse (depending on setting) who tailored his/her intervention to the actual needs of this patient. There is furthermore a good rapport between this patient and the professional. This professional puts sufficient attention to the disorder.<sup>32</sup>

Secondly, this positive attitude is also noted in emergency and surgery department. So, four in five patients admitted in emergency department (ED) and two in three surgery patients accepted alcohol screening. Thereafter participation rate for intervention were respectively two in three for ED and 100% for eligible surgical patients.<sup>35</sup> As dropping out of patients is by over half for appointments made for 2 days ahead or more, those patients need to be counseled as soon as possible after detection.<sup>30</sup>

### ***Accessibility***

As attended, lack of financial resources (no employment, no insurance coverage) as lack of facilities and support (transportation problems, lack of time for consultation due to professionals' or familial responsibilities) are mainly cited as barriers for treatment.<sup>29, 34</sup>

Access to substance abuse treatment can be affected by demographic factors as race/ethnicity. For example, African Americans and Hispanics are less likely to have access to substance abuse treatment than others Americans.<sup>29</sup> On the other hand, based on six studies, Johnson stated that

male were more likely to be approached for screening and interventions than female.<sup>30</sup>

On the other hand, socio-economic-status (SES) seems not to be a major barrier for treatment accessibility. Based on 18 studies, Littlejohn stated that amongst those who are recruited and do attend screening, SES does not necessarily influence outcome of brief intervention. However, as many patients decline to be screened initially, questions remain over the representativeness of those who accept to participate.<sup>33</sup>

Depending more on the organizational level, a lack of capacity in treatment programs is also cited as a barrier.<sup>29</sup>

### ***Acceptability***

Besides the named barriers, 4 reviews<sup>30, 32, 33, 35</sup> found that in general patients are positive about being screened for or about discussing alcohol use with a health care professional. However, acceptability of screening was found to be lower in risky drinkers than in patients in general.

#### ***3.2.1.2 Illustrations from primary research***

Oleski et al.<sup>39</sup> performed a large scale study in 11843 persons (USA) with an AUD, of which 81% did not seek help or perceived a need for care. They found that perceived barriers to care with the highest levels of endorsement were "thought I should be strong enough to handle alone" (41%) and "thought the problem would get better by itself" (33%) and; attitudinal barriers to care were endorsed more frequently than structural barriers to care (e.g. 'health insurance would not cover' was mentioned by only 8% of the respondents).

Brotons et al.<sup>40</sup> explored primary care patients' views and beliefs about the importance of lifestyle and preventive interventions, to assess their readiness to make changes to their lifestyle (diet, physical activity, smoking and risky alcohol consumption) and their willingness to receive support from GPs. The study covered 22 European countries and included 7947 primary care patients, of which 1357 risky drinkers. The overall results showed that alcohol drinkers (as opposed to smokers or patients with other unhealthy habits) do not see, or fail to admit, that alcohol use is a risky habit that needs to be changed. Less than one quarter of risky drinkers would like to receive advice concerning alcohol intake from their GPs. In a related study in the





same population<sup>41</sup> it was found that only 32% of the risky drinkers felt a need to change.

In a Swedish study<sup>42</sup> 9005 respondents of the general population were given four alternative reasons for not seeking treatment (do not believe there is any effective treatment; concerns about confidentiality; would be ashamed to seek help for alcohol problems and do not know where to seek help). They found that 'feeling ashamed' was the most frequent reason why people would not seek help for alcohol problems (>60%) while the other reasons were rated considerably less frequently (<10%).

With regard to stigma, a large scale USA –study<sup>43</sup> (n=6309) found that persons with a lifetime diagnosis of an alcohol use disorder were less likely to utilize alcohol services if they perceived higher stigma (odds ratio: 0.37, 95% confidence interval: 0.18, 0.76).

### 3.2.1.3 *Belgian empirical data*

Aertgeerts et al.<sup>44</sup> studied different screening methods in newly admitted adult male patients during a period of 6 weeks in medical wards of 4 Flemish hospitals. Of the 382 new patients, a minority (11%) refused to be screened.

Alonso et al.<sup>45</sup> performed a cross Europe study on perceived stigma in patients with a mental disorder (n=815, of which 98 from Belgium). Nine disorders were analysed: mood disorders (i.e., major depression episode and dysthymia), anxiety disorders (i.e., social phobia, specific phobia, generalized anxiety disorder, agoraphobia with or without panic disorder, panic disorder, and post-traumatic stress disorder), and alcohol dependence/abuse. Results were not specified for the alcohol group; for the total group 14.8% perceived stigma; in the Belgian subpopulation it was 16.1%.

We already mentioned the study of Brotons et al.<sup>40</sup> that explored patients' views and beliefs about the importance of lifestyle and preventive interventions, to assess their readiness to make changes to their lifestyle (diet, physical activity, smoking and risky alcohol consumption) and their willingness to receive support from GPs. In this study were 201 Belgian (Flemish?) patients from 7 GP-practices. No sub-analysis for Belgium was performed, but the overall results showed that alcohol drinkers (as opposed to smokers or patients with other unhealthy habits) do not see, or fail to admit, that alcohol use is a risky habit that needs to be changed. Less than one quarter of risky drinkers would like to receive advice concerning alcohol

intake from their GPs. A related study in the same population<sup>41</sup> found that only 32% of the risky drinkers felt a need to change.

In a RIZIV-study,<sup>46</sup> it was found that stigma and uninsured status are important barriers to seek help for people with an alcohol dependence; however no numbers or sizes are given.

Filee et al.<sup>47</sup> did a study in 29 GPs of the French speaking community, who sent a screening questionnaire to 2096 patients, only 12 refused to fill it out. Mobius et al.<sup>48, 49</sup> tested a screening procedure on ED-departments of 3 Flemish, 2 Walloon and 1 Brussels hospitals. Of the 194 Flemish patients that were screened, 92% did not bother that they were questioned about their alcohol use; no data are given for the Walloon/Brussels patients.

So, in summary, we have not found much data on barriers/facilitators to seek help in Belgian patients. Based on above studies, it seems that in Belgian patients denial may exist, and also that they may experience stigma. Furthermore it appears that screening on alcohol is acceptable for patients in GP-practices, hospital wards and ED-departments.

### 3.2.1.4 *Discussion barriers in patients*

The factor named in 3 reviews<sup>29, 34, 37</sup> as very important is denial / problem recognition (although not quantified). But from the large scale (n=11843) USA study from Oleski et al.<sup>39</sup> we learned that denial exist in 80% of the patients with AUD; in the 22 European countries (n=7947, of which 1357 risky drinkers) study of Brotons et al.<sup>40, 41</sup> it was found that only 30% of risky drinkers thought they need to change. As long as a patient does not recognize or denies the problem, he will not start seeking help. Other factors start to play a role from the moment a patient recognizes the problem and thinks about getting help (e.g. insufficient knowledge about treatment options), while again other factors only play a role from the moment a patient really starts seeking help (e.g. unable to afford treatment).

So there is not only a variety of and interplay between factors, but also a kind of cascade of factors depending on the stage to which a patient recognizes the problem and really wants help. This is in line with the transtheoretical stages of change model of Prochaska, that says that people with an AUD go through different stages and the first one is the precontemplation phase in which they have no intent to change. To move to another stage people must acknowledge their problem and have some kind



of 'readiness to change' or 'treatment readiness'; this concept has been studied among others by Rapp et al.<sup>50-52</sup> and developed an instrument to measure it. The instrument has been applied later by Mojtabai et al.<sup>53, 54</sup>; in this longitudinal large scale study, it was demonstrated that patients who reported a perceived need were more likely to use these services in follow-up than those who did not report such a need.

Also DiClemente et al.<sup>55</sup> developed and validated an instrument for readiness to change; they found significant but modest influences on higher levels of motivation to change drinking behaviour from greater patient perceived severity of alcohol dependence and reported drinking consequences, less stress and some psychiatric complications, better environmental quality of life, and more positive treatment expectancies.

For practice, it seems important that professionals not only screen for alcohol use, but they also look at treatment readiness in a second step and then at other potential barriers for treatment start.

From the reviews it did not become clear what the prevalence is of barriers in general, neither in the different disease or help seeking stages.

### 3.2.2 Interventions for barriers in patients

#### MAIN FINDINGS Interventions for barriers in patients:

**Interventions targeted at easing patient barriers and help them to seek treatment or initiate behavior change, studied in reviews were:**

- Screening-brief interventions-referral to treatment (SBIRT) by health care professionals,
- internet based screening and awareness programs,
- community reinforcement and family training,
- workplace interventions,
- stigma reducing interventions

Seven meta-reviews showed that SBIRT are effective for reducing alcohol consumption in patients that have hazardous or harmful drinking; no evidence of effect was found for patients that are alcohol dependent. However there is much variety within SBIRT-interventions.

**Based on 2 meta-reviews and 4 systematic reviews it appears that the extent to which SBI increases other treatment uptake is less clear, and is seldom taken as an outcome.**

**One systematic review with 8 included studies showed that of the patients that screen positive, only 25% receives some kind of brief intervention.**

**Eight systematic reviews studied internet based screening and awareness programs. All of these reviews looked at the effectivity of such interventions based on alcohol consumption or health outcomes, but none looked specifically at referral or treatment uptake as an outcome. However, such programs are generally seen as a good alternative to SBIRT by professionals due to the anonymity it gives to patients. Also these internet based interventions were in general well received by patients and considered helpful.**

**One systematic review concluded that there is limited evidence that family members enrolled in rigorous training packages can play an important role in encouraging patients to engage in treatment.**

**One review on workplace interventions state that methodological inadequacy of the included studies inhibited drawing strong conclusions. However, there are some indications that such interventions may have potential to produce beneficial results.**

**One systematic review on stigma reducing interventions found no studies targeted towards self-stigma in patients with an alcohol problem.**

**Only one intervention study with patient data from Belgium was found; this concerned implementation of an electronic SBIRT intervention on hospital ED-departments. Due to very low number of patients with outcome data, no conclusions could be drawn.**



As described previously, persons with an alcohol use disorder face many barriers to seek help. E.g., they deny they have a problem, or they think they can manage it themselves, or they fear being stigmatized, or they don't know what treatment options are available.

According to a recent Dutch inventory,<sup>56</sup> there is a large scale of possible interventions/treatments varying from extensive pharmacological inpatient treatment, different forms of psychotherapy, enhancing treatment readiness or readiness to change, lowering feeling of stigma, encouraging family and friends to give signals to their relative about his drinking pattern, diffusing information leaflets/websites, or a simple few minutes 'brief intervention' in general practice.

Treatment or help has to be seen broad; most (up to 70%) of the people with an alcohol problem are able to change their problematic behaviour without some kind of formal help,<sup>17-20, 22</sup> it could be enough that they receive a signal, e.g. from family, friends or a health care professional, that their drinking may be or is problematic to initiate themselves behaviour change.

In this section we looked at possible interventions that will lead more patients to some kind of help. E.g., by people making more aware they have a problem, or to discuss with them possible solutions or to enhance their 'treatment readiness' or 'readiness to change'.

So not the interventions for the alcohol problem are at stake but only the interventions that lead more people in a kind of help context and or ease barriers in patients to seek help or start self-change. The outcome of interest is 'the number of patients with an alcohol problem that start (seeking) some kind of treatment or help' and not 'the effectivity of those treatments on alcohol consumption or health outcomes'. However, the distinction between 'referral to treatment' and treatment itself is not always clear. Even screening (by a GP, or online) alone can already be helpful<sup>57</sup> and can be regarded as treatment.

A very common mentioned solution in the literature to get more people start treatment is that it is useful to make people aware of their drinking pattern and that therefore it is recommended that healthcare professionals screen patients during a health care encounter, e.g. when people visit their GP, or at a periodic encounter with an occupational doctor, or when they are admitted on a ED-ward or to a hospital. When screening is indicative of a possible problem, it can be followed by some kind of 'brief intervention', like

feedback on the screening result and discussing the problem, give insight to the patient, motivate him to change behaviour, giving advice or refer patients to some kind of help. This intervention is generally known as 'Screening and Brief Intervention (and Referral to Treatment)' (S-BI-RT). The screening element of SBIRT can already be therapeutic on its own, as well as the brief intervention element of it. So people are not always formally 'referred' to treatment.

### 3.2.2.1 *Reviews*

We selected well documented reviews on interventions in which there is an element of facilitating patients to seek help or in which there is an element that patients start changing their behaviour.

We found 63 reviews fulfilling these criteria. The large majority (n=47) concerned 'SBIRT' by health care professionals. Interventions concerned in the other 16 reviews were internet based screening and awareness programs, community reinforcement and family training, workplace interventions and stigma reducing interventions.

Due to the large amount of reviews on SBIRT, we made a further a selection within these reviews to meta-reviews (n=7) for data-extraction and synthesis. However, only 2 of these meta-reviews specifically looked at treatment uptake as an outcome and both found no studies meeting inclusion/exclusion criteria that analysed receipt of and follow up with referrals as an outcome. Therefore, next to the SBI meta-reviews we searched also for recent (>2000) well documented SBI reviews that specifically considered treatment referral/uptake as an outcome; 4 reviews were found.

### **SBIRT**

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive and integrated approach to the delivery of early intervention and treatment services through universal screening for persons with substance use disorders and those at risk.<sup>58</sup> The S-BI-RT intervention is composed of three elements: screening, brief interventions and referral to treatment. Brief interventions are those practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it.





As said, we retained six meta-reviews (in 7 documents)<sup>27, 59-64</sup> concerning SBIRT (characteristics in Table 3).

**Table 3 – Interventions for barriers in patients; characteristics of meta-reviews on SBIRT**

Reference	Methodology	Population characteristics	Intervention(s)	Critical appraisal of review quality
<b>Anderson_2012</b>	N data sources: 4 Searched period: 2000-2010 N included studies: unclear Funding: European Union	Elderly (no dependent)	screening and brief intervention programmes amongst older people	Amstar: 1 Synthesis: descriptive
<b>Gaume_2014</b>	N data sources: 3 Searched period: not clear N included studies: unclear Funding: Wellcome Trust Research Career Development fellowship in Basic Biomedical Science (WT086516MA)	Patients with hazardous and harmful alcohol use	screening and brief intervention programmes	Amstar: 2 Synthesis: descriptive
<b>Jackson_2010</b>	N data sources: 15 Searched period: 1950-2008 N included studies: 27 reviews Funding: NICE	Adults and young people aged 10 years and above	Brief interventions to prevent alcohol misuse amongst adults and young people delivered both within and outside primary care settings by a range of professionals and non-professionals (excluding alcohol specialists)	Amstar: 8 Synthesis: best evidence synthesis according to NICE
<b>Jonas_2012</b>	N data sources: 9 Searched period: 1985-2011 N included studies: 9 reviews 23 RCTs Funding: AHRQ	adolescents and adults with alcohol misuse in primary care settings	Brief interventions to prevent alcohol misuse amongst adults and young people delivered both within and outside primary care settings by a range of professionals and non-professionals (excluding alcohol specialists)	Amstar: 9 Synthesis: Meta-analysis where appropriate and descriptive
<b>O'Donnell_2014</b>	N data sources: 6 Searched period: 2002-2012 N included studies: 24 reviews Funding: European Union	Patients in primary care settings	brief alcohol intervention in primary healthcare settings Brief intervention was defined as a single session and/or up to a maximum of five sessions of engagement	Amstar: 7 Synthesis: descriptive



			with a patient, and the provision of information and advice designed to achieve a reduction in risky alcohol consumption or alcohol-related problems	
<b>Saitz_2010</b>	N data sources: 5 Searched period: 2006-2009 N included studies: 8 reviews Funding: US National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse (grant numbers R01DA025068 and R01AA10019)	primary-care patients with unhealthy alcohol use identified by screening	Brief interventions conducted in-person (not by telephone, mail, or computer). Each could include up to four follow-up sessions	Amstar: 7 Synthesis: they extracted data from the RCTs in the 8 systematic reviews and then pooled the data

All these meta-reviews show that SBIs are effective for reducing alcohol consumption in patients that have hazardous or harmful drinking; no evidence of effect was found for patients that are alcohol dependent.<sup>64</sup> However within 'SBI' there is much variety, starting from a simple screen-question 'do you use alcohol' up to six times motivational interviewing sessions over a 3 month period.<sup>60, 65, 66</sup>

SBI focusing on enhancing motivation is expected to improve early help-seeking among patients with diverse alcohol problem. The extent to which SBI increases other treatment uptake is less clear, and is seldom taken as an outcome. Two<sup>61, 64</sup> of the seven included meta-reviews specifically looked at treatment uptake as an outcome: both found no studies meeting inclusion/exclusion criteria that analyzed receipt of and follow up with referrals as an outcome.

Therefore, next to the SBI meta-reviews that looked at effectivity in general and treatment uptake in particular, we searched also for recent (>2000) well documented SBI reviews that specifically considered treatment referral/uptake as an outcome. Four reviews<sup>67-70</sup> fulfilled this criterion. Based on 8 trials in general practices, Beich et al.<sup>67</sup> conclude that of the patients that screen positive, only 25% receives some kind of brief intervention. D'Onofrio et al.<sup>68</sup> included 32 trials on SBI of which 4 had referrals as outcome; two were in ED-patients and two were in hospital patients; all these four had a positive effect on number of referrals, however, the size of this

effect is not clear from the review. Nilsen et al.<sup>69</sup> included 14 SBI-studies of which only one had referral as an outcome; that study in ED-patients found a positive effect; however, the size of this effect is not clear from the review. Wilson et al.<sup>70</sup> mention one included study in outpatient clinics from which it appeared that 39% of the patients that screened positive received BI.

So, in summary, although BI is expected to lead to referral and treatment initiation, there is only very weak evidence for this. On the other hand it is apparent that SBIRT helps.

### Internet based screening and awareness programs

We found 10 references<sup>34, 71-79</sup> on 8 systematic reviews that studied internet based screening and awareness programs. The included studies in the reviews were by large from USA-origin and often focusing on college students. All of these reviews looked at the effectivity of such interventions based on alcohol consumption or health outcomes, but none looked specifically at referral or treatment uptake as an outcome.

But internet based screening and awareness programs are seen as a good alternative to SBIRT by professionals due to the anonymity it gives to patients. Also these internet based interventions were in general well received by patients and considered helpful.



### Other interventions

Finally we found reviews on community reinforcement and family training,<sup>80</sup> workplace interventions<sup>81</sup> and stigma reducing interventions.<sup>82</sup> Only Roozen et al.<sup>80</sup> looked at treatment uptake as an outcome measure. They compared the efficacy of three approaches ("Community Reinforcement and Family Training" (CRAFT), Al-Anon and Johnson Institute Intervention and concluded based on 4 studies of which 2 concerned alcohol use disorder, that there is limited evidence that family members included in a "Community Reinforcement and Family Training" (CRAFT) can play an important role in encouraging patients to engage in treatment.

With regard to workplace interventions Web et al.<sup>81</sup> stated that none of the included studies showed methodological adequacy, inhibiting drawing strong conclusions. However, there were some indications that interventions contained within health and life-style checks, psychosocial skills training and peer referral may have potential to produce beneficial results.

The review of Livingstone et al.<sup>82</sup> concerning stigma reducing interventions made a distinction between three types of stigma: self-stigma as experienced by the patient himself, social stigma as stigma put on people by society and structural stigma as experienced by professional towards types of patients. They found three studies targeted towards self-stigma, but none of these was carried out in patients with an alcohol problem. With regard to social stigma the review revealed, based on 3 studies, that educational leaflets communicating positive depictions about people with substance use disorders significantly reduced stigmatized attitudes among the general public towards heroin and alcohol dependence; also brief motivational interviews conducted with members of the general public moderately decreased stigmatizing attitudes towards people with alcohol dependence. With regard to structural stigma the review indicated that programs focused on educating medical students about substance use problems and exposing them to people with substance use disorders are likely to decrease their stigmatizing attitudes and increase comfort levels towards working with this population.

### 3.2.2.2 *Belgian empirical data*

Only one intervention study with empirical patient data from Belgium was found.

Mobius et al.<sup>83</sup> piloted the implementation of an electronic SBIRT intervention on ED departments of 2 Hungarian and 2 Flemish hospitals. 236 patients were screened; 11 patients filled out the evaluation questionnaire and 3 reported accessing the Self Help Manual and other 3 the referral guide. Of the referral guide users, two individuals reported that they followed up on their suggested referral, with one 'very happy' and the other 'happy' with their resultant progress in reaching substance use goals. One of the three Self Help Manual users reported that they felt the module was useful in helping them manage their substance use.

### 3.2.2.3 *Discussion Interventions for barriers in patients*

There is an overwhelming amount of evidence that SBIRT interventions are effective to reduce alcohol consumption, except for patients that are alcohol dependent. However, there is a lot of unclarity of what the components of these SBIRT interventions are and if there is always a sequence of screening -> brief interventions-> referral to treatment.

The fact that SBIRT interventions do not seem to be effective for alcohol dependent people, may be explained by recent insights<sup>84-86</sup> that these people suffer from cognitive and social impairments and therefore other approaches are needed.

The extent to which SBI increases other treatment uptake is seldom taken as an outcome. As far it had been measured, reviews found a positive effect but do not clearly present what size the effect is. Only two reviews quantifies it: Beich et al.<sup>67</sup> conclude, based on 8 trials, that of the patients that screen positive, 25% receives some kind of brief intervention and Wilson et al.<sup>70</sup> mention one included study in outpatient clinics from which it appeared that 39% of the patients that screened positive received BI.

The same can be said for other interventions that it is by large unclear to what extent initial interventions help to ease barriers in patients and lead more patients to treatment.



### 3.2.3 *Barriers and facilitators at the level of professionals with regard to screen and/or initiate treatment*

#### **MAIN FINDINGS Barriers and facilitators at the level of professionals:**

**Based on 7 systematic reviews, it is concluded that health care practitioners face many barriers to initiate screening, discuss alcohol problems and/or start intervention.**

**The factors that are mentioned in at least 4 of the 7 reviews are:**

#### **STAFF FACTORS:**

- Lack of appropriate skills
- Lack of knowledge
- Lack of motivation
- Anxiety for affecting the interpersonal patient-provider relationship
- Negative attitudes towards patients with substance use problems (including stigma)
- Lack of confidence in capacities

#### **ORGANIZATIONAL FACTORS:**

- Workload, lack of time and competing demands
- Lack of leadership of managerial support
- FACILITATOR a well-organized practice

**These factors were also found in 13 empirical studies carried out in Belgium.**

Health professionals do not very common discuss alcohol intake and/or screen for possible alcohol problems. E.g., in a large (n= 166.753) USA survey<sup>87</sup> the prevalence of ever discussing alcohol use with a health professional was 15.7% among U.S. adults overall, 17.4% among current drinkers, and 25.4% among binge drinkers. In a recent European study<sup>88</sup> with 120 GPs from 5 different countries, the mean screening rate was as low as 5.9% of patients.

#### 3.2.3.1 *Reviews*

To obtain more comprehensive and recent insight in this issue, we selected reviews presenting barriers and facilitators in professionals. Seven (in 8 documents) reviews<sup>27, 30, 38, 89-93</sup> fulfilled our inclusion criteria.

Some characteristics of these reviews are presented in Table 4.


**Table 4 – Barriers in professionals: Review characteristics**

Reference	Methodology	Population characteristics	Research topic	Critical appraisal of review quality
<b>Bakshi_2014</b>	N data sources: 10 Searched period: 2007-2013 N included studies: 6 Funding: not reported	The samples comprised doctors (n = 2), nurse (students (n = 2), dentists (n = 1), and a mixed sample of health professionals (n = 1). Sized ranged from 68–3,193 participants. Setting was 4x times primary care, 1x ED, 1x nurse student in university Studies origin: Aus 1x Finland 1x Sweden 1x UK 2x USA 1x	Studies examining personal alcohol attitudes, behavior and professional practices	Amstar: 4 Synthesis: descriptive
<b>Funderburk_2008</b>	N data sources: 3 Searched period: 1996-2006 N included studies: 11 Funding: VA Center for Integrated Healthcare, Syracuse, New York	Primary care professionals giving brief interventions. Studies origin: USA 11x	Studies evaluating alcohol brief interventions in primary care settings and the barriers that may be preventing the implementation of these interventions in primary care.	Amstar: 1 Synthesis: descriptive
<b>Gordon_2013</b>	N data sources: 4 Searched period: 2010-2012 N included studies: not clear Funding: VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania	Not well described. Setting: primary care Studies origin: Not clear	Studies in addiction field in the primary care setting	Amstar: 2 Synthesis: descriptive
<b>Johnson_2011</b>	N data sources: 6 Searched period: Up to 05/2009 N included studies: 47 Funding: National Institute for Health and Clinical Excellence (NICE)	Not well described. Setting: most primary care (35/45) Studies origin: - Canada 1x - Denmark 2x - Finland 7x - Germany 1x - New Zealand 1x - Sweden 2x	Studies on barriers and facilitators to effective implementation of screening and brief intervention for alcohol misuse in adults and children over 10 years.	Amstar: 7 Synthesis: descriptive



		<ul style="list-style-type: none"> <li>- UK 19x</li> <li>- USA 9x</li> </ul>		
<b>Rubio-Valera_2014</b>	N data sources: 5 Searched period: Up to 01/2013 N included studies: 35 Funding: no funding	Physicians and nurses Setting: primary care Studies origin: <ul style="list-style-type: none"> <li>- Australia 2x</li> <li>- Canada 1x</li> <li>- Denmark 4x</li> <li>- Germany 2x</li> <li>- Ireland 1x</li> <li>- Israel 1x</li> <li>- Netherlands 1x</li> <li>- New Zealand 1</li> <li>- Spain 2x</li> <li>- Sweden 2x</li> <li>- Switzerland 1x</li> <li>- UK 13x</li> <li>- USA 3x</li> </ul>	Qualitative studies exploring physicians and nurses' perceptions regarding the implementation of primary prevention and health-promotion activities addressed to adults in a primary care context. The phenomena of interest were the factors (barriers and facilitators) that have an impact on the implementation of these activities..	Amstar: 7 Synthesis: meta-ethnography
<b>Van Boekel_2013</b>	N data sources: 3 Searched period: 2000-2011 N included studies: 28 Funding: no funding	study populations included nurses (N = 8), professionals of addiction or mental healthcare institutions (N = 7), and physicians (N = 4). One study focused on physicians as well as nurses. Five studies included patients as study population besides healthcare professionals. Settings were diverse, ranging from country representative samples all nurses, to primary care, to ED-departments or specialized mental health care facilities Studies origin: <ul style="list-style-type: none"> <li>- • Australia 12x</li> <li>- • UK 7x</li> <li>- • USA 5x</li> <li>- • Canada 1x</li> <li>- • Ireland 1x</li> </ul>	Studies about health professionals' attitudes, explanations for negative attitudes, healthcare delivery, or stigma with regard to alcohol and/or drug abuse,..	Amstar: 6 Synthesis: descriptive



		<ul style="list-style-type: none"> <li>• cross-country comparison of eight European countries 1x</li> <li>• USA and the UK 1x</li> </ul>		
<b>Watson_2010</b>	N data sources: 6 Searched period: 1990-2008 N included studies: 24 Funding: not reported	nurses or midwives in different health care settings (both primary and secondary care) Studies origin: <ul style="list-style-type: none"> <li>- Australia 1x</li> <li>- Denmark 1x</li> <li>- Finland 2x</li> <li>- Sweden 6x</li> <li>- UK 4x</li> <li>- USA 1x</li> </ul>	Studies on the involvement of nurses and midwives in screening and brief interventions for hazardous and harmful use of alcohol and other psychoactive substances	Amstar: 4 Synthesis: descriptive

First, the individual reviews are discussed alphabetically below and secondly the reviews are put together in a classification based on the reviews of Johnson-2011 and Rubio\_2014.<sup>30, 38</sup>

Bakshi et al.<sup>89</sup> explored the relationship between health professionals' personal alcohol attitudes and behaviors, and their professional alcohol-related health promotion practices. They found indications that the health professionals' personal alcohol use and attitudes may play a role in their professional practices with their patients. As barriers they identified:

- a lack of confidence
- a lack of knowledge about alcohol use (i.e., what constitutes a unit) and related risk factors
- a lack of time
- a lack of training
- uncertainty about if and how they should raise the topic with their patients

Funderburk et al.<sup>90</sup> reviewed studies evaluating alcohol brief interventions in primary care settings and the barriers that may be preventing the implementation of these interventions in primary care. Factors found are:

- increased demand on primary care physicians with shorter visits and the competing demands of other medical problems

- the time needed to successfully implement the alcohol brief intervention
- time needed to collaborate with specialist services
- no formal training in the management of hazardous alcohol use or alcohol use
- no financial support for additional behavioral health services

Gordon<sup>91</sup> stated that there are considerable barriers to the implementation of screening and brief interventions, including limited time to perform brief interventions and physician knowledge in this area.

Johnson et al.<sup>27, 30</sup> identified barriers and facilitators to intervention implementation at organizational, provider and patient level. These are the factors they found:

- Organizational factors.
  - The most important factors were lack of financial incentives or managerial support
  - management of staff workloads that might limit the extent to which practitioners are able or willing to take on additional responsibilities
- Provider factors
  - professionals did not see the delivery of brief interventions as a part of their role





- perceived lack of knowledge
- lack of confidence in imparting advice
- practitioners were often confused by, or unaware of current guidelines, particularly in view of the multiple definitions relating to alcohol measures and strengths
- anxious not to misdirect advice
- finding drinking a difficult topic to raise
- perceived lack of time
- lack of faith in formal screening tools
- Patient factors
  - particular individual characteristics with a lower likelihood of being approached: female, being employed, Caucasian race
  - negative reactions of patients when asked about drinking

Rubio Valera et al.<sup>38</sup> made a distinction between staff factors (intrapersonal and interpersonal), institutional factors, community factors and public policy that affect both health care professionals' preventative actions in general and more specifically towards substance use.

- Staff-factors, intrapersonal:
  - professionals' beliefs about primary prevention and health promotion
  - their experiences in dealing with a particular risk factor or required lifestyle modification ,
  - appropriate skills and knowledge
  - their motivation
  - their attitudes
  - their self-concept (self-confidence in their capacities and personal experiences with the problem)
  - There are two factors that affect professionals' motivation, the patient and the health system. Even when professionals have a positive attitude towards primary prevention and health promotion, if they feel the patient is not interested, or does not adhere to their recommendations, they feel frustration. Primary care professionals

think that the health system expects them to conduct primary prevention and health promotion activities. This can also prove frustrating if the self-concept is low and/or the resources available are perceived to be scarce. This can affect motivation, changing the attitude towards primary prevention and health promotion and setting up a vicious circle.

- Staff factors, interpersonal processes,
  - From the primary care professionals' point of view, the attitudes and behavior towards primary prevention and health promotion of patients, specialists, practice managers, and colleagues affect the feasibility of implementing primary prevention and health promotion in primary care.
  - The relationship that is established with the patient is mediated by their characteristics, their expectations about what will happen in the consulting room (usually related to the approach to the specific problem that brought the patient to the primary care professional), and their own personal and economic resources. When the professional considers that the patient is not interested or does not have the resources to implement the required changes, he or she may decide not to invest time in providing advice on primary prevention and health promotion. In fact, the professionals prefer not to implement primary prevention and health promotion when they are concerned about damaging the patient-physician relationship, for instance, in dealing with issues related to alcohol consumption when this is not the motive for the consultation
  - Other members of the primary care team can act as facilitators, for example, the "champions" (colleagues who are highly motivated to implement primary prevention and health promotion activities).
  - A further facilitator is that the practice manager is involved and interested in these activities.
  - Confidence in the competence of other team members could be a factor which predisposes the professional to implement the activities.





- The lack of coordination between different levels of care, such as the contradiction between messages coming from specialists and primary care, complicates the implementation of primary prevention and health promotion through primary care.
  - Institutional factors,
    - Professionals perceive that the biomedical model, which prioritizes disease treatment rather than prevention, is predominant in their institutions. This affects the professionals' beliefs, as stated above (Intrapersonal factors), and the organization of the practice. Professionals perceive that this perspective leads to few resources being allocated to implementation of primary prevention and health promotion.
    - Workload, lack of time and lack of referral resources hamper the implementation of primary prevention and health promotion
    - On the other hand, professionals think that the primary health care setting is well placed and has the necessary credibility to implement primary prevention and health promotion
    - A facilitator is a well-organized practice where everyone knows their role regarding primary prevention and health promotion and which has referral services within the practice
    - Financial incentives, such as management by objectives, which reinforce some strategies, are perceived as a facilitator in some cases. In others, they can be perceived as undermining clinical objectives by giving an incentive to provide interventions based on activities that are easy to measure, encouraging quantity rather than quality
    - Tools such as guidelines and alarms/reminders are seen as facilitators for primary prevention and health promotion
  - Community factors
    - According to the professionals, the social, cultural and community context where the patient physician interaction occurs will affect the decisions that the professional makes in relation to the initiation and development of primary prevention and health promotion activities.
  - For instance, in deprived areas where the patients cannot afford the local resources they are referred to, primary care professionals could decide not to assess lifestyles or risks.
  - Also, professionals perceive the patients' cultural aspects (e.g., country of origin or religion) as a potential barrier if they think that they are in conflict with the potential interventions or if they are not aware of what these values might be
  - Citizens' views can also affect what the professional feels is feasible to do in primary care. For instance, drinking advice may be in conflict with citizens' views about drinking as a social activity.
  - This could be supported by mass-media messages reinforcing the idea that moderate drinking can be a healthy habit. Nevertheless, professionals believe that mass media campaigns can be a useful tool in reinforcing health promotion messages.
  - Professionals think that the curriculum in university and the pharmaceutical industry have an impact on their behavior.
  - Lack of undergraduate training in primary prevention and health promotion activities is perceived as a barrier.
  - With regard to the pharmaceutical industry, professionals feel that they are the object of marketing campaigns that promote the use of drugs to prevent diseases. Professionals feel that they are motivated through incentives given by pharmaceutical companies to prescribe drugs even when they perceive that the relative benefit of using drugs in comparison with lifestyle changes is not supported by the evidence.
  - Public policy
    - When extracting first and second-order constructs, the importance of the health system model emerged although it was not directly stated by the professionals interviewed
- Van Boekel et al.<sup>92</sup> focused on professionals' attitude towards substance users (including alcohol). In general they found that health professionals had a negative attitude towards patients with substance use problems. Also they found that health professionals had low levels of knowledge about substance use disorders, and had the feeling they lack specific knowledge and skills in caring for this particular patient group.



Contextual factors such as time, organizational policy, feelings of professionals to work legitimate with patients with substance use disorders, and role support by colleagues, were found to influence the level of therapeutic commitment of health professionals. Organizational support, such as role support, supervision, and possibilities to consult an expert, contributed significantly to an increased willingness and satisfaction to work with these patients. Furthermore, organizational support enhanced self-esteem, perceived knowledge and feelings of empowerment among health professionals.

Finally, Watson et al.<sup>93</sup> found a large body of literature which reports factors that may act as enablers or barriers to nurses' and midwives' screening and brief interventions.

- inhibitors of nurses' involvement in screening and brief interventions were
  - lack of confidence in assuming this secondary prevention role
  - insufficient knowledge
  - negative attitudes towards people with an alcohol problem
  - being reluctant to raise the issue of alcohol use with patients because they were anxious about the potential response, anticipating a negative reaction that would affect the interpersonal relationship that had been built up
  - time constraints were a barrier for many nurses, and particularly those working in hospitals
  - lack of support from senior clinical and management colleagues for the implementation of brief interventions
- it was also shown that the more education nurses received the greater the likelihood that they engaged in screening.

Table 4 gives an overview of the factors that act as barriers or facilitators and if they are mentioned in one of the reviews. In some reviews a factor is titled as a barrier, e.g. lack of training, while in another review the same factor is titled as facilitator, e.g. training helps. So for the table we reversed sometimes a facilitator into a barrier or vice versa.

The factors that are mentioned in at least 4 of the 7 reviews are:

- STAFF FACTORS:
  - Lack of knowledge
  - Lack of appropriate skills
  - Lack of motivation
  - Anxiety for affecting the interpersonal patient-provider relationship
  - Negative attitudes towards patients with substance use problems (including stigma)
  - Lack of confidence in capacities
  - (facilitator) Personal history of provider with addiction
- ORGANIZATIONAL FACTORS:
  - Workload, lack of time and competing demands
  - Lack of leadership of managerial support
  - (facilitator) a well-organized practice



Table 5 – Factors acting as barrier or facilitator in professionals by review

		Reviews	Bakshi 2014	Funderburk_2008	Gordon_2013	Johnson_2011	Rubio_2014	Van Boekel 2013	Watson_2010
		N studies	6	11	?	47	35	28	24
FACTORS									
STAFF FACTORS	intrapersonal	Professionals' beliefs about prevention & role perception	3			x	X		x
		Experience in and familiarity with dealing with a particular risk factor or required lifestyle modification ,	3	x			X	x	
		Lack of appropriate skills	5	X	X		X	X	x
		Lack of knowledge	6	x		x	x	x	x
		Lack of motivation	4			x	X	x	
		Anxiety for affecting the interpersonal patient-provider relationship	4	x		x	x		x
		Negative attitudes towards patients with substance use problems. (including stigma)	4			x	X	x	x
		Lack of confidence in capacities	4	x		x	X		x
		(dis) concordance professional attitude and patient attitude	2			x	X		
		(facilitator?) Personal history of provider with addiction	4	x		x	x	x	
	interpersonal	Attitudes and motivation of colleagues and managers to implement prevention activities	3				X	x	x
		Lack of involvement and interest of practice manager is involved and interested in these activities.	3				X	x	x
		Lack of confidence in the competence of other team members	1				X		
		Lack of coordination between different levels of care.	1				X		
INSTITUTIONAL FACTORS,		Contextual factors such as organisational policy, feelings of professionals to work legitimate with patients with substance use disorders,	3			x	X	x	
		Workload, lack of time and competing demands	7	x	x	x	X	x	x
		Lack of referral resources	1				x		
		Health care setting (general versus specialized)	2				X	x	
		Lack of leadership of managerial support	5		x	x	x	x	x
		FACILITATOR a well-organized practice	4		x	x	X		x
		FACILITATOR: Financial incentives,	3		x	x	X		
		FACILITATOR: Tools such as guidelines and alarms/reminders	2			x	X		



COMMUNITY FACTORS	in deprived areas where the patients cannot afford the local resources they are referred to, primary care professionals could decide not to assess lifestyles or risks.	1	X
	▪ patients' cultural aspects if professionals think that they are in conflict with the potential interventions or if they are not aware of what these values might be	1	X
	○ Citizens' views can also affect what the professional feels is feasible to do in preventive care	1	X
	○ mass-media messages reinforcing the idea that moderate drinking can be a healthy habit	1	X
	○ the curriculum in university and the pharmaceutical industry have an impact on their behavior.	1	X
	○ Lack of undergraduate training in preventive activities	1	X
	○ Incentives from the pharmaceutical industry to prescribe drugs	1	X

### 3.2.3.2 Illustrations from primary studies

To illustrate the magnitude of barriers and facilitators in professionals to initiate screening and/or treatment, a few recent primary studies from European countries are presented below.

Wojnar et al.<sup>94-96</sup> performed a European study across 2435 general practitioners from 9 countries. They found that the six top barriers to initiate screening and/or treatment expressed by the general practitioners were:

- Doctors are just too busy dealing with the problems people present with (64%);
- Doctors are not trained in counselling for reducing alcohol consumption (52%);
- Doctors believe that alcohol counselling involves family and wider social effects, and is therefore too difficult (50%);
- General practices are not organized to do preventive counselling (49%);
- Doctors do not believe that patients would take their advice and change their behavior (48%);
- Doctors do not have suitable counselling materials available (47%),

The six top facilitators for undertaking screening and/or treatment were:

- Support services (self-help/counselling) were readily available to refer patients to (84%);
- Patients requested health advice about alcohol consumption (80%);
- Quick and easy counselling materials were available (75%);

- Training programs for early intervention for alcohol were available (75%);
- Early intervention for alcohol was proven to be successful (73%);
- Quick and easy screening questionnaires were available (71%).

A subanalysis in the GPs from Portugal<sup>96</sup> showed that there are two distinct groups of GPs, some with better attitudes towards drinkers and some with lower attitudes and these experience more barriers to start screening.

A Dutch study<sup>97</sup> in general practitioners (N=180), healthcare professionals of general psychiatry (N=89) and specialists in addiction services (N=78) found that professionals may find that working with people with alcohol problems is dissatisfying, that they can do little to help these patients, that such patients may irritate them, that they are too difficult to work with and that treating them may be a waste of money.

A second Dutch study<sup>98</sup> in GPs (n=185) found as top 5 of most mentioned barriers: lack of time (35%), lack of motivation in patients (20%), lack of knowledge (11%).

A third Dutch study<sup>99</sup> in medical specialists of hospitals (n=70) and medical and nursing personnel of the emergency department (N=288) found as major barriers lack of time, motivation of patients, motivation of specialists and ED not a suitable environment.

A study from Sweden<sup>100</sup> in 68 GPs and 193 RNs working in primary care, found that the most commonly endorsed disincentive was lack of training in counselling for reducing alcohol consumption; 75% answering strongly agree/agree for difficulties in screening because of time constraints (67%)



and that doctors do not know how to identify problem drinkers who have no obvious symptoms of excess consumption (65%). The most common incentives were readily available support services to refer patients to (81%), availability of quick and easy screening questionnaires (74%) and availability of training programs for early intervention on alcohol (72%).

Another Swedish study<sup>101</sup> in primary care physicians (n=1386) and nurses (n=1910) found several barriers to alcohol-preventive activity including lack of time, scepticism regarding the effectiveness of addressing alcohol, fear of potentially negative patient responses, uncertainty about how to ask, uncertainty about how to give advice regarding alcohol, and uncertainty concerning where to refer the patient. Both physicians and nurses in primary health care stated that lack of time (64% of GPs, 36% of RNs) was the most important reason for not addressing alcohol issues.

In the UK Lock et al.<sup>102</sup> looked at potential barriers to SBI in general practice. Hereto GPs (n=419) were asked to indicate their agreement with 15 suggested barriers. Agreement was highest for the statements suggesting that doctors were 'just too busy' (63%); that doctors were not trained in counselling for reducing alcohol consumption (57%); and that the current contract did not encourage work with alcohol problems (48%). The lowest rates of agreement were with statements that doctors have a disease model rather than preventive training (21%); that doctors believe patients would resent enquiry (17%); and that alcohol was not an issue in general practice (14%). To consider potential incentives to early intervention in general practice, GPs were asked to indicate their agreement with 7 suggested incentives. Most statements were strongly endorsed by GPs. Agreement was highest that readily available support services (87%), proving the success of early intervention (81%) and patients requesting health advice about alcohol (80%) would offer an incentive; the lowest rating was for improving salary and working conditions as an incentive (39%).

Another UK study<sup>103</sup> was done in paramedics of the ambulance services (n=142). They reported that facilitators for carrying alcohol screening/treatment interventions were: patients requesting help for their drinking (78%); pathways being available to refer patients to specialist services (75%); early interventions being proven to be successful (71%); training programmes available for SBI (68%); and screening questionnaires and counselling materials being quick and easy to use (66%) and extra payments for staff who provide SBI (62%). The barriers to carrying out SBI

included not having suitable counselling materials (77%); not being trained to recommend reducing alcohol consumption (72%); not having the facilities or time to deal with prevention issues (69%); believing that patients would not accept advice and change behavior (66%); being too busy dealing with the physical manifestation of alcohol problems (66%); not having suitable screening tools (61%) and feeling awkward asking alcohol-related questions (33%).

### 3.2.3.3 *Belgian empirical data*

Findings from the 13 Belgian studies we found on barriers in professionals are presented below in alphabetically order.

Autrique et al.<sup>104</sup> performed a survey in professionals from institutions (n=60) that treat alcohol and drug users; in the questionnaire professionals were asked about barriers towards working with evidence based alcohol and other drugs guidelines. Most frequent mentioned were lack of time, lack of administrative support, lack of an adequate information management system and lack of coaching.

Bloemen et al.<sup>105</sup> surveyed 76 Flemish GP about their attitude towards working with people with an alcohol problem with the Short Alcohol and Alcohol Problems Perception Questionnaire. They found a median score of 4.7 (max 7) on this instrument, indicating a slight positive attitude.

De Timary<sup>106</sup> pointed at a 2011 survey of the French speaking scientific society of GPs SSMG (n=434), from which it appeared that more than 50% felt inadequately educated; only 20% followed some kind of training about working with AUD patients in the past two years and only half of the interrogated GPs stated that they ask patients about alcohol use. De Timary pointed also at a 2009 questionnaire in a Walloon hospital from which it appeared that 75% of the interrogated nurses felt a lack of knowledge for working with AUD patients.

Filee<sup>47</sup> surveyed 362 French speaking GPs. More as 50% felt it difficult to work with AUD patients; 78% felt inadequately trained and only 30% discussed alcohol use when they suspected a problem. Reasons mentioned not do so were: suspected lack of honesty in patients (72%), denial in patients (67%), feeling difficult to discuss this issue (62%), do not believe that treatment work (55%), taking too much time to discuss (42%), being afraid to lose the patient after discussing (19%), unavailability of effective





treatments (29%), lack of knowledge (19%), no interest in doing so (12%) and afraid to raise the issue (10%).

As part of a large WHO-project<sup>107</sup> Pas et al. performed focus groups in Flemish GPs. They stated that GPs experienced a major emotional burden in dealing with alcohol problems, expressed as 'workload' or 'lack of time'; also feelings of ineffectiveness, powerlessness and deception after major efforts to help people were expressed in the focus groups. GPs felt they are not trained and have no time to deal with ongoing counseling of patients with alcohol misuse. Also they pointed at a lack of public support for such work with AUD patients. Finally they complained about inadequate training and insufficient facilities.

Jacques et al.<sup>108</sup> investigated the perceptions among twelve first-year postgraduates in psychiatry (UCL Louvain) with regard to alcohol and tobacco dependency, making use of visual analog scales. It was found that they had helpless feelings and did not systematically investigate alcohol use in their patients.

Ketterer et al.<sup>109</sup> interviewed in 2012 10 Flemish and 10 Walloon GPs. GPs were strongly influenced by their personal representations of abuse, which included the balance between their professional responsibilities toward their patients and the patients' responsibilities in managing their own health as well the GPs' abilities to cope with unsatisfying patient outcomes without reaching professional exhaustion. GPs perceived substance abuse along a continuum ranging from a chronic disease (whose management was part of their responsibility) to a moral failing of untrustworthy people; personal experiences of emotional burdens (including those regarding substance abuse) increased feelings of empathy or rejection toward patients. Time constraints and personal investments were cited as important barriers. Satisfaction with treatment was rare. A lack of theoretical knowledge and training were secondary to personal attitudes and motivation. They also mentioned the long waiting lists at specialised care centres as a major concern. Multidisciplinary practices and professional experiences were cited as important factors with regard to engaging GPs in substance abuse management.

Kolsek et al.<sup>110</sup> did a European qualitative study on community and primary health care involvement on alcohol and tobacco actions in seven European countries, including Belgium. In Belgium, focus groups were held with Flemish GPs, psychologists, psychiatrists, nurses and pharmacists. The

paper does not present the results by country, but barriers mentioned in all countries were: perceived role (we are here to treat patients, not to teach them) and feelings of powerlessness to work with AUD patients.

In an intervention study<sup>49</sup> to implement SBI in 1 Brussels, 3 Flemish, 2 Walloon and 1 Brussels hospital ED-department, barriers in professionals to do so were investigated. Common barriers were workload, staff shortage, lack of time, lack of skills, feeling unsure and feeling it difficult to raise the issue of alcohol.

Another study of Mobius et al.<sup>83</sup> concerned the implementation of an electronic SBIRT in 2 Flemish and 2 Hungarian hospital ED-departments. Lack of time, lack of resources, lack of motivation and role perception were mentioned as barriers.

Sannen and Wilms<sup>111</sup> did a study in GPs who followed a training for the Me-assist screening instrument and found that most frequent reasons not to screen were lack of time (51/111), lack of knowledge about screening instruments (43/111), difficult issue to raise (27/111) and resistance in patients (21/111).

Van Leeuwen<sup>112</sup> performed focus groups with 38 GPs in the Gent-region; she found barriers at the personal level of the GPs (lack of knowledge on what consist problematic use, about existing guidelines for screening and treatment, lack of knowledge about effectiveness of screening and treatment options, lack of skills for screening and treatment, GPs don't regard AUD as a priority, lack of time and too much workload, not their role), barriers at the patient-provider interaction level (patients with AUD deny the problem and do not ask for help, alcohol use is difficult issue to discuss, prejudice of GPs that patients with AUD will not be honest, GPs fear that discussing alcohol use will be too much intruding for patients and will negatively influence patient-doctor relationship) and barriers at the a more societal level (alcohol use is generally accepted in society and sort of taboo to discuss it, alcohol use is a hidden phenomenon, GPs do drink themselves, insufficient second line capacity to treat persons with AUD). A facilitator mentioned in the focus groups was deviant lab-values, what make initiating the talk easier. And although the GPs were not enthusiastic for screening for AUD, some saw also possible advantages like facilitating the discussion on alcohol use and leading more patients to treatment.



Finally, in the Up-to-Date study<sup>109, 113, 114</sup> questionnaires were sent to general practitioners (413 respondents, both Dutch and French speaking) and occupational physicians (274 respondents, both Dutch and French speaking), and focus groups were performed with a selection of both professional groups. The questionnaire was on substance use in general and some specific questions on alcohol use. Although 86% of the GPs regarded treatment of alcohol use problems as part of their role, more than 30% found it difficult to do and 57% experienced feelings of powerlessness; also fear of breaking the therapeutic professional-patient relationship and fear of burn-out through starting treatment were mentioned as barriers. Facilitating factors to initiate screening and treatment appeared to be having more knowledge (sources) on the topic, confidence in their capability, an attitude of caregivers that patients are not to be blamed for their alcohol use problem, patients that themselves initiated the discussion and more possibilities to easily refer patients. In the occupational physicians group 32% mentioned to have inadequate specific communication skills.

In summary, Belgian (from both Dutch and French speaking communities) studies found the same barriers in professionals as were mentioned in the reviews and in other countries. Also here the most frequent mentioned barriers are lack of time and lack of knowledge and confidence.

### 3.2.3.4 *Discussion barriers and facilitators at the level of professionals*

Health care practitioners face many barriers to initiate screening, discuss alcohol problems and/or start intervention. Common mentioned barriers are lack of time and lack of knowledge and confidence. These results were found across different professionals, different settings, different countries and since many years.

It can be discussed if lack of time is a real barrier or rather frequently mentioned as kind of excuse. It is easier to say there is no time, than to say I don't like working with AUD people or it is not part of my job. Pas et al.<sup>107</sup> phrased *"that GPs experienced a major emotional burden in dealing with alcohol problems, expressed as 'workload' or 'lack of time'".* E.g., a trial<sup>115</sup> in which consultation time for GPs was experimentally changed from 6 to 10 minutes resulted only in increase of alcohol use discussion from 1.4% to 3.3%.

### 3.2.4 *Interventions targeted at barriers in professionals with regard to screen and/or initiate treatment*

#### **MAIN FINDINGS Interventions targeted at barriers in professionals**

- **Four systematic reviews found that some form of education/training had a positive impact on knowledge and attitude and may improve screening rates, applying brief interventions and raise the issue of alcohol use.**
- **The reviews showed that higher intensity of education/training and multi-component interventions led to more positive effects.**
- **However, all reviews stated as well that there was a lot of diversity in training formats and intensity, making it difficult to synthesize the results and to define the optimum duration and format of such initiatives.**
- **Also all four reviews stated that the studies examined were very heterogeneous, and often not scientifically rigorous enough to provide conclusive answers.**

**Six Belgian empirical intervention studies also found that some kind of training may improve screening rates and the application of brief interventions by health care professionals.**

In the previous chapter we saw that there are many obstacles in health professionals to discuss alcohol intake and/or screen for possible alcohol problems to do so. In this section we looked at interventions that were studied to increase the rate of screening, giving brief interventions or raise the issue of alcohol.





### 3.2.4.1 Reviews

We made a selection of well documented systematic reviews that included interventions studies towards health care professionals and specifically related to the alcohol field AND presented outcome data on either number of patients screened, number of patients given brief interventions of frequency of raising the issue of alcohol consumption.

We found 4 systematic reviews (in 5 references)<sup>93, 116-119</sup> that fulfilled our inclusion criteria. Of note, we discovered a very recent review<sup>120</sup> that currently was only published as a conference abstract and is not yet included in the data-synthesis awaiting publication<sup>a</sup>.

Some characteristics of these reviews are presented in Table 5.

**Table 6 – Interventions for barriers in professionals: Review characteristics**

Reference	Methodology	Population characteristics	Intervention(s)	Critical appraisal of review quality
<b>Anderson_2004</b>	N data sources: 8 Searched period: up to 2001 N included studies: 12 Funding: not reported	All of the providers were accredited general practitioners or family practice physicians, with the exception of the study by Rodney et al. (1985), in which the providers were family medicine residents Primary care  Studies origin: - Australia 2x - Canada 2x - multi-country 3x - UK 5x - USA 2x	Studies testing the effectiveness of different strategies to engage general practitioners in managing alcohol problems (excluding alcohol dependence) Interventions were most frequent (10x) some kind of education/training sometimes with additional co-interventions, such as telephone follow-up,	Amstar: 6 Synthesis: meta-analysis
<b>Nilsen_2006</b>	N data sources: 4 Searched period: up to 03/2005 N included studies: 11	921 GPs, 266 nurses, 88 medical students and 44 “non-physicians” participated Primary care	Studies on training components for physicians and/ or nurses to implement Brief Interventions	Amstar: 4 Synthesis: descriptive

<sup>a</sup> In august 2015, this review has been published as early view article (<sup>121</sup>). We did not further assessed methodological quality nor did we a full data-extraction, but the findings are in line with the four other reviews we included.



	Funding: not reported	Studies origin: - Australia 3x - Denmark 1x - Finland 1x - multinational collaborative study 1x - Sweden 2x - UK 2x - USA 1x	Interventions were telemarketing, educational materials, training, support and communication strategies in different combinations	
<b>Walters_2005</b>	N data sources: 5 Searched period: unclear N included studies: 17 Funding: not reported	practitioners to provide services in the community Primary care Studies origin: Not clear	Studies on training in some psychosocial intervention for substance abuse (e.g., motivational, cognitive-behavioral, counseling, brief advice);	Amstar: 4 Synthesis: descriptive
<b>Watson_2010</b>	N data sources: 6 Searched period: 1990-2008 N included studies: 9 Funding: not reported	Nurses and midwives both in hospital, ED, primary care, and nurse students Studies origin: - South Africa 1x - Sweden 1x - UK 3x - USA 4x	Studies on the involvement of nurses and midwives in screening and brief interventions for hazardous and harmful use of alcohol and other psychoactive substances Different types of interventions	Amstar: 4 Synthesis: descriptive

The individual reviews are discussed alphabetically below

Anderson et al.<sup>116, 117</sup> performed a systematic review of studies testing the effectiveness of different strategies to engage general practitioners in managing alcohol problems. They included 12 studies (up to 2001) and did a meta-analysis across 12 different interventions and 23 outcomes. The average screening and counselling rates were 45% (95%CI, 33%-56%) for the intervention groups and 32% (95%CI, 20%-43%) for the comparison groups, a difference of 13% (95%CI, 8%-18%). The most promising programs were those that had a specific focus on alcohol, and that were multifaceted. They concluded that it seems possible to increase the engagement of general practitioners in the management of alcohol problems.

Nilsen et al.<sup>118</sup> reviewed the available literature (up to 2005) on the effectiveness of promoting brief intervention implementation by healthcare providers in primary health care. They included 11 studies in which 5 different interventions were descriptively analysed. In general the interventions consisted of distribution of brief intervention materials alone or in combination with some kind of education/training in brief interventions with additional components as booster telephone contacts. A key finding was that implementation effectiveness generally increased with the intensity of the implementation effort, i.e. the amount of training and/or support provided. Nevertheless, the overall effectiveness was rather modest, according to the authors.



Walters et al.<sup>119</sup> reviewed the effectiveness of workshop training for psychosocial substance abuse treatment. They included 17 studies of workshop training. Eight studies concerned general health care providers as general practitioners and nurses; the other nine studies concerned more specialized 'behavioural health care providers'. The training concerned one or more elements such as basic communication skills, brief motivational interviewing, patient-centered counselling, or cognitive behavioral therapy. They synthesized the material in a descriptive way. In general, training tended to improve attendees' knowledge, attitudes, and confidence in working with clients who have substance abuse problems. In particular, there was evidence that relatively brief trainings improved skills and increased the frequency of brief screenings and interventions in medical settings.

Finally, Watson et al.<sup>93</sup> did a review of the literature on the involvement of nurses and midwives in screening and brief interventions for hazardous and harmful use of alcohol and other psychoactive substances. The review looked at different aspects, such as at the effectivity of brief interventions performed by nurses, at barriers and facilitators in nurses to do so and at ways to overcome the barriers in nurses to perform brief interventions. Concerning the latter they included 9 studies on some kind of training in different forms and in different intensity. In their descriptive analysis they found that most studies of training suggested that educational interventions may have a positive impact on nurses' knowledge, skills and attitudes regarding alcohol screening and brief interventions. It was also shown that the more education nurses received the greater the likelihood that they engaged in screening.

So, in summary all four reviews have conclusions in the same direction, and found that some form of education/training had a positive impact on knowledge and attitude and may improve screening rates, applying brief interventions and raise the issue of alcohol use. Also they are in concordance that higher intensity of education/training and multi-component interventions led to more positive effects. However, all reviews stated as well that there is a lot of diversity in training/education formats and intensity, making it difficult to synthesize the results and to define the optimum duration and format of such initiatives. Also all four reviews stated that the studies examined were very heterogeneous, and often not scientifically rigorous

enough to provide conclusive answers. Moreover, it was not clear from the reviews to what control conditions the interventions were compared to.

The findings based on the 4 reviews are in line with a more recent narrative review of Anderson<sup>122</sup>, who stated that education and training can increase the involvement of primary-care providers in managing alcohol- and tobacco-use disorders, with the impact enhanced by additional support and other organizational factors. This view was recently confirmed by a 'state-of-the-art' article of O'Donnell et al.<sup>63</sup>.

Although the included reviews point in the same direction, the evidence is not fully convincing. Moreover the latest evidence included in the reviews dates already from 2010. It may be assumed that there are many more studies done since. So we await the publication of the Keurhorst 2014 review<sup>120</sup> that was presented at the Inebria conference in 2014. Also the results of the large scale multi-country multi-centre ODHIN cluster randomized trial<sup>123</sup> deserves attention before we can come to final recommendations.

Finally, we like to pay attention to the systematic review of Livingston et al.<sup>82</sup> We did not include this review here because no outcomes on screening rate or BI-implementation were analysed. However this review is interesting since they studied interventions to overcome stigma and found that results across several studies included in this review indicated that programs focused on EDUCATING medical students about substance use problems and EXPOSING them to people with substance use disorders are likely to decrease their stigmatizing attitudes and increase comfort levels towards working with this population.

#### 3.2.4.2 *Belgian empirical data*

Findings from the 6 Belgian studies we found on interventions for barriers in professionals are presented below in alphabetically order.

In the review of Anderson,<sup>116</sup> one unpublished Belgian study of Pas et al. was included. In that randomized study a single multifaceted educational outreach visit and six educational telephone contacts (for GPs, n= 129) were tested and they found no significant differences in screening rates or giving brief interventions.

In the review of Nilsen et al.<sup>118</sup> there was a four-country (including Belgium) study<sup>124</sup> included. This study was performed in 340 GPs, of which 129 in



Belgium. The randomized controlled trial evaluated the effectiveness of training and support in increasing screening and brief alcohol intervention. They found that training and support significantly increased GPs' screening and brief intervention rates (likelihood of screening for hazardous and harmful alcohol use [Odds ratio (OR) = 2.2, 95% confidence interval (CI) = 1.3–3.1] and intervening for those found to be at risk (OR = 2.8, 95% CI = 1.6–4.0)). However, it did so only for practitioners who already felt secure and committed in working with drinkers. Training and support did not improve attitudes towards working with drinkers and, moreover, worsened the attitudes of those who were already insecure and uncommitted. There were no specific Belgian results presented.

Filee et al.<sup>47</sup> organized a training for 40 French speaking GPs concerning screening and brief interventions and evaluated the effect afterwards by questionnaires; 22 GPs responded and stated in general the training improved their knowledge, their screening rate and rate of advice to AUD patients.

The study of Funk et al.<sup>125</sup> examined the impact of marketing strategies on the dissemination of a brief alcohol intervention program to general practitioners. GPs were randomly allocated into one of three marketing conditions (direct mail, telemarketing and academic detailing [personal visits]). The GPs who requested a brief intervention program and agreed to use it were stratified by previous marketing condition and randomly allocated into one of three implementation strategy groups: written guidance, outreach training and outreach training plus ongoing telephone support. It was a 6 country study, in which 979 Flemish GPs were approached by a marketing strategy. Acceptance of the brief intervention program was more effective with use of telemarketing (65% total, 72% Belgium) and academic detailing (67% total, 72% Belgium) than with direct mail (32% total, 28% Belgium) for promoting awareness about and consideration of a brief alcohol intervention program. The median proportion of patients screened was higher for trained GPs (6% total, 2% Belgium) and supported GPs (9% total, 1% Belgium) than for control GPs (1% total, 2% Belgium), who received only written guidance on how to conduct brief intervention. Similarly, the median rate for giving advice to at-risk patients was higher for trained GPs (3% total, 2% Belgium) and supported GPs (3% total, 1% Belgium) than for control GPs (0% total, 1% Belgium).

Jacques et al.<sup>108</sup> found that training in motivational training in twelve first-year French speaking postgraduates in psychiatry improved their systematic anamnesis of (alcohol/smoking) consumption habits in patients.

Finally, Sannen et al.<sup>111</sup> evaluated training for GPs concerning the use of alcohol screening instruments in their practice. The evaluation was done by questionnaires to 198 Flemish GPs. After the training 63% of GPs that did not screen before training, stated they will do from now on.

Currently the French speaking scientific society of GPs SSMG is doing a project with 'visiteurs médicaux' to implement S-BI-RT in GP-practices, not yet published.

#### 3.2.4.3 *Discussion Interventions targeted at barriers in professionals*

We included four reviews<sup>93, 116-119</sup> concluding in the same direction. They found that some form of education/training had a positive impact on knowledge and attitude and may improve screening rates, applying brief interventions and raise the issue of alcohol use. Also the reviews were in concordance that higher intensity of education/training and multi-component interventions led to more positive effects. However, all reviews stated as well that there is a lot of diversity in training/education formats and intensity, making it difficult to synthesize the results and to define the optimum duration and format of such initiatives. Also all four reviews stated that the studies examined were very heterogeneous, and often not scientifically rigorous enough to provide conclusive answers. Moreover, it was not clear from the reviews to what control conditions the interventions were compared to.

The findings based on the 4 reviews are in line with a more recent narrative review of Anderson,<sup>122</sup> who stated that education and training can increase the involvement of primary-care providers in managing alcohol- and tobacco-use disorders, with the impact enhanced by additional support and other organizational factors. This view was recently confirmed by a 'state-of-the-art' article of O'Donnell et al.<sup>63</sup>.

Although the included reviews point in the same direction, the evidence is not fully convincing. Moreover the latest evidence included in the reviews dates already from 2010. It may be assumed that there are many more studies done since. So we await the publication of the Keurhorst 2014 review<sup>120</sup> that was presented at the Inebria (International Network on Brief



Interventions for Alcohol and other Drugs) conference in 2014. Also the results of the large scale multi-country multi-centre ODHIN cluster randomized trial<sup>123</sup> deserves attention before we can come to final recommendations.

The Belgian studies concerned all some type of training, mostly for GPs, and showed the same tendency as was found in the reviews, that training may help to increase screening and brief intervention rate. A striking finding in one of the Belgian studies<sup>125</sup> is that the proportion of patients screened and/or the median rate for giving advice to at-risk patients by GPs is as low as 2%, even after training. So there seems to be much room for improvement.

### *3.2.5 Barriers and facilitators at societal level*

#### **MAIN FINDINGS Barriers at societal level**

- From two reviews it is clear that there is a societal stigma on people who have an alcohol use disorder, and this may act as a treatment barrier for patients. Also the societal stigma may influence resource attribution for alcohol treatment and research.
- From one review it appeared that preventative tasks of health care professionals, as screening for alcohol use, are less rewarded by society than treatment activities.
- In many societies drinking is seen as a social activity, and mass-media messages reinforce the idea that moderate drinking can be a healthy habit. This may cause that a drinking advice from a professional may be in conflict with citizens' views.
- The scarce Belgian data also point at the social stigma and that there is not much societal support for making alcohol use disorders an important topic.



## 3.2.5.1 Reviews

Table 7 – Societal barriers: Review characteristics

Reference	Methodology	Population characteristics	Research topic	Critical appraisal of review quality
<b>Kulesza_2013</b>	N data sources: 2 Searched period: 1990-2011 N included studies: 28 Funding: training grant	mixed, mostly on patients with substance abuse, only 4 about AUDs alone Studies origin: - Asia 2x - Canada 2x - Europe 2x - USA 22x	Substance Use Related Stigma	Amstar: 2 Synthesis: descriptive
<b>Schomerus_2011</b>	N data sources: 5 Searched period: up to 2010 N included studies: 17 Funding: Glaxo SmithKline and Lundbec	General population Studies origin: - Brazil 1x - Ethiopia 1x - Europe 7x - New Zealand 3x - North America 5x	The stigma of alcohol dependence compared with other mental disorders	Amstar: 2 Synthesis: descriptive
<b>Rubio-Valera_2014</b>	N data sources: 5 Searched period: Up to 01/2013 N included studies: 35 Funding: no funding	Physicians and nurses Setting: primary care Studies origin: - Australia 2x - Canada 1x - Denmark 4x - Germany 2x - Ireland 1x - Israel 1x - Netherlands 1x - New Zealand 1 - Spain 2x - Sweden 2x - Switzerland 1x - UK 13x - USA 3x	Qualitative studies exploring physicians and nurses' perceptions regarding the implementation of primary prevention and health-promotion activities addressed to adults in a primary care context. The phenomena of interest were the factors (barriers and facilitators) that have an impact on the implementation of these activities..	Amstar: 7 Synthesis: meta-ethnography





In the preceding sections on barriers in patients and professionals, it was already mentioned that there are also experienced barriers that are more on societal level.

With regard to patients, Kulesza et al.<sup>31</sup> found that individuals who use drugs (including alcohol) were seen as significantly more responsible for their disorder, and least worthy of help but more able to overcome their condition than either those with mental illness or in a wheelchair. Moreover they found that alcohol users are more stigmatized in society than people who use other drugs. Also they found that people with a higher level of perceived public stigma were less likely to have a history of past year treatment utilization.

This is in line with the review of Schomerus et al.<sup>36</sup>, who found, based on 17 general population studies, that alcoholism is severely stigmatized in society and it is thought that people with an alcohol problem are self responsible for causing it. Also they found that alcohol-dependent people evoked more irritation, anger and repulsion than people with schizophrenia or depression, but less empathy, understanding, pity and desire to help. Alcohol problems were also seen as a health condition for which resources could be cut down and preferences for public funding of research identified alcoholism as an illness on which research funds should not be spent first or should rather not be spent at all.

With regard to professionals, Rubio et al.<sup>38</sup> mentioned several 'societal' barriers:

- Health systems expecting general practitioners to perform preventative health care activities, as alcohol screening and discussing but not making resources hereto available, causing lack of motivation in GP
- In society and in many health care organizations there may be a predominance of the biomedical model, which prioritizes disease treatment rather than prevention, leading to few resources being allocated to implementation of preventive actions
- In many societies drinking is seen as a social activity, and could be supported by mass-media messages reinforcing the idea that moderate drinking can be a healthy habit. This may cause that a drinking advice from a professional may be in conflict with citizens' views
- Socioeconomic and political context affects the (lack of) distribution of resources

### 3.2.5.2 *Belgian empirical data*

In a RIZIV-study (Fedito Brussel 2014), it was found that stigma and uninsured status are important barriers to seek help for people with an alcohol dependence; however no numbers or sizes are given.

In the multi-country WHO study<sup>107</sup>, it is mentioned in the chapter on Flanders that they did not succeed at federal and Flemish governments to get the study on implementation of SBI in general practice funded due 'to competing priorities in the ministerial budgets at that time'.

In a sample of Belgian companies, Tecco et al.<sup>126</sup> found that most are permissive as it possible and easy to drink alcohol at work on many occasions. Efforts to inform, educate, appraise or react are modest. Few companies have a clear substance abuse policy.

### 3.2.5.3 *Discussion Barriers at societal level*

We did not find many reviews about societal barriers. And the reviews themselves did not identify many primary studies on the extent of societal barriers.

The reviews showed that there is a societal/public stigma towards people with an alcohol use disorder, causing a barrier for patients to seek help on the one hand but also on the other hand that public resources and funding will not easily be directed to treatment and research on this topic. Moreover, drinking is seen as an accepted social activity, making it difficult to problematize the topic.

Next to these preventative actions from health care professionals, as alcohol screening, are less valued by society than treating diseases. This may cause lack of attributed resources for such activities and lack of motivation in professionals. People want to spend public money rather on treatment than on prevention.

It was not clear from the reviews what the magnitude of those factors is and to what extent it refrains treatment uptake.





### 3.2.6 Interventions for barriers/facilitators at societal level

#### MAIN FINDINGS Interventions for barriers/facilitators at societal level

- There is very scarce and only weak evidence on interventions for societal barriers.
- However, educational leaflets with a positive message and motivational interviewing may lower societal stigma.
- Also mass media campaigns are suggested as a means to lower societal barriers.

#### 3.2.6.1 Reviews

**Table 8 – Societal interventions: Review characteristics**

Reference	Methodology	Population characteristics	Intervention(s)	Critical appraisal of review quality
<b>Livingston</b>	N data sources: 11 Searched period: up to 2010 N included studies: 13 (of which 3 concerning social stigma) Funding: Health Canada's Drug Treatment Funding Program	General population  Studies origin: UK 3x	- educational factsheets - educational leaflets with photographs depicting positive stories of people with substance use disorders in recovery/remission - motivational interviewing	Amstar: 6  Synthesis: descriptive
<b>Rubio-Valera_2014</b>	N data sources: 5 Searched period: Up to 01/2013 N included studies: 35 (of which 2 clearly related to societal interventions) Funding: no funding	Health care professionals  Studies origin: - Australia 1x - Israel 1x	social marketing campaigns	Amstar: 7  Synthesis: ethnography meta-



We found two reviews in which interventions at societal level were discussed.

Firstly, Livingston et al.<sup>82</sup> found three interventions studies performed in the general public with social stigma as outcome; all 3 studies were performed in the UK. In the first study educational factsheets were tested with no significant difference between intervention and control groups in attitudes towards alcoholism. In the second study leaflets with positive stories of people with substance use disorders were tested, resulting in a significant decrease in stigmatizing attitudes towards people with heroin and alcohol dependence. The third study found that brief motivational interviews conducted with members of the general public moderately decreased stigmatizing attitudes towards people with alcohol dependence.

Secondly, Rubio et al.<sup>38</sup> refers to two studies from which it would appear that social marketing campaigns that reinforce the message from primary care professionals may be effective; also they recommend (although not clear on what studies they base this) the use of assessment campaigns (e.g., the alcohol trimester, the exercise trimester) which could provide professionals with the excuse to deal with issues that could be perceived as delicate; no clear description of the intervention content was given.

#### 3.2.6.2 *Belgian empirical data*

We found no Belgian empirical data on interventions for barriers at a societal level.

#### 3.2.6.3 *Discussion Interventions for barriers/facilitators at societal level*

In line with the scarce literature on societal barriers, there is even less evidence about societal interventions concerning minimizing the treatment gap.

The two interventions for which some evidence was found that they may help lower societal stigma were educational leaflets and motivational interviewing. However one may question what the feasibility is of both: must educational leaflets be spread mailbox by mailbox? And must motivational interviewing be done with everyone? Who has to organize such activities and who is willing to pay for it?

Mass media campaigns were also suggested, but it was not clear what exactly the content of these must be or to whom these must be directed. Neither it was clear what effect can be expected of it. A recent Cochrane review<sup>127</sup> looked at the effect of mass media campaigns effect on stigma related to mental health in general and concludes that these may lower prejudice, but also there is large variety in content of interventions.

#### 3.2.7 *Theories*

The first research question of this project was formulated as follows 'Is there a theoretical model that gives elements to highlight the low uptake of persons with alcohol use disorders in the care system?'

We did not specifically search for theories, but throughout the literature we searched concerning barriers and facilitators in AUD patients to seek help and or in professionals to screen and start treatment, theories were frequently mentioned.

In fact two types of theories were encountered: 1/theories that explain behaviour and interventions to attain behaviour change, both in patients and in professionals and 2/theories about intervention-dissemination to reach target groups.

##### 3.2.7.1 *Behavioral (change) theories*

#### **Prochaska and DiClemente Transtheoretical stages of change model**

The most common theory we encountered is the 'Transtheoretical stages of change model', initially developed by Prochaska and DiClemente in the beginning of the eighties of the past century. This theory has further been refined and tested in many studies in the following years. One of early publications of this model from 1982<sup>128</sup> has been cited almost 3000 times, according to Google Scholar.

A recent review of Noordman et al.<sup>129</sup> about the effectiveness of communication-related behaviour change techniques in primary care included 23 studies, of which 21 used the Prochaska Transtheoretical stages of change model as theoretical base of the intervention.

Another recent review<sup>130</sup> on theories of behaviour and behaviour change across social and behavioural sciences found 82 theories that were applicable. They found that the transtheoretical stages of change model of Prochaska et al. was most frequently used (cited in 91 articles); the Theory



of Planned Behaviour of Ajzen was found to be used in 36 manuscripts, on a second place, and the Social Cognitive Theory of Bandura was found to be used in 29 manuscripts, on the third place. However, Davis et al. also stated that although the theory of Prochaska appeared most frequently to be applied, it also has been criticised on several grounds and its empirical support has been questioned by systematic review findings.

Recently Heather et al.<sup>131</sup> reviewed the critiques on the Prochaska model with regard to the application in the field of alcohol use disorder and they concluded that although ameliorations could be done, it still is a very useful theory to explain disease course and the different stages a patient goes through.

The stages of change model is also referred as a useful resource in foreign<sup>12, 132, 133</sup> guidelines on alcohol use disorder, as well in Flemish<sup>10, 134, 135</sup> and Walloon/Brussels<sup>136, 137</sup> practice guidelines.

The most state-of-the-art publication about the stages of change theory is the 2013 published book 'Substance abuse treatment and the stages of change. Selecting and planning interventions'.<sup>138</sup>

The main message of this book is that persons with substance use problems go through different stages and that interventions have to fit these stages in order to be beneficial/effective. According to the transtheoretical model, if an individual does not plan to change his/her behavior, there will be no motivation to change. So before initiating some type of intervention, health care professionals do have to assess patient's readiness to change. For instance, the guideline of the Flemish Association for Alcohol and other Drugs<sup>135</sup> states that advice to change behavior is not useful when a patient is in the precontemplation phase and that it may be contra-productive.

Below there is a table from that book 'Substance abuse treatment and the stages of change. Selecting and planning interventions',<sup>138</sup> in which the 5 stages of change and suitable interventions in each stage are presented.

The authors remark that the stages of change are not linear and that people commonly regress and/or cycle back from an advanced stage to an earlier one.



Table 9 – Prochaska &amp; DiClemente transtheoretical stages of change model

STAGES OF CHANGE AND ASSOCIATED FEATURES (from Connors et al., page 10)			
Stage of change	Main characteristic of individuals in this stage	To move to next stage	Intervention match
Precontemplation	<ul style="list-style-type: none"> <li>- No intent to change</li> <li>- Problem behavior seen as having more pros than cons</li> </ul>	<ul style="list-style-type: none"> <li>- Acknowledge problem</li> <li>- Increase awareness of negatives of problem</li> <li>- Evaluate self-regulatory activities</li> <li>- Create interest and concern</li> </ul>	<ul style="list-style-type: none"> <li>- Do not focus on behavioral change</li> <li>- Use motivational strategies</li> </ul>
Contemplation	<ul style="list-style-type: none"> <li>- Thinking about changing</li> <li>- Seeking information about problem</li> <li>- Evaluating pros and cons of change</li> <li>- Not prepared to change yet</li> </ul>	<ul style="list-style-type: none"> <li>- Make decision to act</li> <li>- Engage in preliminary action</li> </ul>	<ul style="list-style-type: none"> <li>- Consciousness raising</li> <li>- Self-re-evaluation</li> <li>- Environmental re-evaluation</li> <li>-</li> </ul>
Preparation	<ul style="list-style-type: none"> <li>- Ready to change in attitude and behavior</li> <li>- May have begun to increase self-regulation and to change</li> </ul>	<ul style="list-style-type: none"> <li>- Set goals and priorities to achieve change</li> <li>- Develop acceptable and effective change plan</li> </ul>	<ul style="list-style-type: none"> <li>- Same as contemplation</li> <li>- Increase commitment or self-liberation</li> <li>-</li> </ul>
Action	<ul style="list-style-type: none"> <li>- Modifying the problem behavior</li> <li>- Learning skills to prevent reversal to full return to problem behavior</li> </ul>	<ul style="list-style-type: none"> <li>- Apply behavior change methods for average of 6 months</li> <li>- Increase self-efficacy to perform the behavior change</li> </ul>	<ul style="list-style-type: none"> <li>- Methods of overt behavior change</li> <li>- Behavioral change processes</li> </ul>
Maintenance	<ul style="list-style-type: none"> <li>- Sustaining changes that have been accomplished</li> </ul>	<ul style="list-style-type: none"> <li>- Integrate change into lifestyle</li> </ul>	<ul style="list-style-type: none"> <li>- Methods of overt behavior change continued</li> </ul>



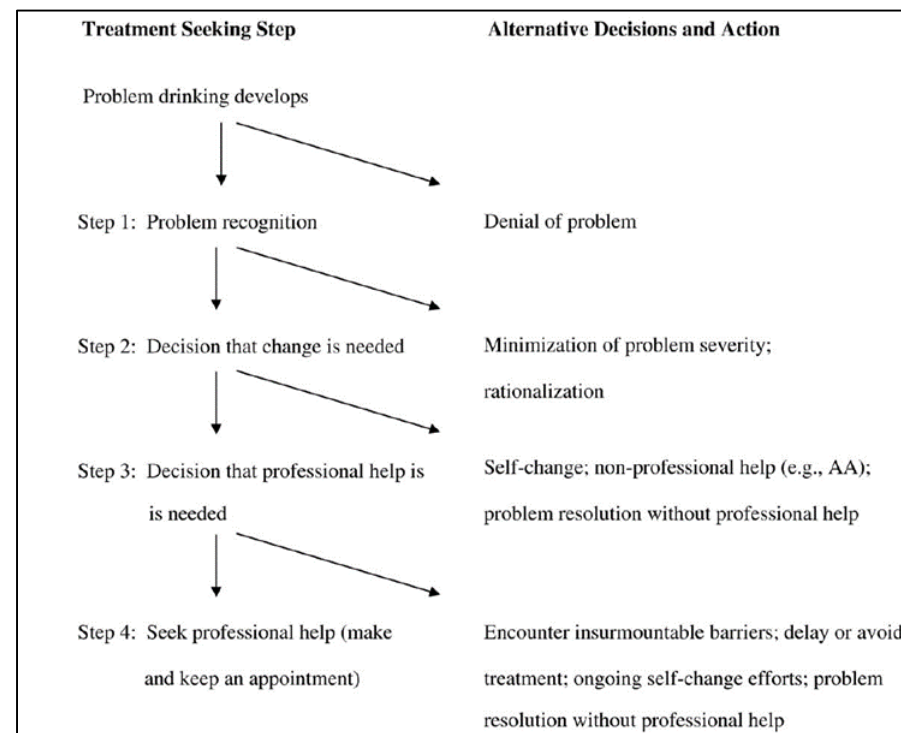
### Other theories for behavioral change

Besides the Prochaska & DiClemente theory, we also encountered different theories that have been used in the field of alcohol use disorders and the change the patients have to make. And as already referred to, the review of Davis et al.<sup>130</sup> found 82 different theories that are applied in the behavioural sciences.

We will not go across all these theories; this is beyond the project boundaries. However, we encountered a theory that is specifically about the help-seeking process and the barriers in this and we encountered two theories that are cited in Belgian documents from the AUD-field and deserve some more explanation.

First we look at the help seeking process model of Saunders.<sup>139-141</sup>

**Figure 1 – treatment seeking process** <sup>140</sup>



In the publication of 2006 specifically related to AUD<sup>140</sup> a 4 step help seeking process was sketched, each with some kind of decision that either lead to the next step of help seeking or to an alternative such as denial or self change. In the 2007 manuscript, concerning help seeking for mental health problems in general,<sup>139</sup> they made it a 7 step help seeking process:

1. recognize that there is a problem,
2. decide the problem is mental health related,
3. decide change is needed,
4. make efforts to effect change,
5. decide professional help is needed to effect change,



6. decide to seek professional help,
7. seek help

Besides demographic factors that influence help seeking (such as gender, race, marital status, education, financial resources). Saunders et al showed that barriers and incentives are different at each step. For instance at step 1 'problem recognition' can be hindered by denial of the problem but also due to a lack of knowledge, and on the other hand problem recognition is easier when the problem is causing more distress and symptoms. Step 2, recognizing the problem is mental and not physical, may be hindered due to the stigma patients feel and think others may have with regard to a mental health problem. At step 3 many persons "think the problem will get better by itself", and they deny change/action is needed, and especially in the case of substance use disorder they simply do not want to change because of the perceived benefits of their abuse. A barrier for Step 5 may be that patients don't believe there is a good type of treatment. Step 6 assumes that patients have knowledge about available and suitable health care professionals and institutions. The final step of seeking help may be hindered by treatment accessibility and affordability.

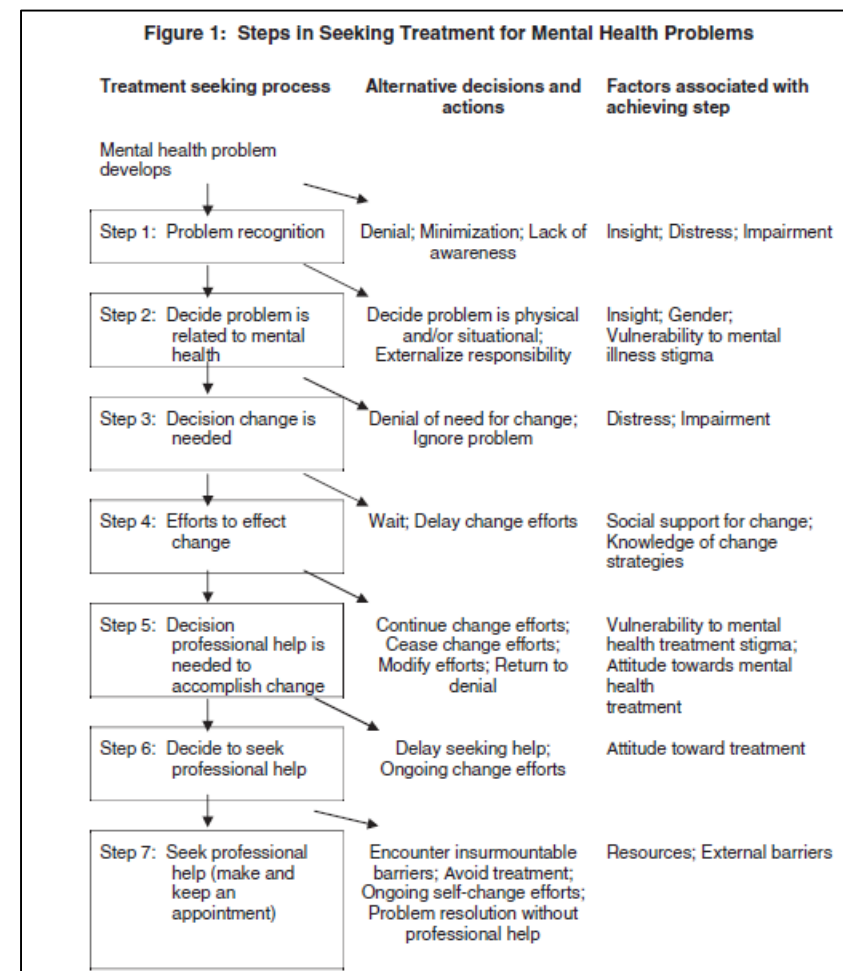
Saunders et al.<sup>140</sup> conceptualised treatment barriers as either "person-related" (cognitive or emotional) or "treatment-related" (availability or cost); in their research they found that person-related barriers tended to predominate throughout the treatment-seeking process, but treatment related barriers as access, availability, insurance issues were in fact only present in the later steps when a decision that professional help will be sought was made.

Likewise, encouraging people to overcome denial is an early process intervention, whereas making treatments more accessible and affordable is a latter process intervention.

Across all steps, Saunders et al. argued that social support is a main facilitator.

In the 2007 paper, they sketched barriers/facilitators at each step of the help seeking process as depicted below.

Figure 2 – Steps in seeking treatment for mental health problems <sup>139</sup>



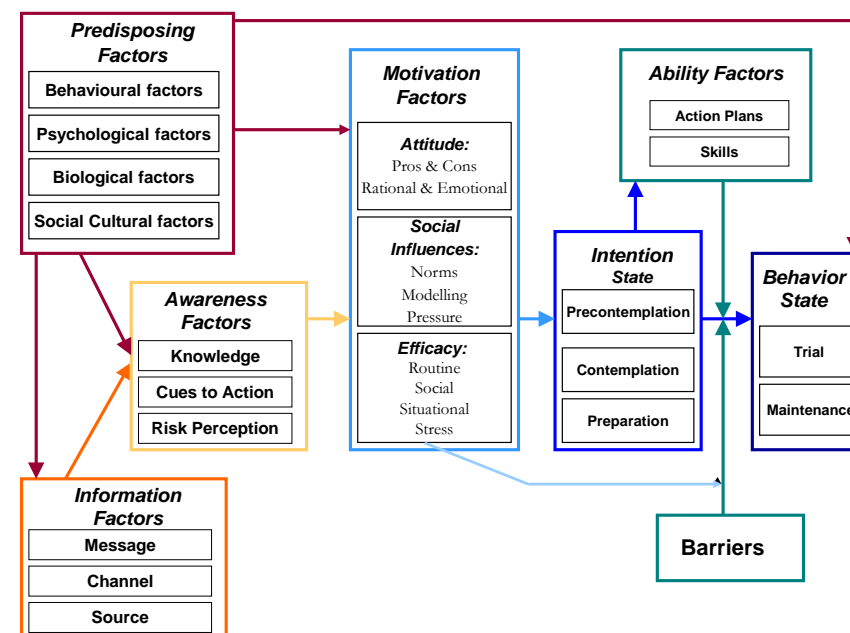
The Flemish manual for care of problematic alcohol use by Ansoms et al.<sup>134</sup> described in short several theories that are used in alcohol treatment. They plea to apply theories that contain physical, psychological and social aspects and the interrelationships between these. They considered the 'dynamic system approach' as a very useful theory. However, they placed the application of this theory mainly in the treatment phase and not as much as theory that explains barriers and facilitators for treatment uptake. With regard to this aspect they used in a following chapter also the Transtheoretical model of Prochaska and DiClemente as explanatory framework.

Ketterer et al.<sup>109</sup> used the I-change model of de Vries, that was applied in, among other fields, smoking cessation programmes.<sup>142-144</sup> According to Ketterer, based on de Vries references, "The Integrated Model (I-Change Model) for explaining motivational and behavioral change was derived from the Attitude–Social influence–Self-Efficacy Model, which is an integration of Ajzen's Theory of Planned Behavior, Bandura's Social Cognitive Theory, Prochaska's Transtheoretical Model, the Health Belief Model, and goal setting theories". Ketterer et al. chose this model because of broad applicability and the embedded motivational cycle in it. More information on the model can be found at <http://www.maastricht-university.eu/hein.devries/interests/i-change-model>. The theories mentioned by Ketterer that are integrated in the I-change model, have frequently been applied, according to the Davis-review: the Theory of Planned Behavior of Ajzen was found to be used in 36 manuscripts, on a second place after Prochaska; the Social Cognitive Theory of Bandura was found to be used in 29 manuscripts, on the third place; the Health Belief Model of Rosenstock was found to be used in 9 manuscripts, ranking 5<sup>th</sup> in Davis list and the goal setting theory was found to be used in 1 manuscript. So, the I-change model integrates at least the three most frequently used theories, as found by Davis et al.<sup>130</sup>. The I-Change Model states that covert and overt behaviors are determined by a person's motivation or intention to carry out a particular type of behavior. The I-Change Model is a phase model and assumes that at least three phases in the behavioral change process can be distinguished:

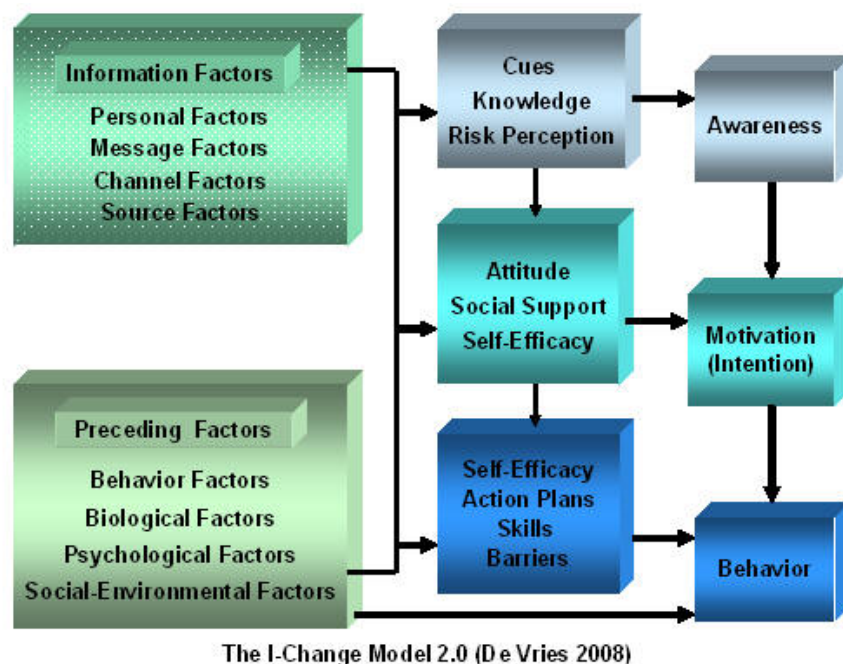
1. Awareness;
2. Motivation;
3. Action/behavior.

For each phase particular determinants are more relevant.

Figure 3 – The I-Change Model <sup>145</sup>





**Figure 4 – The I-Change Model 2.0** <sup>144</sup>

A charming aspect of the I-change model is that it can be used to explain both patients' behaviors (e.g. start seeking treatment) and professionals' behaviors (e.g. start screening on alcohol or start giving brief interventions). E.g. in the Ketterer study, all data from the qualitative interviews with general practitioners could be categorized in one of the boxes of the model. The study found that most of the GP statements regarding working with substance abusers could be classified under 'attitude' from the major 'MOTIVATION' part and may explain why GPs don't 'ACT'; also lack of knowledge within the 'AWARENESS' part played a major role not to 'ACT'. They conclude that if you want to improve 'ACTION', it will be necessary to work on all influencing factors together and simple training to increase knowledge would certainly not be enough.

Studies of de Vries showed that the model is also helpful to explain 'awareness', 'motivation' and 'action' in patients (e.g. in smokers<sup>142, 145</sup> or general public's need and perceptions concerning receiving information on the role of hereditary factors with regard to cancer<sup>145</sup>).

### 3.2.7.2 Implementation theories

Next to theories applicable for patient interventions, we frequently encountered theories applicable to implement new interventions in practice and to persuade health professionals to apply the necessary interventions.

For instance, Bywood et al.<sup>146, 147</sup> performed a systematic literature review of the most commonly used strategies designed to increase the uptake of innovations into professional practice with regard to alcohol and other drugs. They found several theories, some focus on individuals as the unit of change, whereas others address change at the level of the community, organisation or system. They made a distinction in 3 types of theories:

- Intrapersonal: Theories or models that attempt to explain or predict change in an individual's attitudes, knowledge, behavior or intentions to act
- Interpersonal: Theories or models that attempt to explain or predict change in the way individuals act in the context of their social environment
- Ecological / Organisational: Theories or models that attempt to explain or predict change at the level of the organisation or wider social system.

However, according to Bywood, it was difficult to ascertain which theory/model was most effective as there was no consistency in the use of theoretical frameworks and no single theory accounts for all possible variables that contribute to an individual's behaviour or to an organisational change culture and not all theories are useful in all circumstances.

Currently, there is a large European project<sup>120, 123</sup> in which also a systematic review is performed on implementation strategies for reducing harmful drinking. Preliminary results, presented at the 2014 INEBRIA conference,<sup>120</sup> showed that combining strategies targeted at patients as well at professionals as well at organizations as well at society showed strongest effects.



Earlier the UK National Institute for Health and Care Excellence NICE's behaviour change guidance<sup>148</sup> concluded that interventions were more effective if they simultaneously targeted variables at different levels (e.g., individual, community and population). Yardley & Moss<sup>149</sup> gave clear and useful directions how to operationalize the NICE recommendations.

This in line with findings of earlier general reviews<sup>150-152</sup> on implementation theories and strategies which mention that comprehensive multifaceted approaches at different levels (patients, professionals, organizations, wider environment) and tailored to specific settings and target groups are most effective.

Also the KCE report<sup>153</sup> on guidelines dissemination in Belgium concludes that multifaceted interventions produce a larger effect than single interventions and are the most suitable to overcome barriers at all levels.

### 3.2.7.3 Discussion Theories

There is an overwhelming amount of theories available that may be helpful in explaining barriers, facilitators and influencing factors, both in patients not to seek help and in professionals not to initiate screening or start treatment for patients with an alcohol use disorder. Some theories are very specific about behaviour of patients with a substance use disorder, while others are more general about behavioural change in patients and/or professionals. Moreover, some of these theories also take organizational and societal perspectives into account and may give directions toward comprehensive interventions targeted at different levels and so to increase their overall effectiveness.

Important lesson of the theories are that behavioural change is a several stage process, and in each stage barriers and facilitators may differ and so interventions have to be tuned to each specific stage in order to have most effect and to avoid adverse effects. It is not one size fits all.

E.g. it has not much sense to train all GPs in motivational interviewing with alcohol use disorder patients, if most GPs are not motivated to work with this type of patients or don't see as their role. Similarly it has not much sense to refer harmful drinkers to specialized treatment as long as they don't recognize their problem.

The I-change model of de Vries appears to be a suitable theory to explain behaviours of patients and professionals and the barriers/facilitators on patient, professional, and societal level, since it is based on several other change theories, including the most frequently used theories on behaviours of patients with substance use disorders, and is already applied in the Belgian context.

Next to behavioural change theories, we encountered theories about implementation strategies for interventions in health care. These learn that combining strategies targeted at patients as well at professionals as well at organizations as well at society showed strongest effects.

However, although we encountered many theories, of which some look very appealing and applicable, we did not analyse formally how good the theories are for really explaining practice and/or to frame hypotheses testing studies.

## 3.3 Discussion and conclusions

In this literature review, we found a large amount of research (reviews and meta-reviews) concerning barriers and facilitators for patients to seek/get help, as well concerning barriers and facilitators for health care professionals to start screening and some kind of help.

Main barrier in patients to seek help seems to be they deny they have an alcohol use problem, and consequently do not seek help. From the moment they recognize they have a problem, they still may think they can handle it on their own, or it will disappear by itself. Patients are reluctant to seek help e.g. through the fear of being stigmatized. From the moment they seek help, other barriers may come across.

Main barriers in professionals to start screening or initiate treatment seem to be lack of time, lack of knowledge and lack of motivation.

Also there are barriers at the societal level, mainly stigma towards people with an alcohol use disorder.

Also a large amount of research was found to overcome these impediments. The amount of research was that large we had to limit our analyses to reviews, or even meta-reviews on some topics, only.

Main intervention for patients is making them aware of their problem, e.g. by screening on alcohol use and motivational brief interventions.

Main interventions for professionals is to train and to motivate them to screen and give brief interventions.



Interventions at a societal level are less clear.

This literature review focused on alcohol problems, and therefore we certainly have missed useful insights from the larger field of addiction or mental health problems in general. E.g. the studies on stigma on mental illness of Pescosolido<sup>154, 155</sup> contain useful information that could be applicable to alcohol problems.

Also there appeared a large amount of literature about theoretical models that may help explain the phases patients go through in their disease and steps involved in seeking and getting help and by which factors these are influenced. The behavioural change theories are not only applicable to patients, but also to health care professionals who have to change their attitudes and behaviour for case finding and give these patients some kind of help.

However, we also learned from the theoretical models about behavioural change and about evidence dissemination that there is a complex interplay between many factors on the individual patient level and his social environment, many factors on the professional level and the organization structure they work in, many factors about how the society handles alcohol consumption and alcohol problems and governmental policies. Action is needed on all levels, not sequentially but simultaneously. To lower the alcohol treatment gap successfully, it is necessary that all barriers, on all levels, are tackled and a combination of interventions is applied.

Finally, an important aspect that also merged from the literature is that many patients are able to self change once they recognize their problem, and do not always need formal professional treatment. Therefore, it seems of utmost importance to start societal interventions that make people aware that drinking is not sexy and may lead to serious damage and health problems; also there is a need for a variety of low key easy accessible/approachable anonymous interventions to support patients in problem recognition and start self-change.

## 4 QUALITATIVE STUDY: VIEWS FROM PERSONS WITH AN ALCOHOL USE PROBLEM AND CARE PROFESSIONALS

*Chapter Authors: Frédéric Ketterer, Corine Tiedtke, Marie-Claire Lambrechts, Lode Godderis, and Marc Vanmeerbeek*

### 4.1 Methods

The DSM-5 definition of Alcohol Use disorders (AUD) was a reference for the researchers, as it considers AUD as a single disorder with mild, moderate and severe sub-classifications.<sup>156</sup> However, the definition of AUD is rather new and its implementation in practice is still ongoing. So, in this research, we used the term “Alcohol Use Problems” (AUP) in a more comprehensive way (i.e. people with alcohol problems), but without a strict connection to DSM-5 criteria.

This study aims to analyse and reduce the ‘treatment gap’, i.e. the reasons why only a small proportion of adults with AUP seek or receive help or assistance.

Reasons for the treatment gap can be looked for both at the patient and professional level, as with societal factors. Individuals with AUP as well as healthcare professionals are directly involved in the topic. Professionals who are not specialised in AUP, e.g. social workers, can act as observers and may provide a comprehensive view of the problem: they can try to initiate reflection on alcohol consumption with these people and/or communicate signals of problematic use to specialised health care professionals and/or general practitioners (GPs). It was therefore important to know what all those individuals, both on the patient and professional side, specialised and non-specialised, can teach us about the barriers to or difficulties with therapeutic management faced by those with AUP. Some specific roles can be underestimated (e.g. for social workers, peers or relatives), while barriers to specialised treatment can be misunderstood. A qualitative study was thus the preferred approach to gain an in-depth understanding of the treatment gap in Belgium.

Binge drinking among adolescents and alcohol use during pregnancy were considered beyond the scope of this study.



#### 4.1.1 Objectives of the qualitative approach

The objectives of this part were in both (groups of) professionals and individuals with AUP

- To identify the factors on a personal, organisational and societal level that impede or facilitate the screening and advice given by professionals, initiation of treatment, and treatment-uptake by individuals with AUP;
- To understand the complex interactions between those factors;
- To identify the interventions/measures the surveyed individuals and professionals would consider effective in reducing the treatment gap from the point of view of the professionals and patients.

#### 4.1.2 Data collection

Focus groups with health professionals and face-to-face interviews with patients were held. Four healthcare experts in the treatment of AUP (GPs, psychiatrists) were interviewed in person. These experts were expected to give the researchers a broad point of view on the topic.

Face-to-face interviews are the best way to gain an in-depth understanding of personal factors and experiences.<sup>157</sup> In a previous study, the researchers identified the importance of external and motivational factors (attitudes, social influences, and self-efficacy) and the usefulness of this type of qualitative research<sup>109, 113</sup>. However, it was impossible to organise multiple and exclusive individual interviews in the planned period of this study; that was the first reason for performing focus group interviews for professionals, except for four experts for whom interviews were planned. A second reason is that we expected to reap the benefits of group dynamics, since we also wanted ideas to emerge from the group. A minimum of four participants per group was thus required.

##### 4.1.2.1 Data collection process

The interviewing guides focused on the research questions addressed in this study as a second step, in a close collaboration between the research team and the KCE researchers.

Interviewing guides for both professionals and people with AUP explored similar themes:

- For professionals:
  - Ice breaking: what is AUP (for professionals)?
  - First contact with person with AUP: warning signs, perceived consistency between professional role and initiation of dialogue about AUP;
  - Exploration of the treatment gap: difficulties in help-seeking or treatment initiation for individuals with AUP;
  - Experience of practical ways to initiate treatment: collaborations, techniques, resources;
  - Barriers and facilitators: training, organisational issues, social issues, personal factors;
  - Suggestions for improvement.
- For individuals with AUP:
  - Ice breaking: thanks for collaboration; focus on their own experience;
  - Decision to take up treatment: personal journey towards decision; influence of people, health issues, social or professional issues;
  - Barriers and facilitators: lapse of time, steps, people who can support and/or help;
  - Role of professionals: suggestions for improvement.

Attention was paid during the interviews to risky, heavy, hazardous or harmful drinking to encompass a broad range of AUP (quantity, dependence, and physical, financial, social or working issues). As the AUD definition from DSM-5 is seldom used as a reference by health professionals, we used an ice-breaking question clarifying the concept of AUP for the professionals, so that the professionals' representations, i.e. the way somebody apprehends the reality and reacts accordingly to it, could be taken into account during the interviews.<sup>158</sup>



#### 4.1.2.2 Participants

##### Healthcare professionals

This study thus focused on healthcare professionals, both specialised and non-specialised in alcohol problems, which gave us an original/comprehensive point of view on the treatment gap.

We considered it important to include a broad range of non-specialised professionals, given the frequent effects of AUP on physical, social (in family, at work) and financial areas in this broad continuum. Moreover, “appropriate care” includes activities and actions concerning medical, psychological and social aspects. We hypothesised that people with problematic alcohol use are frequently in touch with primary care health professionals, social workers (at work, at home, or when encountering legal difficulties) or home care facilities. Contacts can be initiated for various problems, not only related to AUP, and trusting relationships are common. Primary care and social workers also receive information from relatives on an individual’s AUP, and can therefore play an important signalling role for people with AUP who are not yet diagnosed. If this signal is not perceived, it can be part of the treatment gap. Based on a large definition of problematic use, not every drinker is a “subject” for treatment in organisations specialising in alcohol problems.

The healthcare professionals interviewed were either field practitioners (e.g. GPs, nurses), able to deliver opinions and/or experiences based on their own practice, or experts in management and/or training for alcohol-related problems (e.g. psychologists).

General practitioners (GPs) and occupational physicians (OPs) were recently interviewed by the researchers (Belspo *Up to Date* research)<sup>114</sup> and therefore not approached again for this study. Numerous facilitators and barriers were already mentioned in this study, and are considered in the discussion section.<sup>109, 113</sup>

Four focus groups were planned with healthcare professionals specialised in alcohol problems:

- Two focus groups with psychologists and social workers, from ambulatory care facilities (1 French-speaking and 1 Dutch-speaking group);

- Two focus groups with psychologists and social workers, from residential care facilities (1 French-speaking and 1 Dutch-speaking group);

Eight focus groups were planned with healthcare professionals *not specialised* in alcohol problems

- Two focus groups with social workers (CPAS/OCMW), ambulatory home care coordinators, family support workers, and home-care nurses (1 French-speaking and 1 Dutch-speaking group);
- Two focus groups with prevention advisors specialised in the psychosocial aspects of work (1 French-speaking and 1 Dutch-speaking group);
- Two focus groups with physicians specialised in internal medicine (gastroenterologists, neurologists) (1 French-speaking and 1 Dutch-speaking group);
- Two focus groups with emergency physicians of general hospitals (including “Eenheid voor Psychiatrische Spoed Interventie”/ “Services des urgences psycho-médico-sociales) (1 French-speaking and 1 Dutch-speaking group);

Four face-to-face interviews with experts (GPs, psychiatrists) *specialised* in AUP (2 French-speaking and 2 Dutch-speaking)

A balance between urban and rural areas was considered in each language group.

Healthcare professionals were recruited from within the working networks of the participating departments of Liege and Leuven, and the support organisation Vereniging voor Alcohol- en andere Drugproblemen (VAD), part of the federal umbrella non-profit organisation iDA (<http://www.ida-fr.be/accueil>). Due to difficulties in recruiting for focus groups, (additional) individual interviews were performed with prevention advisors specialised in the psychosocial aspects of work, physicians specialised in internal medicine, and emergency physicians.

The focus groups and individual interviews with healthcare professionals were held in various provinces and in the two linguistic regions to ensure a diversity of local factors that can influence the treatment gap. All groups were led by a trained facilitator and co-facilitator. The meetings and interviews were audiotaped and transcribed.





### Individuals with AUP

Fourteen individuals were interviewed (7 French-speaking and 7 Dutch speaking). They were seen either at home, at the university or in a neutral place, according to their wishes.

Volunteers were recruited through Anonymous Alcoholic groups, GP practices, and/or specialised ambulatory or residential care centres. We paid special attention to diversity when recruiting these individuals (age, urban/rural, socio-economic characteristics, and sex). Although AUP is more prevalent in men, some women were included to look for issues that may differ between men and women (e.g. specific shame and stigmatisation).

#### 4.1.3 Analysis

A thematic analysis was used as a qualitative approach<sup>159</sup>. It was initiated by one researcher in each language group (FK and CT), and then reviewed by another senior researcher (MV) from the transcribed content of the focus group and face-to-face interviews. Results were then structured in a framework to make a distinction between elements linked to individuals with AUP, professionals, relationship between individuals and professionals, and trajectory of care. Elements involved from a more societal point of view and political elements concluded this framework.

#### 4.1.4 Ethical approval

Ethical approval was obtained from the University of Liege (approval no. 2014/345, January 6<sup>th</sup>, 2015) and the University of Leuven (approval no. G-201501134, January 20<sup>th</sup>, 2015).

### 4.2 Results

Interviewee characteristics are described in tables 1 and 2. Due to recruitment difficulties, some focus groups were replaced by individual interviews involving a minimum of four professionals.

**Table 10 – Characteristics of individuals with alcohol use problems**

Language	Sex		Age		
	Male	Female	< 50	50-60	> 60
<b>French-speaking</b>	4	3	1	4	2
<b>Dutch-speaking</b>	5	2	1	3	3
<b>Total</b>	<b>9</b>	<b>5</b>	<b>2</b>	<b>7</b>	<b>5</b>



Table 11 – Characteristics of professionals

	Language	Function	Interviewed In focus group	Individual interviews	Amount of participants
<b>Ambulatory mental health facilities</b>	Dutch-speaking	Social workers, psychotherapist, psychologists, Pedagogue	4	1	5
	French-speaking	Social workers, psychologists, occupational therapist	7		7
<b>Residential mental health facilities</b>	Dutch-speaking	Psychiatrists, psychologists, head managers psychiatric wards	4		4
	French-speaking	Psychologists, social workers	4		4
<b>Emergency physicians</b>	Dutch-speaking	Emergency room physicians	5		5
	French-speaking	Emergency room physicians	2	2	4
<b>Social Workers, ambulatory home care</b>	Dutch-speaking	Family Help, White-Yellow Cross	4		4
	French-speaking	Nurses, coordinators, family help	9		9
<b>Prevention Advisors</b>	Dutch-speaking	Psychologist, prevention advisors (psycho-social aspects)	2	2	4
	French-speaking	Psychologist, prevention advisors (psycho-social aspects)		2	2
<b>Internists physicians</b>	Dutch-speaking	Gastro-Enterologists Hepatologists	2	1	3
	French-speaking	Gastro-Enterologists Neurologists	2	2	4
<b>experts</b>	Dutch-speaking	Psychiatrist, GP		2	2
	French-speaking	Psychiatrist, GP		2	2





#### 4.2.1 Individual with an alcohol use problem

When problem awareness regarding an alcohol problem is needed to change behaviour, the individuals in this research all have a rather chronic alcohol problem.

##### 4.2.1.1 Awareness of the existence of an Alcohol Use Problem

The individual's awareness of the existence of an AUP is considered by those with AUP as well as professionals to be the first condition for seeking help. According to specialised professionals, it should occur as early as possible if there are to be behavioural changes. However, it was often described as a long process, arising progressively during the treatment, and not necessarily at the starting point.

The belief in his/her ability to stop drinking alcohol at any time was common among AUP interviewees. It seems that a lot of them, i.e. the most intoxicated ones over a long period took a long time to be convinced that there was something wrong, which contributed to them not seeking professional or medical help. The drinking problem often became worse over a period of years, and bad habits tended to become part of everyday life, contributing to a delay in awareness of the problem.

*Je me disais « dans quel état je suis ? Il faut que j'aille travailler », parce que j'ai continué à assumer. Beaucoup de mes collègues ne se sont même jamais rendus compte que j'avais eu un problème de ce côté-là. (Patient)*

In the early stages of AUP, patients reported that their social life could be maintained. But progressively the quality deteriorated in combination with increased social isolation. However, those who were interviewed assessed their situation as satisfactory for a long time. This gap between the real and perceived quality of their social life tended to delay awareness of the problem and the need to seek help. In fact, unless there were performance or relational difficulties, they did not perceive that there was a problem at all.

A confrontation with serious consequences (job loss, legal issues – related to traffic accident or child care duties, divorce, direct intervention of the supervisor at work) was often, but not always, experienced as a trigger for awareness.

*Mais les éléments déclencheurs qui vous disent qu'il y a un souci c'est qu'on perd pied partout. Aussi bien dans sa vie professionnelle que dans sa vie familiale que dans son propre esprit. Et donc pour ma part, je ne me souviens plus des dates exactes mais ça a commencé de cette façon-là. (Patient)*

In fact, according to specialised physicians, some of the situations described above were incentives to seek professional help, while others were barriers, depending on the individual.

At a later stage, specialised professionals (psychologists from mental health facilities and emergency physicians) mentioned that some patients who agreed to start treatment still believed they would be able to keep drinking socially. These AUP individuals were not aware of the need to abstain permanently to avoid future problems, according to specialised professionals. According to professionals from residential mental health facilities and experts, experiences and relapses among individuals with AUP (after a failed first treatment) led them to change their mind later.

*C'est obligatoire de passer par là, je pense. C'est vraiment lié aux réalités de la problématique. Je ne pense pas qu'on saurait... Je pense que c'est un peu comme un fruit qui doit mûrir.*

*Donc il faut qu'ils passent par des expériences ratées ?*

*Oui. Ça fait partie du processus. (Residential mental health facilities)*

Seeking alcohol became the number one goal in life for the most intoxicated people at a severe stage of AUP, so that they didn't have either the energy or the time to start seeking help. They felt weak and did not always know what else to do. With regard to the (un)awareness, experts warned against blaming the patient for his/her denial of the alcohol problem, since they might not be in a position mentally to decide to be sober and down-to-earth because of their drinking pattern.

*...ik ga nog een eindje voortdoen op de ingeslagen weg (...) eens dat dat gezin is opgeblazen (...) en dan raakt ge terug in een diep dal en dat is uw reddingsmiddel bij manier van spreken om de zorgen te vergeten...(Patient)*

Examples of individuals with AUP who were 'not ready' to be treated were given by professionals. Internists witnessed that those experiencing problematic alcohol use have to make a complete mental switch before they



can accept that there is a problem that needs addressing. Primary home care workers (social workers and home helpers) confirmed that awareness and acceptance are the first steps in dealing with the alcohol problem, but they also felt that patients didn't know what to do next, where to go for advice; something that was also confirmed by internists.

*Est-ce que le patient sait à qui s'adresser ? Il a un problème d'alcool, OK, mais on en parle à qui ? Le généraliste, il connaît la maison, il connaît la famille, c'est peut-être gênant, c'est peut-être embêtant. [...] Ça ne doit pas être facile pour le patient non plus de s'y retrouver. On a mal à l'estomac, on va chez le gastro, mais [si] on boit, pourquoi le gastro ? (Internist)*

Prevention advisors mentioned "co-alcoholism" at work (i.e. a reciprocal dynamic between colleagues hiding the problem from the employer, and consequently perpetuating the problem) as an additional difficulty in detecting the problem. Some colleagues start with good intentions when helping to hide the problem of their colleague with AUP and cover for his/her failures at work. In some cases, they can also be involved in this problem. But this can be inappropriate since it delays awareness of the problem. On the work floor, colleagues (rarely) or the supervisors (more frequently) could report the AUP.

As the alcohol use problem evolves gradually over the years, it takes a long time for the individual to become aware of the existence of a problem and to seek help.

There seems to be a gap between the individual's real and perceived quality of social life, which tends to postpone the awareness of the problem and the need to seek help.

Individuals with problematic alcohol use have to make a complete mental switch before they can accept that there is a problem that needs addressing.

Individuals with AUP don't seem to be aware of the need to abstain permanently to avoid future problems.

#### 4.2.1.2 Acceptance of the existence of an AUP

The AUP interviewees came up against many barriers before they were willing to ask for and accept help. Usually they did not want to admit they needed help, because they felt ashamed of not being able to help themselves (felt like a loser) and therefore they tried to reduce their alcohol use.

*... het is moeilijk om zelf te bepalen: 'ik heb een probleem' en als je het bepaalt, zit je al in het stadium dat je er zelf niks meer aan kunt doen... (Patient)*

The feeling of losing power or control and losing face was often dominant. Other reasons were that they saw admission to a hospital as a punishment, or felt that they might not trust the health care professionals. On the one hand, they felt "protected" by hospital care, on the other they also feared the zero-tolerance measure.

Individuals with AUP said that, prior to acceptance, a long period of denial prevented them from taking action. In the beginning, they did not regard their alcohol consumption as dangerous or problematic, even when their friends or relatives gave some serious warning signals. This was experienced as a stumbling-block for seeking professional help.

*...ik gaf wel toe dat er veel problemen in ons gezin waren, maar ik gaf niet toe dat ik die probeerde op te lossen met alcohol (...) ik wist het wel, maar ik ontkende: er zit een groot verschil tussen iets weten en iets niet willen weten... (Patient)*

*C'est d'abord des alertes je vous disais, dans des consommations de festivité, dans des consommations de week-end : « Tu as beaucoup bu », ou parfois même des petites disputes « Tu ne vas pas prendre la voiture. Ne conduis pas, je vais conduire » « Mais non ça va. Je n'ai pas bu. Je rentrerai bien ». Et par fierté on dit « non, non, je n'ai pas bu, je vais pouvoir conduire la voiture ». Et donc ce ne sont pas des situations agréables pour le conjoint. (Patient)*

The individuals with AUP further stressed the importance of not accepting treatment in order to please their relatives, and to repair social problems.

*Il ne faut pas arrêter pour quelqu'un d'autre. Parce que tu vas arrêter pour ta femme, le jour où ta femme te déçoit, que tu la retrouves dans*



*le plumard avec un copain, je crois que, tout de suite, tu vas à la rechute. Faut arrêter pour soi, mais pas pour les autres. (Patient)*

A kind of “magic moment” or “last stream awareness” is often experienced before seeking help and undergoing treatment: being disgusted with themselves, an attempted suicide, clear warning signals from family members. Patients demonstrate that they have to take advantage of a kind of ‘sensitive period’ to undergo treatment. After removing the mask, a few words are sometimes enough to express the feeling of desperation:

*...ik zei eigenlijk maar drie woorden, ik zei: help me, help me alstublieft... (Patient)*

But, according to psychologists from mental health facilities, these external reasons are not enough to really resolve the AUP.

Many professional interviewees, both specialised and non-specialised, agreed that denial was a major barrier to approaching the problem with a patient. However, the specialised professionals provided several likely explanations or clarifications for this phenomenon, according to their specific professional background (experts, emergency physicians, social workers, residential mental health facilities). Denial can also be a defence mechanism linked to some personality disorders (borderline, psychopaths, impaired emotions management and cognition, consumption concealment, egocentric and narcissistic image); in that case, denial makes the diagnosis more difficult. Denial is also enhanced by the difficulty of accepting the loss of control over drinking.

*...iemand die volop aan het drinken is: dat brein is anders (...) dat brein is niet nuchter (...) en dan is de stuwing om te drinken zo evident en groot, onze ervaring leert dat en dat kan gemakkelijk 4-6 weken duren voordat men een beetje in staat is om zichzelf vragen te stellen over hun leven en waar ze mee bezig zijn... (Ambulatory social worker)*

Indeed, ambivalence was also frequently mentioned by specialised professionals: even when patients were already undergoing treatment for AUP, some of them still didn't recognise that they really had a problem. Non-specialised professionals, such as social workers from home care, stressed that the comparison with other drinkers' habits, the lack of recognition of beer as an alcoholic beverage for some of these individuals, and the lack of knowledge of the consequences of drinking habits delayed the awareness.

*Quand il a raccroché [après avoir appelé les AA], il était tout content de me dire que « tu te rends compte » il me fait : « je ne suis pas alcoolique, moi. Celui avec qui j'étais au téléphone c'était un ancien alcoolique, il buvait plus d'un casier de bières à lui tout seul par jour. Je ne bois pas tout ça moi... ». Je me dis « merde alors, ça n'a servi à rien » parce qu'il ne s'est pas dit alcoolique parce qu'il buvait moins que celui qui était au téléphone et qui était le thérapeute, si on veut. (Family help from home care)*

According to specialised professionals (ambulatory and residential care), the first demand for help is not necessarily focused on alcohol consumption. The person needs time to identify the problematic domains of his/her life with relation to alcohol, which can temporarily act as a crutch. The patient's objectives are more relevant than the professional's; their representations of the problem must be confronted.

*Et moi j'ajouterais que la demande n'est pas toujours ciblée sur le produit. La demande est parfois une demande sociale par exemple, une perte de logement ou heu. Donc c'est parfois une demande qui concerne, je vais dire, les effets collatéraux et pas spécialement ciblée sur le produit au départ. Donc, on part de cette demande-là et puis, ben, une fois que la relation de confiance est établie et que les difficultés premières sont en passe d'être résolues, on peut alors aborder le produit dans un deuxième temps. (Psychologist from ambulatory mental health facilities)*

It was also mentioned that individual concerns can be related to social aspects more than addressing the AUP. Although individuals with AUP can suffer various personality disorders and alcohol is used as an anxiolytic substance, in the professionals' opinion an important reason for resistance is an inappropriate referral to a mental health professional, often against the person's will or using a kind of blackmail.

The patients' refusal to accept all or part of the treatment, and the changes in willingness to follow a treatment, were particularly difficult. Yet, inappropriate management of the patient leads to real despondency among professionals, when there is no consensus on the goals between professionals and those with AUP (ambulatory mental health facilities).



The feeling of shame, losing control, losing face and the fear of being admitted to a mental hospital are all barriers to acceptance.

Individuals with AUP demonstrate that they have to take advantage of a kind of 'sensitive period' (being disgusted with themselves, clear signals from family members) to start seeking help.

The person concerned needs time to identify the problematic domains in his/her life in relation to alcohol use: inappropriate understanding of consequences delays awareness and acceptance.

Acceptance is no guarantee that individuals with AUP will follow treatment.

#### 4.2.1.3 Reasons for maintaining drinking pattern/habit

An important element was discussed by patients – even those who were aware of their AUP –, and by specialised and non-specialised professionals: the fear of the treatment, of the change in behaviour needed. Alcohol is part of everyday social life and is even valued in some circles (e.g. wine lovers). By contrast, abstinence can be seen as a social exclusion, and a reason to change everything in life, for a whole lifetime.

*Je l'ai fait, moi j'allais au café puis je buvais un café, un tonic, un Perrier mais je suis avec les mêmes personnes que quand je bois, moi je ne m'amuse plus de la même façon. Parce que les couillonades qu'ils racontent, quand je bois avec eux ça me fait marrer avec eux. Mais quand moi je suis safe, ça ne m'amuse plus du tout. (Patient)*

Although considered essential, abstinence seemed an unattainable objective to some patients. The perceived constraints in residential facilities (rules, community living) could also have impeded the willingness to be treated: it was perceived as a loss of freedom, a regression (felt like children).

Many interpretations were presented by professionals or mentioned by patients to explain AUP, which can also be interpreted as barriers to stop drinking and/or to start treatment.

In a global interpretation, professionals described the use of alcohol as a means of escaping social pressure that people can't cope with. For a large part of their life, alcohol has acted as a solution to their problems. Elderly alcohol consumption could also be seen as being linked to loneliness, a feeling of social uselessness, a lack of social recognition (emergency physicians).

The experts raised the ethical question behind stopping alcohol use if the patient feels unhappy. If a psychiatric illness that was hidden by alcohol then presents, is it a success or a failure? Alcohol brings pleasure, not only disadvantages, and some people can feel the benefits of drinking (according to social workers from mental health facilities). These considerations can impede professionals' willingness to intervene, or favour a postponement of intervention.

*Si vous avez quelqu'un qui ne s'est jamais réalisé, qui est vraiment dans la merde qui se fait de toute façon taper dessus par son mec à longueur de journée et qui a eu ses enfants qui sont morts... Enfin voilà, qu'est-ce qu'elle a à gagner ? (Emergency physician)*

More specifically, AUP was mainly seen by professionals as a consequence of unresolved problems: at work, in the family circle, financial problems, depression, feeling abandoned or unhappy. These problems (and their link with AUP) were confirmed by the patients interviewed.

*...wanneer had ik alcohol nodig: op het moment dat ik verdriet had, op het moment dat ik aan het piekeren was, op het moment dat ik tegenslagen had, op die momenten allemaal (...) het is zo'n duivel, maar het doet geen pijn hè... (Patient)*

In that way, alcohol was a common solution for avoiding questioning oneself, or even regarded and used as a coping mechanism.

*...als ik problemen heb, dan ja, ze zeggen automatische processen en ik geloof daar voor een deel in: het is hetgeen ge jaren gedaan hebt, dat ge gewoon zijt van doen, het is ergens normaal dat ge die oplossing zoekt... (Patient)*

So, according to specialised professionals, it might be dangerous to withdraw consumption when it is used to deal with problems in life, or behavioural problems. Stopping alcohol consumption (without making changes in other aspects of life) could be dangerous for the individual's life





balance, and lead to ineffective intervention by professionals, because it won't prevent relapses.

Abstinence can be an unattainable objective for individuals with AUP.

Fear of treatment including the change in behaviour needed, can be a barrier to stop drinking.

Alcohol use can be a solution for everyday problems (feeling lonely, useless).

Professionals need to be aware of the risk of disturbing a person's life balance by motivating him/her to stop drinking.

#### 4.2.1.4 AUP influence on social life

Linked to the awareness of AUP, some important elements intervene in people's social life. The social environment can impede help-seeking behaviour. Numerous environments stimulate drinking: after work with colleagues, with the spouse, with the parents, attending a reception, workaholics, etc. Some individuals, mainly those in the catering sector, mentioned that alcohol was sometimes a part of their professional life; they cannot have one without the other. The specialised professionals also stressed the link between habits and stress at work in this case. When working in those settings, it may be difficult to be aware of increased alcohol consumption.

The social or friends' network of an individual with AUP that is still in place after a few years is often made up of people like him/her. This can act as a vicious circle in the willingness to seek help or to reduce consumption. Patients confirmed that acquaintances met at the pub help perpetuate the problem, while some were afraid of losing their friends, their social network, if they decided to stop drinking. It is certainly a barrier to stop drinking when one feels "it is not done in my circle".

*...wie regelmatig reist voor zijn werk die moet morgen naar een meeting in Madrid, die gaat naar de luchthaven, die wacht op zijn vliegtuig, is frequente flyer, gaat naar de lounge, pintje. Komt in het vliegtuig, glaasje wijn 'waarom niet'. Komt in zijn hotel, ietske eten, hij zegt toch 'alé, een glaasje wijn erbij', nog een pintje voor het gaan*

*slapen: zijn toch al 4,5 eenheden. De dag daarop een zakenlunch 's middags; het is toch warm in Madrid, terrasje gaan doen met de collega, 's avonds nog een keer eten, glaasje wijn en zo gaat dat door en dat gaat altijd gevaarlijker zijn. En dan geloof ik oprecht dat daar mensen zijn, die zich niet altijd bewust zijn, dat ze eigenlijk te veel drinken... (Internist)*

*Je trouvais ça naturel, dans le sens où tous ceux qui m'entouraient étaient comme moi. Parce que les gens qui vont au café tous les jours, la plupart ce sont des alcooliques. (Patient)*

Prevention advisors also confirmed that the workplace culture partly favours alcohol consumption, as do inconsistencies from the management (e.g. official policy aimed at reducing alcohol consumption on the work floor, and availability of alcohol at staff parties).

*Dans le milieu du travail, ça peut être la culture d'entreprise où effectivement on tend à - c'est logique - aller boire vendredi un verre tous ensemble. Alors un verre c'est pas grave mais très vite ça peut dévier. Ça peut faire partie de la culture de l'entreprise, cette proximité ou en tout cas cet alcool à disposition et où on ne sensibilise pas non plus sur les risques que ça peut engendrer. (Prevention advisor)*

Life events within the relatives' and acquaintances' network can compete with the management of AUP, even if the individuals are aware of it. They can feel a kind of conflict of loyalty, having to choose between the management of another's problem or theirs.

Alcohol (use) is part of social life (friends, social network), which can prevent individuals from seeking help.

Alcohol can also be part of professional life (e.g. catering sector), which can impede awareness of progressive alcohol use.



#### 4.2.1.5 Role of relatives

##### Concerning detection:

According to the interviewees with AUP experiences, relatives or acquaintances have a role to play in their motivational process. It begins with minor remarks (“don’t drive your car in that state”), becomes more and more specific (“Let’s try a week-end without alcohol”) and can progress to more direct advice (“let’s go to the hospital”).

Sometimes this advice comes too early, before there is a real awareness of the problem or a will to change, and is thus ineffective. But at the most critical moments, relatives can save an isolated individual with AUP and make sure that specialised help is provided.

*...ik wilde de deur niet opendoen, ik wilde geen telefoon opnemen. Ik vond dat ik verlaten was van iedereen en ik had alles voorbereid om er een einde aan te maken (...); ik had een afscheidsrede geschreven aan mijn kinderen, mijn zussen, mijn vrienden (...) maar omdat mijn kinderen vonden dat het niet juist was, zijn ze binnengekomen met de huisdokter en die zei: dat kan niet meer en dan ben ik binnengekomen in spoed... (Patient)*

Relatives can trigger acceptance and awareness of the damage caused by alcohol consumption. The spouse may suddenly announce he/she wants a divorce. A child might call his parent an “alcoholic”.

*...mijn zoon komt thuis (...) en hij riep: ge hebt weer gezopen zeker en dat was gelijk een mes dat door mijn lijf ging (...) dat heeft me eigenlijk ertoe aangezet om te telefoon op te nemen en de AA te zoeken... (Patient)*

But some patients also revealed that the close environment can be part of the problem, particularly if the spouse also has AUP (co-addiction). This element was confirmed by specialised professionals: for those with family habits, there is a risk of multi-generation reproduction. As a result, alcohol consumption is part of the culture in some families, even from an early age. The balance in some families depends on alcohol. Alcohol withdrawal can be feared, because of the changes in behaviour that might follow/be required?.

*Maintenant j’ai quand même l’impression que il y a quand même au niveau sociologie de la famille, enfin c’est intuitif je n’ai pas fait d’étude là-dessus, mais généralement les gens qui picolent il y a quand même une tradition de picole dans la famille, plus ou moins modérée. Il y a un historique quand même chez l’un des parents. Oui voilà. Vous avez l’affreux canard, évidemment dans la famille personne ne boit, qui se met à picoler pour faire chier le monde. Mais ça c’est plutôt rarissime. On est souvent chez des gens où il y a une tradition liée à la consommation d’alcool plus ou moins gérée et puis un qui ne gère plus du tout. (Emergency physicians)*

From the professionals’ point of view, the relatives were not always aware of the seriousness of the problem, which is often hidden (home care teams and internists). Moreover, they were often unaware of what to do or they felt desperate, not knowing how to handle their spouse, parent, or sibling who drinks too much in their opinion (experts). Trying to maintain a normal family life without speaking about alcohol tends to delay adequate management. Some professionals suggested that never-ending family support is not always appropriate, since constantly ‘tidying up the mess’ could exacerbate or perpetuate the individual’s alcohol problem (emergency physicians and home care workers).

The close environment could also play a positive role, according to interviewed physicians. Relatives/acquaintances could encourage individuals with AUP to seek help; the fear of losing one’s family or job, if necessary blackmailed by relatives, might act as a motivation for treatment (home care units’ workers, internal medicine specialists, prevention advisors).

*Il y a quelques années, j’avais eu un bénéficiaire comme ça, enfin une bénéficiaire, et sa fille l’avait menacée que si elle n’arrêtait pas de boire, elle ne verrait plus ses petits-enfants. Et ça avait marché. (Family help from home care unit)*

When relatives were present during medical encounters, they frequently gave the physicians relevant information about the alcohol consumption, with or without the consent of the patient.



**Concerning treatment:** the interviewed patients stressed the importance of family support, to keep going in the right direction. Once a person has made the decision to stop drinking, family support is sometimes really experienced as a matter of life or death.

*...als de problemen met mijn kinderen niet oplossen, dan is de kans zeer groot dat ik teruggrijp naar dat hier waar ik machten controle over heb (...) dan ga ik daar weer mee verder, in het kwadraat en nog een keer in het kwadraat en nog een keer in het kwadraat... (Patient)*

From the professionals' side, relatives or close acquaintances should be considered in the management for various reasons. They can provide some useful help in detection and/or support for the patient; either they are part of the problem, whether they drink or not; or they need support for themselves (experts, internists, home care teams, prevention advisors). This idea was confirmed by specialised professionals. Professionals should collaborate with and support the patient's relatives to offer them an opportunity to adopt a more appropriate attitude, and to rebuild a useful network around the patient. Families should also evolve, and learn how to manage the problem, taking into account the changes in family functioning that arise from the patient's behaviour. The relative's appropriate involvement could help to prevent relapses (emergency physicians and professionals from mental health facilities).

*C'est aussi important pour le succès de la prise en charge, du soin, c'est vraiment de réinscrire ces patients dans un réseau, de remonter, de réexpliquer qu'il ne s'agit pas de volonté, que l'on peut bien comprendre que les gens s'épuisent dans leur contact, qu'ils n'y croient plus, mais qu'il est possible aussi d'apporter du soutien à l'entourage et pas qu'au consommateur. (Emergency physician)*

The support of relatives (by making minor observations) can enhance awareness for individuals with AUP.

Relatives can provide useful help in encouraging individuals with AUP to seek help (e.g. advise treatment uptake).

The close environment can act as a barrier in case of co-addiction of family members (spouse, parent, and child).

Relatives can feel desperate when they don't know how to handle a family member with AUP.

#### 4.2.1.6 Biomedical symptoms

On the one hand, AUP was often detected because of its biomedical effects. Patients reported that physical symptoms or impaired laboratory tests have sometimes acted as a trigger for treatment. This was confirmed by the different professionals and experts (GPs and psychiatrists). The internists reported that they were frequently consulted for physical signs of chronic consumption (e.g. biological tests impairment, neuropathy, cirrhosis, and pancreatitis), or serious withdrawal symptoms that the person is confronted with at a certain point in his 'alcohol career'. In addition to these physical symptoms, the professionals specialised in addiction (social workers and psychologists from mental health facilities or emergency rooms) mentioned injuries, behavioural and personal problems, and panic attack as signs of AUP. All these signs described by professionals may act as a trigger to start more in-depth screening and/or initial treatment.

On the other hand, some psychiatric comorbidities were cited by social workers from ambulatory and residential mental health facilities as factors that could impede the treatment initiation.

*...het is aangenamer van dronken te zijn dan depressief bijvoorbeeld (...) anderzijds lokt ook de psychopathologie een vorm van verslaving uit, bijvoorbeeld door vereenzaming, door een zeer groot gevoel van onmacht, van onrecht dat men aangedaan is en waar men eigenlijk zoekt naar compensatie om wat aangename momenten te hebben, tegenover voortdurend depressief of psychotisch te zijn; en dat maakt, als ge de alcohol ook stopt of wegneemt, de psychopathologie ook*





*veel duidelijker wordt en meer naar boven komt met die confrontatie...  
(Ambulatory social worker)*

The experts (GP and psychiatrist) stressed the role of cognitive impairment related to chronic alcohol consumption, particularly at the stage of Korsakoff's dementia (memory, strategy for taking a decision, overestimation of one's own ability to stop drinking) as another barrier.

Internists are frequently consulted for physical signs of chronic alcohol consumption.

Experiencing physical symptoms can act as a trigger for AUP treatment.

Psychiatric comorbidities are cited as factors that can impede treatment initiation.

Severe cognitive impairment can lead to overestimation of one's own ability to stop drinking alcohol.

## 4.2.2 Professional knowledge and self-efficacy

### 4.2.2.1 Knowledge

Most of the professionals (specialised as well as non-specialised) were aware of the prevailing WHO norms concerning safe alcohol consumption in terms of preventing health problems (on average no more than 14 units per week for females and no more than 21 for males). Besides using the norm (which doesn't take into account cultural aspects), specialised professionals more especially pointed at signs of decline in performing at home, at work or other problems, e.g. causing damage, in specific areas of life.

An emergency physician stressed how important it is to make a distinction between acute and chronic alcohol consumption: even if a patient comes to the emergency room for an acute intoxication, it is necessary to make a distinction between acute (and rare and exceptional) abuse and chronic abuse (i.e. "alcoholism").

The French-speaking experts stressed the current situation of AUP during the physicians' basic training, never taught in its own right, always part of another topic, and divided over various medical specialities

(gastroenterology, neurology, psychiatry), because of its numerous complications.

*Au niveau de la formation médicale, le médecin n'est pas du tout préparé à aborder les problèmes de l'alcool, mais pas du tout, mais pas du tout. On n'est pas du tout formé dans nos universités en tout cas, on n'a pas de formation, c'est fort dispersé. C'est le spécialiste du foie qui nous dit « ah entre autres la cirrhose peut être due à l'alcool » et puis c'est le neurologue qui nous dit « ah des crises d'épilepsie, l'alcool peut jouer etc. ». Quant au psychiatre, l'explication qui va être donnée est une explication très psychanalytique comme ça, on avait pas très bien compris mais voilà. (Expert)*

As a consequence, most of the professionals confessed a current lack of knowledge (GPs, psychologists, social workers, occupational physicians, etc.). This lack of knowledge concerned screening, assessment (types of consumers, dependence), referral, and management (experts).

*Je pense qu'on a un déficit de connaissances. L'alcool est la deuxième cause de morbi-mortalité dans le monde. On peut discuter sur les chiffres, mais y a des chiffres qui disent que c'est un mort toutes les dix secondes. Comment se fait-il qu'on n'enseigne pas aux médecins à s'occuper des problèmes d'alcool ? Avouez que là, l'enseignement est donné dans un drôle de sens. On va mettre sur le marché des praticiens qui ne savent pas gérer la deuxième cause de morbi-mortalité. Donc dans la formation de base, à mon sens, il y a un véritable problème. (Expert)*

AUP should become the initial point, taught as a whole, a specific topic, including screening, treatment, and rehabilitation, in its medical, psychological, and social aspects. Although it is already organised by the scientific societies, targeted Continued Medical Education (CME) should also be developed on various topics: physical complications, underlying determinants of AUP, communication skills (motivational interviewing), cognitive disorders, drug therapy during withdrawal, and maintenance treatment (ambulatory mental health facilities, emergency physicians).

Only the specialists in internal medicine reported sufficient medical knowledge on the topic, since they had treated a lot of patients with liver problems. They declared that 30 to 50% of the patients in hepatology wards consisted of individuals with AUP. They considered psychological support



as a role for other professionals. Collaborative work with GPs, psychiatrists, and CME, are opportunities to enhance their skills.

*...ja, ik denk niet dat het aan ons is om die psychotherapie te geven tijdens de consultatie, want daar zijn we ten eerste niet voor opgeleid en dat gaat ons veel te veel tijd kosten (...) ik denk dat een gemotiveerde huisarts het beste is voor deze patiënten en dat we ons laten omringen door centra die daarin gespecialiseerd zijn en vlot toegankelijk zijn... (Gastroenterologist)*

Some professionals expressed a need for enhanced relational skills for better management of patients with AUP. The non-specialised professionals wanted to know how they should act, or wanted some practical skills in psychology for approaching patients with AUP, for discussing the problem; specialised professionals asked for theoretical aspects and management tools.

Professionals are aware of the prevailing WHO norms concerning safe alcohol use in terms of preventing health problems.

With regard to AUP detection and treatment, specialised professionals more especially point at signs of decline in performing at home, at work or at other problems causing damage because of alcohol use.

It is necessary to make a distinction between acute and chronic abuse.

The lack of knowledge among professionals concerns screening, assessment and referral of persons with AUP, which can impede detection and management.

#### 4.2.2.2 Legitimacy

On the one hand, some non-specialised professionals didn't feel entitled to intervene or even to talk about AUP, even if they are early observers of the problem (e.g. professionals of the home care units). In this case, AUP was seen as a private issue and professionals didn't dare ask about alcohol consumption. GPs don't screen because they don't know what to do with a positive answer, according to the experts. Physicians specialised in internal medicine, who are usually confronted with health problems due to excessive or chronic alcohol use, declared that the problem should be approached by

psychologists. Prevention advisors intervened only if AUP had consequences on the work floor. Their intervention consists mainly of referral.

AUP was underestimated by physicians during medical encounters, especially in women (pregnancy monitoring) (specialised professionals, emergency physicians). The non-specialised physicians and the prevention advisors admitted they didn't systematically ask about alcohol consumption. As a consequence, medical records often lack information about alcohol consumption (about 50% of them, according to one expert), even if it is the 2<sup>nd</sup> cause of death in the world.

*Si l'item « tabac » du dossier médical est régulièrement rempli, l'item « alcool » est rempli dans moins de 50 % des cas. Ce qui veut déjà dire qu'avant d'identifier quelqu'un qui a un problème, on ne pose même pas la question de savoir si quelqu'un consomme de l'alcool ou pas. Voilà, c'est là qu'est tout l'enjeu justement. (Expert)*

On the other hand, some professionals felt concerned, because they think AUP is a part of their job and/or of the patient's health. The prevention advisors were directly contacted about problems functioning at work, including impaired safety at work (even though they said dealing with job problems is a role for the employer): by the employers (in case of an employee's performance problems because of suspected problematic alcohol use), the HR department, and colleagues, in case of conflicts or claims for harassment. The individual himself sometimes reported difficulties and asked for advice. Incidentally, an admission interview at the prevention service could be a confidential means of defining the problem. Gastroenterologists specialised in liver diseases explained that they have a professional and 'legal' obligation to ask patients about their alcohol consumption, since many liver problems are caused by alcohol abuse. Their job is inseparable from alcohol, and it is the same for neurologists who manage neuropathies. Some of them mentioned they probably handle the difficulties associated with these patients better than the average in their professional group, and were reinforced by the few success stories they had had. Emergency physicians declared they were willing to mention the damage and its causes to patients coming to the emergency room after acute alcohol intoxication. From the experts' point of view, GPs shouldn't think their mission is to save people; they have to inform, and take care of the patient, as for any chronic disease.



Since AUP is seen as a private issue non-specialised professionals do not feel entitled to intervene or talk about alcohol consumption.

Professionals do not always feel the need to detect or intervene; they pass the buck as far as tackling AUP is concerned.

Physicians may underestimate the problem of AUP; as a consequence, medical records may lack information about alcohol consumption.

If professionals experience AUP as a part of their job, they are more concerned and try to do their utmost and inform the person or take care of him/her.

#### 4.2.2.3 *Feeling of powerlessness among professionals*

All the professionals interviewed had felt powerless in various degrees to manage AUP.

In their opinion, even with basic training, or good will, they were confronted with denial or refusal among the patients. This element was stressed more specifically by non-specialised professionals (i.e. workers in the home care units, prevention advisors, and internists).

Furthermore, on the work floor, the prevention advisors reported the same feeling of powerlessness among employers or HR managers when the Collective Labour Agreement 100 (including an alcohol and drugs policy on the work floor) is not really applied, because prevention advisors don't have the tools to be efficient or to intervene in the event of employees' alcohol problems. Moreover, some occupational physicians don't think about shared professional secrecy and hide some useful information, which prevents employees getting help for their alcohol problems.

The intricate link between AUP and social problems (e.g. loneliness) can also make the physicians uncomfortable (emergency physician).

Professionals (employers, HR managers, occupational physicians) can feel powerless to manage AUP because of a refusal by the individual concerned.

Lack of time is a reason for referring individuals with AUP directly to a psychiatrist.

#### 4.2.2.4 *Resources/tools*

It was mentioned that ideally the consultation time for a first appointment to talk about AUP should not be too short, and should occur at a quiet moment (experts, patients). Some non-specialised professionals meet the patients rather sporadically, or for a quick encounter (nurses, internists). This schedule makes it difficult to screen or assess alcohol consumption, and to build a trusting relationship that allows professionals to approach the problem.

*Ce qui est difficile avec nous les infirmières, c'est que quand on est là c'est maximum une demi-heure. On a peut-être un passage tous les jours mais on n'a pas une action... (Nurse from home care service)*

However, some internists were taking the time and trouble in a busy schedule to make patients progressively aware of the problem and face its consequences.

Some resources or specific tools were cited by professionals as helping them in the area of AUP. Keeping patient files, using inquiry or screening forms (e.g. AUDIT) were cited as an easy means of detection at the first level (if they had enough time), albeit early detection was experienced as difficult by experts.

*...het blijft bijzonder belangrijk om mensen vroeg te gaan detecteren en ik denk dat dat de moeilijkste groep is omdat die mensen eigenlijk nog geen problemen van hun gebruik ondervinden... (Expert)*

Screening should be followed by brief intervention according to experts.

Multi-lingual, neutral, informational folders with options for alcohol help care were seen as accessible and very useful by all the categories of professionals. One expert sharply rebuked the producers of the AA folders for asking the question "are you an alcoholic?", as this reduces its effectiveness as a useful tool.



Professionals from ambulatory care also recommended providing approachable E-health information with anonymous online help, including the possibility to chat with a social worker. Specific tools were developed to assess and confront patient's and professional's representations (ambulatory mental health facilities).

According to specialised professionals, using protocols, motivational interviewing (including the stages of change) seems to be an initial concept in specialised treatment, effective methods for setting goals to suit the patients and reducing the professional's workload.

*Je reviens sur, vraiment, les techniques d'entretien motivationnel, qui sont super pratiques et très efficaces. Ce n'est pas magique, hein, mais moi, ça m'aide vraiment dans le sens où je ne m'épuise plus, c'est le patient qui travaille finalement. Et je l'aide bien sûr, je suis présent, je suis un incitant, mais je ne suis plus à moi tout seul le moteur de la prise en charge, et le patient reprend ce rôle, en disant « moi, mon attente c'est de continuer à consommer, alors comment est-ce que je peux recommencer en essayant peut-être de faire de la réduction des risques ? » et en donnant des informations utiles pour qu'ils puissent le faire en se sécurisant. (Emergency physician)*

Additionally, cognitive-behavioural therapy or even psychotherapy can be initiated, to address comprehensively the person's life domains and his/her "meaning of life". The use of a drinking diary might also be a first step.

*...ik zie toch heel wat collega's met technieken uit de cognitieve gedragstherapie aan de slag gaan en ik denk dat daarnaast mensen met een wat zwaardere persoonlijkheidsproblematiek, die dan baat hebben bij een langdurig traject psychotherapie... (Ambulatory social worker)*

On the work floor, the prevention advisors stressed the role of the collective labour agreement (CAO/CCT 100) which puts the focus mainly on an employee's performance or behavioural consequences in the workplace, leading to easier interventions, because AUP can be approached because of problems at work, while respecting privacy. So it is recognised that prevention advisors can intervene legitimately and there are some procedures for helping prevention advisors to deal with employees.

*...wij begeleiden geen cliënten, wij proberen hen handvatten aan te reiken om verder te kunnen: dat betekent heel vaak ook doorverwijzing naar gespecialiseerde instanties zoals een AA, zoals een afkickcentrum. Wij werken daarin ook samen met de huisarts, dus wij nemen altijd contact op met de huisarts zodat dat ook medisch voor een stuk gecoverd is, maar het blijft, ja, die tussenfunctie. Wij gaan de persoon zelf niet therapeutisch begeleiden, dat is ook onze rol niet, maar wij weten wel iets beter dan die gespecialiseerde hulpverlening wat het effect is van de therapie die iemand volgt op het werk, en is dat zichtbaar voor een leidinggevende... (Prevention advisor)*

Keeping patient files, using inquiry or screening forms are cited as an easy way to detect AUP at first level.

Professionals need to be aware of the importance of taking time to talk about AUP during a first consultation.

Neutral, informal and multi-lingual folders, with options for alcohol help are found to be useful.

Motivational interviewing and cognitive-behaviour therapy were mentioned as effective treatment methods.

#### 4.2.3 Professional/patient relationship in AUP context

##### 4.2.3.1 Confident and empathetic relationship

Specialised as well as non-specialised professionals experienced that treating patients with AUP is difficult and time-consuming, which may result in not broaching the problem or even considering the patient as being responsible for the problem, rather than being a victim. Furthermore, the analysis revealed that professionals might not feel at ease with patients with AUP, not knowing how to address the problem constructively.

It can be concluded that professionals as well as patients tend to wait for a clear signal from each other to discuss the problem or to look for solutions.





However, numerous examples were given by various professionals of a positive approach: welcoming the patient, empathy, no stigma or judgement even when they have their suspicions concerning the topic, relational skills, approach starting from the patient's request rather than from the consumption issue, and attempts to manage the person's sense of guilt and motivate without pressure. This "soft" approach is intended to avoid causing offence and to show that the person is valued.

*Bah, une écoute empathique de manière générale, effectivement, partir avec l'idée qu'on croit ce que la personne nous raconte. C'est-à-dire voir et être à leur écoute. Et si même à un certain moment, il peut y avoir des doutes sur une consommation d'alcool et s'ils nous disent que non, ce n'est pas forcément à ce moment-là à approfondir le sujet. Peut-être y revenir dans un second temps bien sûr. Et puis il faut, bien entendu il y a l'empathie, la manière de poser les questions, la manière de rentrer, enfin tout l'art de la relation. (Emergency physician)*

In that way, even non-specialised professionals reported relevant experiences, avoiding judgement and exploring possible targets, taking the opportunity to provide some help and make agreements on alcohol use, or set milestones. Physicians are aware that caution is needed when addressing an alcohol problem, but specific techniques such as motivational interviewing were rarely cited. Specialised professionals start with a patient's demand for help and try to make patients progressively aware of the problem and face its consequences. In their experience it is difficult for individuals with AUP to consider their problem as a disease that takes time to be treated. But each attempt to set up goals without the patient is felt as worthless. The choice of treatment type should also be made by the patient. According to professionals, this approach is part of the basic training that is required to treat alcohol-related problems. Specialised professionals expressed the importance of sustainable objectives, defined together with the patient; high level demands at the beginning of the process seem to be counterproductive. Patients might ask for an open discussion about alcohol as soon as the problem is suspected by a health professional. At that moment there is no place for stigmatisation, but rather a comprehensive approach.

From the patients' point of view, the confidence should be based on the lack of judgemental attitudes, the type of care proposed (with or without drugs), and the type of profession (GP, psychologist, psychiatrist). The patients expressed specific needs with regard to initiating the process, both for initial care as well as for the numerous relapses.

*Je crois que le Dr G. [son médecin traitant] est, pour moi, un homme qui a toute mon admiration, il a très bien compris le problème la première fois qu'il m'a vue et a mené l'histoire avec beaucoup de psychologie. (Patient)*

It was also important to support the patients in their trajectory of care and their willingness to change, and have a positive attitude towards them despite difficulties or possible relapses – the importance of not judging individuals with AUP was stressed (residential mental health facilities' workers). The interviewed patients were very grateful for this attitude during the process of seeking help. They appreciated professionals who could adopt a motivating and understanding approach when looking at their specific life trajectory, and consider AUP as an illness. Patients especially appreciated respectful support and not feeling under pressure to start treatment, regardless of the professional or the acquaintance (relatives, friends, members of AA groups, health professionals).

*...en dan is het probleem om de juiste persoon op de juiste plaats te vinden die kan meegaan in dat verhaal en jammer genoeg, zo zijn er niet veel... (Patient)*

*Je crois que si une personne étrangère, ou un copain, une copine, mais pas de ma famille en tout cas, était venu m'expliquer exactement ce qu'était la dépendance alcoolique, en me disant qu'il n'y avait aucune honte à cela, que c'était une maladie, et que ce n'était pas compliqué, il suffisait de s'abstenir, non pas pour en guérir, on n'en guérit pas, mais pour bien vivre, tout simplement je crois que cela m'aurait aidée. (Patient)*

Bad experiences with the first professional they encountered for managing AUP were reported by some patients, with psychiatrists, GPs, AA; these experiences were seen as a barrier to seeking help or starting treatment. Similarly, previous experiences in psychiatric wards were barriers to continuing treatment because of the lack of identification with other psychiatric patients, e.g. the difficulty to admit that you are in a similar



situation to that of psychotic patients (reported by residential mental health facilities).

*Quand je suis arrivée là et que j'ai vu des gens, c'était un choc au X [hôpital psychiatrique]. Je les ai engueulés, vous m'avez conduite ici, je suis chez les fous. Dans ma tête j'étais chez les fous. (Patient)*

Specialised professionals also mentioned some patients' lies and manipulations that led to inappropriate attitudes from some other professionals; the consequence could be a lack of willingness to help these patients or to build a trusting relationship with them. This attitude can prevent an open discussion.

Moreover, individuals with AUP can feel ambivalent about the professional's knowledge of the topic of AUP. Incomprehension is often felt, after taking 'the big step'. Some would rather see a GP with an AUP to discuss their problem. Because alcohol is a delicate topic, it is seen as ineffective when an 'inexperienced' professional says: I know what it is. The 'white coat' may intimidate them and provoke resistance.

On the other hand, the role of knowledge or fully skilled professionals seems limited. Individuals with AUP feel that motivation is the basis for seeking help and contacting any professional in this aspect.

*...ge kunt overal naartoe stappen, maar als het niet met uw volle goesting is, gaat ge het niet horen, gaat ge het niet zien en staat ge heel kritisch. Zolang dat basispunt er niet is, moogt ge met van alles en nog wat afkomen, dan gaat het niet lukken... (Patient)*

Treating patients with AUP is experienced by professionals as difficult and time consuming.

Professionals as well as individuals with AUP stress the importance of building up confidence and a relationship, which seems crucial in the treatment of those with AUP.

A cautious approach is needed to address an alcohol problem: showing empathy, and being non-judgemental.

Sustainable objectives, defined together with the person with AUP, helps professionals intervene.

#### 4.2.3.2 Information

Clear and simple messages are understandable, according to the experts: WHO's recommended maximum intake, no drinking during pregnancy. During consultation, it's possible to give specific questions and explanations ("no memory of the end of the party: you were above 3 gr", "I know what will be your cause of death"). This is not telling patients what to do; this is experienced as giving pure information. Reducing consumption might also be a goal.

In addition to creating the right atmosphere and taking enough time, confrontation with the addiction and informing the person with AUP about the consequences is experienced as one of the helpful messages during consultation or treatment. According to the experts, a medical rather than a moral perspective should be presented. Patients have to know that it is not simply a matter of willpower. That has a positive effect on the attitude of patients as well as some professionals.

*...mijn collega zei: het motiveert mij meer om toch het gesprek aan te gaan, je kijkt er anders naar: je ziet het ook als een zieke patiënt die hulp nodig heeft en niet als de manipulatieve, want verslaafden zijn natuurlijk heel vaak manipulatieve mensen... (Expert)*

In addition to creating the right atmosphere and taking enough time, confrontation with the addiction and informing the person with AUP about the consequences is experienced as a helpful message.

According to experts a medical rather than a moral perspective should be presented to the patient.



#### 4.2.4 Care trajectories

##### 4.2.4.1 Accessibility of care

There is a lack of knowledge concerning availability of care for patients. In the beginning, individuals with AUP are probably not fully aware of the existing and available (professional) support as mentioned by non-specialised professionals.

*...mensen weten ook niet altijd direct naar waar ze moeten gaan, ik denk dat het op zich ook niet zo super bekend is waar dat ge terecht kunt en hoe dat allemaal marcheert. Ik denk dat dat soms ook wel meespeelt dat mensen gewoon niet goed weten tot wie zich te richten... (Prevention advisor)*

The interviewed patients confirmed that they experienced difficulties in finding relevant information about the support services for alcohol management. Visibility and a great availability of support structures or people were mentioned as facilitating factors: telephone hotline, posters in public places, AA visiting hospitals, short delays for a first meeting.

Non-specialised professionals stressed the delay in accessing a centre or a multidisciplinary network to manage patients. According to the experts the delay is due to organisational issues and lack of availability. Mental health facilities may use specific admittance procedures that also require the patient to show his/her motivation to undergo treatment, which can lead to the rejection of some patients who mainly need medical help. Patients can also produce a discourse that is expected by some institutions, even if they don't trust it:

*Quand ils viennent en demande d'entrée, avant d'arriver chez nous, ils ont quand même déjà été ... en contact avec d'autres services. Et je pense qu'il y a le premier discours pour pouvoir rentrer dans une posture qui est un discours, on va dire superficiel, de reconnaissance. Mais si on investit et qu'on gratte un petit peu, parfois là on voit quand même qu'il y a encore beaucoup d'ambivalence ou que tout compte fait, moi ça m'arrive souvent, qu'il y ait des gens qui par rapport à la durée du traitement, on voit que leur priorité n'est pas spécialement de se soigner mais plutôt de « oui je suis d'accord de me soigner mais un certain temps parce que j'ai mon boulot » ou il y a*

*d'autres raisons qui passent, ou une vie affective ou des choses comme ça. (Psychologist from residential mental health facilities)*

In general, direct access to specialist centres (ambulatory care) is not possible. First, people have to consult an application team, having been referred by the GP already. This is the way ambulatory facilities work.

For patients with associated mental health problems ('co-morbidity', e.g. borderline personality disorder and AUP), appropriate care facilities are difficult to find. A clear lack of available psychological support (from psychiatrists, ambulatory and residential facilities, who are able to manage alcohol patients) is thus observed.

*Le délai d'attente, on essaie de gérer. On a fait une liste d'attente. A certains moments, on est à saturation chez les assistants sociaux ou chez les psys, on ferme la liste d'attente. On essaie de renvoyer dans d'autres centres de santé mentale et on apprend que, là aussi, c'est trois mois, six mois d'attente, ça c'est quelque chose vraiment... Il y a un moment, on sait que la motivation est là, comme c'est un cheminement, la motivation c'est fluctuant. Ben, parfois quand on les rappelle après trois mois, on fixe un rendez-vous chez l'AS, ben la personne ne vient pas. (Ambulatory mental health facilities)*

More barriers are mentioned: the practical distance in accessing care (lack of mental health facilities, no public transport) and the costs; the financial barriers for the person with AUP. Moreover, because alcohol addiction is not seen as an illness, experts see no possibility of forced intake, for instance after an accident because of drink-driving. No reimbursement from insurance companies can be expected, which can be a barrier. In addition, no equal repayments regarding treatment have been introduced yet. This means there is a marked lack of flow from first line help to specialised treatment.

In the case of multiple problems of the patient (no network, no money, problems in various areas of life, suffering a lot), social workers might not be able to provide suitable help.

According to the interviewed experts, consultation and hospitalisation in psychiatric wards is not always adequate. Individuals with AUP don't identify with mentally ill patients. Emergency physicians experience some difficulties when referring a patient with AUP to a psychiatric department. These patients would rather be treated in the neurology department. The internists





tended to believe that the patients prefer a medical ward than a psychiatric one. Internists preferred dual-discipline hospital wards, managed by both psychiatrists and internists. Hospitalisation in internal medicine is seen to be more acceptable than in psychiatry.

*Vous n'êtes pas obligé d'aller dans un hôpital psychiatrique en cure avec une bande de foldingues pendant un mois. Une semaine de désintoxication dans une clinique normale peut vous en sortir. Mais cela, il n'y a jamais personne qui me l'a dit comme cela, simplement. Il fallait un prétexte pour être hospitalisé, il y le foie qui, il y a les Gamma GT, il y a... Bon. Ne pas diaboliser et simplifier. Voilà, vous pouvez vous désintoxiquer dans n'importe quelle clinique sur une semaine de temps. (Patient)*

Professionals believe that more neutral places are needed: general hospital wards, primary care (with new partnerships), websites and forums. It can allow for a patient to bypass the difficulty of consulting a psychiatrist (fear, lack of identification with insane people), or even a psychologist in a specialist care centre, and can be interesting and relevant alternatives for people who have a negative image of these professionals.

Obstacles are also linked to patients and their life: in order to keep his/her job it may not be possible to stay in residential facilities for the long term. For younger woman and/or divorced men it may not be possible to go into residential facilities because there are children to be cared for.

*...ik kan niet opgenomen worden, want dan verlies ik misschien mijn kinderen... (Patient)*

Some proposals were made with regard to improving accessibility of care. For example, better management of AUP requires more coordinated action. A current pitfall is the fragmented assistance. Networks are changing, and continuous updates are needed. The best way to collaborate is through local meetings that allow for a better knowledge and understanding of what other professionals do. But GPs are reluctant to come to coordination meetings (lack of time, lack of professional recognition). Professional secrecy is still a barrier. Therefore, incentives are needed. A proposal, made by specialised professionals and experts, concerned free access to care. Just as there are financial incentives for prevention of smoking, so there should be similar incentives for AUP.

*Moi ça me fait rire les tabacologues, là, enfin je veux dire c'est remboursé mais pourquoi est-ce qu'on ne rembourse pas les alcoologues ? Il faut qu'on teste l'efficacité de ce genre de pratique (Emergency physician)*

In addition, the ability to join forces with support groups was also cited as a means by which specialised, non-specialised professionals and experts could manage AUP. Experts mentioned that peer groups such as AA are valued differently by individuals with AUP. While for one individual it is the most suitable help, because of the familiarity, respect, warmth and attention experienced, for another it may seem unremarkable. According to the AUP people, AA and health care professionals manage the problem in different ways. More openness from AA would be useful, so that they are not seen as a sect or religious group. But AA can be considered as complementary since this kind of help can be effective for patients.

The lack of knowledge and relevant information concerning availability of care is experienced as a barrier in AUP management.

On the one hand, specific admittance procedures in mental health facilities underline the delay in accessing care; on the other hand, individuals with AUP do not identify with mentally ill patients.

More neutral places are needed: hospitalisation in internal medicine is seen as more acceptable than in a psychiatry ward.

Peer groups such as AA are valued differently by those with AUP. AA can be experienced as the most suitable help but also as a sect or religious group, which can be a deterrent.

#### 4.2.4.2 Collaboration in care

All the professionals interviewed stress the importance of working in a multidisciplinary network (including GPs, internists, emergency physicians, psychologists, and psychiatrists) because it makes it easier to detect a patient with AUP and then intervene. But they also point to the huge volume of informed consents required from the patient with AUP for any telephone call to be made.



Indeed, multidisciplinary networking, when it exists, allows for a tailored choice for each patient, to manage the psychological, social, and medical aspects of the problem. It is this customised approach that seems to help reduce the treatment gap. Multidisciplinary networking is required to be able to manage these patients, because an alcohol problem can have many consequences in different aspects of life. This kind of team work is for example experienced as useful when discussing complicated client files with participatory psychologists, or referring patients to a psychiatrist. After all, several areas of life are the subject of treatment. Ambulant and residential social workers believe in an integrated comprehensive approach: alcohol addiction should not be treated as an isolated problem, as it has diverse personal characteristics and aspects. Patients also appreciate a comprehensive approach. Taking care of their financial problems (joblessness, lack of resources) or their psychological distress was described as the trigger that enabled them to start treatment. Integrated care centres that offer various services were seen as convenient facilities.

*J'ai appris qu'à H, il y avait le service de santé mentale, et qu'il y avait le service psychologie, psychiatrie, assistante sociale. Je me suis dit « Bon, il y a les trois qui sont réunis dans un même centre, je vais téléphoner, voir ce que c'est, et je vais me diriger là directement ».*  
(Patient)

In order for it to work properly, a reference person is needed to coordinate the different partners; GPs were cited by ambulatory care workers as relevant in this role, but the patient himself might be best placed to choose a reference person. The important role of GPs in the network was underlined, both to coordinate professional interventions, and to make the link between ambulatory and residential care. But a partnership has to be developed. The current situation is not felt to be ideal: GPs have to prove their efficacy in the domain to be accepted as reliable partners. Dutch-speaking prevention advisors often contact the GP and try to refer the person with AUP to specialised centres. They would prefer more cooperation between the relevant parties (employer, employee, GP, social worker), but they also focused on professional secrecy, and the fact that they might be an intermediary with the employer on the one hand, and the employee on the other.

Some positive examples were given. "Medical homes" were cited as an example of coordinated structures (multidisciplinary care including

psychological facility, referral system, work objectives) that are willing to participate in larger networks (ambulatory mental health facilities). Family helpers were cited as network members with growing importance, particularly for early detection and referral (ambulatory mental health facilities).

Emergency rooms of general hospitals are suitable places for detecting problematic use of alcohol (e.g. traumatology, physical or psychiatric disorders induced by acute or chronic consumption) when there is collaboration between emergency physicians and acute mental health units. Specialists from the emergency department try to do as much as they can in the 15 minutes they see the person: first aid and a short consultation. Usually, these physicians can do no more than detect, monitor and refer the person. By contrast, some hospitals lack adequate resources, so it is difficult to start any treatment.

*...je moet ervan uitgaan dat je op uw spoedgevallendienst vijf nieuwe patiënten ziet per uur. Met de intake van een persoon met een alcoholprobleem ben je al 5 minuten bezig (...) dan moet je de familie nog even horen en dan nog een aantal contacten leggen met de psychiater om te kijken waar er een bed vrij is enzo meer, en is uw beschikbare tijd voor die patiënt weg... (Emergency specialist)*

*Mais il faut du temps, c'est chronophage. C'est ça le problème. Mais bien souvent, on a envie, on aimerait bien de creuser, parce qu'on a envie d'aider, on est là pour cela. Mais, à un moment donné, on doit s'arrêter, on passe la main ou bien les gens s'en vont, et ils ne reviendront plus ou ils reviendront. (Emergency physician)*

Mobile teams (section "107") are experienced as an added value: they can help individuals with AUP in their trusted environment and may bridge the gap between primary and residential care. Home care workers notice intensified issues regarding alcohol problems and regret the fact that the contacted mobile teams, who are really supportive, have a limited staff and long waiting lists, which is experienced as inadequate. Assistance for the patient with AUP is then seriously delayed.

Specialised psychiatrists can play an excellent role in the management of alcohol-related problems, along with other health care professionals (gastroenterologists).



Multidisciplinary networking seems an important facilitator in detecting individuals with AUP, as it allows for a tailored choice of professional.

Partnership between GPs and ambulatory and/or residential care has to be developed because mistrust exists on both sides.

Family helpers are cited as network members with growing importance for early detection and referral.

Mobile teams are experienced as an added value as they could bridge the gap between primary and residential care.

#### 4.2.4.3 Importance of first line care

For all professionals interviewed, first line (i.e. ambulatory) care, and especially GPs, seems the best way to detect AUP. In the experts' opinion, GPs are perfectly entitled to recognise patients with AUP, because they are generally experienced as sensitive professionals with regard to physical and social problems. GPs are seen to have the most comprehensive understanding of a patient's environment, a clear idea of their socioeconomic level, and their alcohol consumption.

*Il le connaît, il connaît son patient, il connaît la famille, il connaît le milieu socio-économique, il connaît le tissu social, où il habite et tout. C'est une ressource qui n'a pas de prix, le médecin traitant.*  
(Emergency physician)

Although the patients interviewed indicated there was a certain threshold for seeking help, GPs usually seem to know their patients. Consulting this professional might be a good start for individuals with AUP.

*...ik heb een huisarts waar ik zeer gemakkelijk tegen kan praten. Die mens maakt een keer tijd, het is geen psycholoog, maar toch luistert hij. Ik zeg altijd: een goed gesprek met een huisarts, is al een halve genezing... (Patient)*

Various professionals in primary care (GPs, family helpers, and occupational physicians) might also detect problematic consumption. Family helpers are showing more interest in the topic, and referral from these organisations is growing. Concurrently, specialised social workers, who contact GPs regularly, notice that GPs don't always bring up the alcohol topic for

discussion immediately. So, GPs' attitudes (personal preference for the topic) or work style might also be involved.

*...ik heb deze week een huisarts aan de lijn gehad die al op 10 bezoeken 'alcohol vraagteken' in het dossier had staan van de patiënt, maar nog nooit met de patiënt zelf had besproken daarover...  
(Residential care worker)*

Although GPs don't always bring up the topic of alcohol for discussion, in experts' opinion they are perfectly entitled to recognise and detect patients with AUP.

#### 4.2.5 Social acceptance of alcohol, not of AUP

##### 4.2.5.1 Different views on stigma/illness underlined in results

With respect to the way in which AUP is regarded, there is a major difference, depending on whether AUP is considered an illness or a moral failure. Stigma concerning alcohol consumption is linked to the idea of willingness, of personal responsibility for one's own health: a moral interpretation rather than a medical one. In society AUP is associated with a moral failure.

*Moi je pense à quelque chose qui bloque éventuellement l'accès aux soins : c'est finalement l'image que la société a des personnes qui ont une dépendance vis-à-vis de l'alcool. C'est « l'alcoolique », il n'a pas de volonté, il... Pour la plupart des personnes, c'est un manque de volonté. Et donc c'est un souci aussi de dire : « ben oui, j'ai une dépendance à l'alcool ». Il y a le regard des autres, je pense que cela doit souvent bloquer l'accès aux soins et que, si au niveau de la société on avait un autre regard, je pense que ça pourrait aider.*  
(Psychologist from ambulatory mental health facilities)

This negative image was also shared by those with AUP, which might be why they don't seek help. According to the interviewed participants, having a problem with alcohol use is considered a big social taboo. Individuals with AUP, as well as professionals, come out with all the common statements about AUP ("the umpteenth drunk", "boozer"; "once an alcoholic, always an alcoholic"; "a bad person", "an untrustworthy liar", "a danger to society"),



which means that people don't feel accepted and understood in society. They feel criticism, which is really discouraging.

*...ja, dat is zoiets als mensen met een andere geaardheid uit de kast moeten komen, ook zoiets naar de buitenwereld toe dat je een drankprobleem hebt (...) Mensen die het ofwel niet hebben meegemaakt of niet in hun naaste omgeving hebben meegemaakt, beschouwen een drankprobleem als self-affected: ge doet het u zelf aan, je moet er maar afblijven dus het was eigenlijk een beetje het onbegrip, het taboe ja, dat mij ervan weerhield om die stap te zetten van: ik heb een probleem en ik moet opgenomen worden er moet iets aan gedaan worden... (Patient)*

The professionals interpret the difficulties the patients have asking for help as a consequence of shame about this embarrassing topic. Internal reasons (low self-esteem and self-image), and external reasons (fear of judgement, lack of willingness, inappropriate attitudes on the part of some professionals) were mentioned in this aspect. It seems to be extremely difficult to admit having an alcohol problem, but one of the experts believes that experiencing this stigma, especially for those with a long history of AUP, can be a pretext for avoiding professional help.

There was a consensus among experts that AUP should be considered an illness, a chronic disease which requires treatment and not a cure.

*Après, on est vraiment dans l'accompagnement d'une pathologie chronique, je trouve aussi que ça marche bien. Apprendre à faire un peu le deuil de son idéal de guérir. Moi je ne guéris pas un diabète. Je ne sais pas s'il y a déjà des médecins qui ont guéri un diabète. Peut-être en faisant maigrir beaucoup les patients. Bon, je rigole un peu mais on sait bien que c'est une pathologie chronique quoi. Donc, je pense que ça c'est important, ça marche bien aussi d'accompagner ces gens et, du coup, ils vont avoir une autre relation. (Expert)*

Residential care workers highlight the fact that the AUP, which is in general the focus of treatment, is only the tip of the iceberg. Stigmatisation hides a lack of knowledge concerning AUP, which can lead to inappropriate attitudes from professionals.

Stigma is a difficult concept to get to grips with.

In society AUP is associated with a moral failure because it is linked to a person's responsibility for their own health.

People with AUP don't feel accepted or understood by society: the criticism they feel is discouraging.

Experts stress that AUP should be considered an illness.

#### 4.2.5.2 Professionals and their own alcohol consumption

The way in which professionals dealt with the alcohol topic appeared to stem from their personal history: own consumption, family history of AUP. A worrying matter is that professionals accuse colleagues of being drinkers and that patients accuse professionals of being drinkers. Professionals who drink alcohol on a regular basis might underestimate this topic more frequently. From that perspective, "an alcoholic is somebody who drinks more than the physician".

*Alors vous savez pour le médecin, je le dis parfois en boutade, mais est alcoolique, pour un médecin, celui qui boit plus que lui. Alors si même le médecin a la gentillesse de dire : « Oh là, vous avez des Gamma-GT etc., vous buvez beaucoup ? » et si la personne dit : « Vous savez moi, je bois une demi-bouteille de vin par jour et puis 2 trappistes ». Eh bien, si le médecin boit sa bouteille tous les jours, il aura tendance à dire : « oh ben non c'est pas bien grave ». (Expert)*

This was not experienced in the same way by all professionals, but it shows that specialised as well as non-specialised professionals sometimes wrestle with the topic. Furthermore, it might hide a lack of collaboration between the parties involved. On the other hand, when patients encounter professionals with AUP, this can have contradictory effects when it comes to consulting them and asking for help.

*...ik ken alle psychiaters in de omgeving en ik schat die niet heel hoog, moet ik zeggen, zijnde dat ik de twee die ik het beste ken, zouden misschien zelf een keer mee naar AA gaan... (Patient)*





*...die huisarts, die heeft een aantal tips gegeven. Want kijk, die begreep het grotendeels wel, dat was ook iemand die net een echtscheiding achter de rug had en die ook zijn 'vriend' staan had naast hem of in zijn lade of wat ook... (Patient)*

Professional's own alcohol use can have contradictory effects: they might have more empathy with the AUP individual, or they may underestimate the problem.

#### 4.2.5.3 Social acceptance of alcohol: anyone to blame?

The interviewed professionals stressed that alcohol is an integral part of Belgian society with its "Burgundian culture" (Flemish internists). Availability of alcohol is a major facilitator to consumption because it is everywhere and linked to pleasure. Furthermore its distribution and sale is legal to consumers from the age of 16 (18 for spirits), and advertising is also legal<sup>160</sup>. The social pressure to consume alcohol is high in various contexts (e.g. to move up the career ladder). Alcohol and pleasure are strongly associated in people's minds. You are odd if you don't drink half a bottle of wine on a daily basis. The interviewed persons with AUP regarded this known fact as part of the reason for their existing alcohol problem.

*...in een warenhuis (...) passeert ge eerst door de drank en u eindigt ook aan de kleine fleskes aan de kassa (...) ge wordt direct geconfronteerd met uw 'lieveling'... (Patient)*

Despite its numerous consequences (injuries, absenteeism, liver diseases, etc.), according to specialised professionals, alcohol is not seen as a top priority in public health. Society and the government might feel ambiguous (morbidity-mortality versus advertisement and tax revenues). Experts feel confronted with the fact that there is no global view on the problem. There is a parallel between, on the one hand, the availability of alcohol and alcohol-related problems, and, on the other hand, the availability of sugar and fat and the prevalence of obesity and diabetes.

*A dessein ou sans dessein, on est dans une société où il y a de l'alcool partout. Et donc on voit les gens devenir dépendants. Eh bien on est dans une société où on trouve du sucre et de la graisse partout,*

*et qu'est-ce qu'on voit, les gens grossir. Ce n'est pas compliqué. (Expert)*

But alcohol is not as prominent in public health concerns as it should be. The consequences of alcohol consumption are minimised and the number of deaths attributable to alcohol remains unknown, in the opinion of patients.

As a consequence, a lack of public health initiatives to limit alcohol consumption is emphasised. To change this mentality, clear messages concerning the risks of alcohol consumption are needed. Various targets and methods should be considered. Information about alcohol-related risks should target both professionals and the general public, even from an early age (at school). It should address the various ways consumption can become problematic. Alcohol could be considered as an acceptable "social" drug like coffee, vitamins, stimulants; but the rules for its safe use should be taught.

*...alcohol is lekker, kan aangenaam zijn en als je het op een goede manier doet hoeft het echt niet problematisch te zijn... (Gastroenterologist)*

All available media should be used to inform people about the risks (with particular emphasis on binge drinking and alcohol consumption during pregnancy). The final aim of all these initiatives is to change the mentality surrounding alcohol consumption, not to forbid the product. A parallel is made with tobacco: society has succeeded in changing attitudes towards smoking. Is it possible to do the same for alcohol? Changing people's mindset about alcohol should be a goal; it could reduce its attractiveness. The public health campaigns against tobacco haven't been launched against alcohol. "Alcohol is damaging to your health" is different from "tobacco kills".

The social pressure to drink alcohol is high: it is easily available and associated with pleasure.

It is felt that there is a lack of public health initiatives to limit alcohol consumption: clear messages concerning the risks are needed.

People's mindset about alcohol has to be changed: like tobacco, alcohol can be damaging to health.



#### 4.2.6 Political level: actions and ambiguity

The most important thing, stressed by the interviewed professionals, might be the ambiguous policy in Belgium concerning alcohol. There is no global alcohol plan, due to a suspected lack of political willingness and lobbying by alcohol manufacturers. Alcohol is thought to be an important source of income for the State. That's why advertising is felt to be unrestricted and legal; alcohol can be purchased legally from the age of 16 and marketing pressure is huge. In Belgium, 24/7 access to alcohol is far too easy.

*On va commencer par le début : déjà une meilleure prévention, une politique vraiment active et authentique par rapport à cette disponibilité, parce que là, on est quand même dans quelque chose de très schizophrénique : qu'est-ce que c'est facile de consommer quoi, quelle manne céleste, finalement, cela rapporte à l'Etat. Donc il y a là un premier travail à faire. (Emergency physician)*

In order to reduce the accessibility and advertising of alcohol, measures are needed to change the image of alcohol in society. It is found that people take a long time to admit that they are having problems because of drinking too much. The motivation to start treatment may still be a long way off.

*Je pense que la publicité et la diminution de l'accessibilité doivent faire partie des mesures politiques. La prévention, non pas par des messages grand public en disant « attention l'alcool » mais donc les messages à l'école, dans l'éducation, dans les différentes formations que les gens reçoivent au cours de leur existence, ça doit aussi changer. Mais toutes ces choses-là sont importantes. Si on ne fait qu'une mesure, ça va foirer. (Expert)*

To reduce the treatment gap, a focus on social conditions and the way people live is also proposed. Studies on alcohol problems are split into different parts, which prevents a global view. Some professionals also stressed that the main problem is not AUP, as this is a consequence of social problems. Politics should first try to solve social problems (poverty, unemployment, feeling of unease). Disadvantaged people should be helped. A higher social level is perhaps a facilitating factor, mainly in terms of cultural or financial support. Persons with a low socio-economic status should benefit from structured and comprehensive support, like the sort that mental health facilities or "medical houses" can currently provide.

To enhance treatment uptake, health care professionals as well as individuals with AUP proposed measures in two areas: 1/ information (image, social service agencies) and 2/ clinical supervision and communication. On the other hand all the interviewees warn against overestimating the effect of these measures. Public campaigns and supervision, as well as communication between agencies are required. Society has to be made more aware of the subject. Therefore, the message should be: 'having a problem with alcohol is not something to be ashamed about and proper help is available'. Unfortunately, people suffering from AUP do not always know where to turn. Information about first-line help and social service agencies (and their trajectories) is highly appreciated. Available low-threshold, free, and online help might be a good starting place for reaching (younger) people. Without adopting a 'big brother' approach, people should interact with individuals suffering from AUP.

In order to reduce the accessibility and advertising of alcohol, measures are needed to change the image of alcohol in society.

To enhance treatment-uptake global measures are proposed on information, communication and collaboration between agencies.

More public health messages are required: having a problem with alcohol is not something to be ashamed of and proper help is available.

Available low-threshold, free, and online help might be a good starting place for reaching (younger) people.

### 4.3 Discussion

This qualitative research was set up to investigate barriers and facilitators with regard to the existing treatment gap for AUP. Our global approach was a qualitative paradigm (thematic analysis) allowing us to explore the phenomenon from the viewpoints of all the actors involved: experts, individuals with AUP, specialised and non-specialised professionals. Barriers, as well as facilitators to seeking help and starting treatment, have been extracted from the interviews and focus groups and confirm previous studies concerning Belgian General Practitioners and Occupational physicians.<sup>109, 113</sup>



Different barriers as well as facilitators are experienced by individuals with AUP and professionals. It appears that the treatment gap is a multiple phenomenon. Some elements are related to the individuals with an AUP, some others to the health professionals, and, more globally, in the socioeconomic context. The barriers and facilitators for the different parties and levels are outlined below and compared to the literature (first to the “Up to Date” studies conducted by the same research team,<sup>114</sup> secondly to other Belgian studies and then to international findings, if relevant).

Four main themes could be deduced from the interviews:

Firstly, the trajectory of an individual with AUP can be long: they can go through a long and stepped process before becoming aware of and recognising their problem. In general, a lot of work, full of trial and error, has been done before help is accepted. It can be a long time before awareness develops in individuals suffering from AUP.

*Secondly, the relatives can play a role.* Relatives (at home or in the social network) and colleagues (at work) play an important role along the patient trajectory. They can be a help as well as a hindrance. At the beginning, the close family is confronted with the first signs of AUP. Out of loyalty, spouses and children first try to support the person concerned. Similar behaviour was described on the work floor with colleagues. But at a certain point, which can take years, relatives can move away from the individual with AUP.

*Thirdly, not all professionals are effective or reliable partners for individuals with AUP.* The analysis revealed that some professionals lack the time, knowledge, skills and proper attitudes. Furthermore, they pass the buck when it comes to tackling the AUP. Specialised professionals and experts feel more able to manage the alcohol problem than non-specialised professionals, but they lack the time.

*Fourthly, society and the healthcare system are affected.* The origin and treatment of AUP are largely influenced by societal habits and views. Furthermore, there is a lack of political action to de-motivate alcohol use.

#### 4.3.1 Individuals' trajectory

The awareness of the problem among the affected individuals, and the professionals' management seems to be a stepped process. Some steps can be directly related to the stages of change of Prochaska's transtheoretical model<sup>161</sup>. However, the steps described below can be interpreted as successive levels of change (but not necessarily as a linear process), each of them requiring its specific motivational process. Moreover, interruptions and relapses within the process are common.

1. **A total absence of awareness of the problem.** This first step is the beginning of AUP in the person's life. It was often described as a very gradual beginning; old consumption habits tended to become increasingly and insidiously important.
2. **Outbreak of obvious harmful consequences.** This step was raised by those with AUP, for whom it was the first experience of damage linked to their consumption, and professionals, who could see the first signs of a potential consumption problem. Those consequences can arise in one or several dimensions of health: medical (health issues related to alcohol consumption), psychological (alcohol psychological dependence related to a life balance, communication or relational difficulties), and/or social (family tension with a spouse or children, problems at work, judiciary issues).
3. **Willingness to mitigate or eliminate the harmful consequences.** Once the harmful consequences have been perceived by the individual, some attempts are made to mitigate these consequences, without reducing the alcohol consumption. The awareness of an AUP and the need for a more global change in life are not yet perceived. At this stage, a person can agree to be treated to satisfy the requests of those around them (family, work, judiciary) and reduce the negative consequences, at a medical or social level.
4. **Global awareness of AUP.** At this step, the persistence or the renewed outbreak of the problems described above, the difficulty or impossibility of finding a final solution, leads the individual to believe that alcohol is the key issue and that the difficulties experienced in daily life are a consequence of its consumption.





5. **Individual attempt at regulation.** Once AUP is considered central, attempts to regulate consumption can begin. This can be related to the refusal to acknowledge AUP at a social level, or the feeling of shame that comes with the awareness of the problem. In their opinion when becoming aware, after long-term denial, it then takes time to recognise that they (might) need help. The feeling of losing face (“being an alcoholic”) and the fear of losing control in their personal and/or professional life initially prevents them from seeking help. In the literature, this social stigma is also found to be a barrier for initiating treatment.<sup>31, 36</sup>
6. **Awareness of the need for external help.** If individual attempts at regulation fail, the recognition of the need for external help may arise in the person’s mind. The individual admits his/her AUP and its negative identity, and his/her inability to effectively manage the problem. Professional help can be considered at this step. If the individual integrates the concept of AUP as a disease, it allows him to seek medical help, because, in that case, AUP then means more than just a personal weakness for that person. The shift from “weakness” to “disease” was described both by professionals and patients as an important step towards successful professional management. Indeed, not considering their problem as a disease is found to be another barrier for those affected by AUP. Once they start seeking help, they might not know, or cannot decide, who to approach. The participants interviewed mentioned that they lack information on this aspect. This treatment-related barrier coincides with the findings from Council and McKellar et al.<sup>29, 34</sup>. What people with AUP do know is that they do not consider themselves mentally ill, so, in any event, they fear being admitted to a (mental) hospital, and being punished in that way for their AUP.
7. **Seeking and demanding professional and medical help.** This can vary from impersonal seeking (e.g. on the web or help lines) to more personal seeking, as a direct and clear demand to GPs; patients’ demand for help was underlined in Ketterer’s Belgian study as a predictor of professional management of AUP<sup>109</sup>. Practical, psychological (e.g. lack of confidence in professionals) and financial barriers (e.g. being employed and fearing dismissal) are experienced, which can also give way to ambivalent feelings regarding the request for help and treatment. This ambivalence can also hide a lack of

motivation at a specific moment because people feel insecure about seeking and accepting help. In contrast, clear family signals, a good network and a stable environment can *facilitate* help-seeking behaviour. With support from relatives, patients feel inclined to start doing something. According to McKellar et al<sup>34</sup> and Tsogia et al<sup>37</sup>, family influence indeed facilitates problem recognition and help-seeking. Similarly, remaining in employment facilitates faster improvement and the mitigation of alcohol consumption’s harmful consequences, as also described for mental illnesses and complex addiction problems.<sup>162-164</sup> Furthermore, being confronted by the professional (e.g. the GP) with the addiction in the right atmosphere, and receiving information about the consequences is felt as a facilitator too. In this aspect, the professional’s skills and attitude, along with the proposed suggestions, were crucial. The role of supervisors was considered as very important in the Up To Date study. In the opinion of Occupational Physicians they have to confront the employee with performance problems which can motivate changes in behaviour.<sup>113</sup> Leong & Tam also found the interaction between the patient and the professional and tailored interventions important.<sup>32</sup> Individuals with AUP seem to take advantage of critical events (e.g. after an accident or suicide attempt). This, in combination with a ‘sensitive period’ (a match regarding awareness and willingness), facilitates help-seeking behaviour. This is in line with the ‘readiness to change phase’ in Prochaska’s transtheoretical model.<sup>161</sup> Moreover, direct access to neutral environments, with skilled professionals (able to manage alcohol problems), would be welcomed, especially in the ‘readiness to change phase’.

#### **Awareness of the necessary fundamental changes at a personal level.**

This last step is related to the frequent relapses, each of which can also include a treatment gap. As specialised professionals mentioned, the successful management of AUP requires far-reaching life changes. Once withdrawal is completed, new lifestyle habits and behavioural changes are needed for abstinence maintenance (this is part of the difficulty encountered in the case of psychiatric comorbidities, according to professionals). Individuals with AUP reported the importance of family support and social environment (which can favour or prevent relapse). The fact that each attempt at light consumption tends to cause a relapse of AUP, makes it



progressively obvious that abstinence is often essential, albeit difficult to accept. This fact was confirmed by professionals.

From the previous scale, it appears that successive treatment gaps should be considered for each person. For some individuals with AUP, the first four steps can be sufficient (awareness is always necessary), with consumption being regulated without professional intervention. In the literature, there is evidence that, indeed, most people with an alcohol problem are able to change their problematic behaviour without any kind of formal/professional.<sup>16-20, 22</sup> The way in which we recruited individuals with AUP (by health professionals) had a clear impact on the kind of experience that they reported. This issue is further discussed in the “limitations of the study” section.

A first attempt at seeking help/treatment can also occur in the third step. However, this can be insufficient for severe AUP, which might require going through the whole process until the eighth step.

The gap between the seventh and eighth steps seems to contain the numerous failures in recurrent or chronical professional management; a bad environment is also deeply problematical at this stage, as professionals have little influence on it.

These steps are not necessarily experienced as different moments in a person's life; some steps can be skipped (e.g. global awareness (4) can come just after the awareness of harmful consequences (2) skipping the willingness to mitigate them (3)).

In our study, website help was suggested. Patients themselves did not mention or talk about these interventions, but most of them were older than 50. These websites for screening and informing might be more effective for younger people.

#### 4.3.2 *Place and role of relatives*

Some of the results concerned relatives. By “relatives”, we mean family, acquaintances, friends, but also colleagues. It appears that relatives can play a positive role in decreasing the treatment gap, and put pressure on the individual to seek help: if there are tensions in the family, if the person fears losing his/her personal network (e.g. divorce or losing his/her children). In the same way, colleagues at work can inform the management of a problem.

Nevertheless, it appears that there is also some ambiguity regarding relatives' attitudes. Even when affected by AUP, they don't always know how to react. They can be tolerant or patient, expecting the problem to resolve itself or to be solved only by personal willingness. This attitude can delay seeking help. It underlines a lack of information concerning AUP from family. But it can also be a feeling of shame, a refusal to communicate about what is considered a personal or an intimate problem. For these reasons, information about AUP should be widely disseminated. In this regard we like to refer to the work of Orford et al.<sup>165-167</sup> who described the experiences of family members of persons with AUP and how they can be supported.

This is apparently what happens in the workplace: the Collective Labour agreement 100 (CLA 100) is a preventive framework that focuses on consequences at work. It can work as a trial to tackle AUP.<sup>113</sup> It provides information to workers, but also helps the management to know how to act when an alcohol-related work problem occurs.

Acquaintances and friends can play a negative role in looking for help: when AUP is serious and chronic, a friendship network is often composed of other people with AUP, and it tends to become the “normal” way of life. So, looking for help and trying to reduce or to stop alcohol consumption can require a complete change in lifestyle, with the risk of losing friends. Even during treatment, this friend network increases the risk of relapses that professionals have difficulty remedying.

But, when relatives put pressure on an individual to seek help, this can be very helpful for professionals, who can work in collaboration with them and involve them in AUP management.

This study didn't involve any relatives of individuals with AUP. It might be interesting in a further study to interview some of them to obtain another point of view.



### 4.3.3 Professionals concerns

#### 4.3.3.1 Knowledge and competency

The lack of professional's competency in AUP management was frequently mentioned in this study. The interviewed professionals experienced *barriers* to detecting a person with AUP, primarily because of a lack of knowledge, time, and/or a lack of collaboration between professionals to be able, and then, to manage this problem. The fear of losing the patient after the discussion, and the lack of interest concerning this topic, are frequently reported in the literature, in particular in other Belgian studies, although they were not found in this study.<sup>47, 49, 109, 111, 112</sup> Lack of knowledge about alcohol use and its risks (including training on the topic) and lack of time seem to be barriers in the Belgian context, as Belgian studies demonstrated.<sup>47, 49, 104, 106, 109, 111-113</sup>

GPs' lack of theoretical knowledge and training in this area are important determinants of their behaviours. The Up To Date study concerning Occupational Physicians (OPs) revealed that the lack of knowledge among OPs differed depending on the product, and was determined by their past experience with employees using alcohol and/or other drugs.<sup>113</sup>

Pas et al.<sup>107</sup> suggested that lack of time can be used as an excuse for not wanting to work with people with AUP. Professionals also accused each other of (not) being responsible for the AUP detection, perhaps also an excuse. Despondency is felt when, in the professional's opinion, a person with AUP is not motivated. This also acts as a barrier. This is in line with the findings in the studies by de Timary, and Filee.<sup>47, 106</sup> But the long delay in obtaining an appointment for the patient and/or the long waiting lists for treatment, especially at specialised care centres, as mentioned earlier among Belgian GPs and OPs, are felt as major barriers.<sup>109, 113</sup>

These findings concerning the Belgian context are also found in the literature about other countries. For example, studies by Jackson *et al.* and Johnson *et al.* point to these perceived role barriers for professionals, especially regarding the delivery of brief interventions or the feeling of despondency which can act as a barrier to intervention.<sup>27, 30</sup> We might consider the waiting list as a referral barrier, according to Rubio-Valeria et al.<sup>38</sup>

For *professionals*, education would be a good intervention with regard to screening and initiating treatment.<sup>93, 117-119, 124</sup> Except for the home care

workers, none of the (non-specialised) professionals openly admitted a lack of skills/ knowledge. Actually, emergency physicians and prevention advisors felt they had enough medical or psychological skills, but they did not consider screening a part of their role.

#### 4.3.3.2 Multidisciplinary networking

Multidisciplinary networking, as well as interest in the subject (and thus for individuals with AUP), was experienced as a facilitating factor for professionals to intervene. According to Rubio-Valeria et al, this is effective only if the patient is motivated.<sup>38</sup>

In the eyes of specialised professionals, it is helpful when GPs and emergency physicians in particular also feel responsible for detecting the person with AUP and make enquiries on a regular basis. GPs should therefore be involved in the management as reliable partners who, at a first level, can motivate the patient and take practical steps (referral or adapted advice). This is of particular interest since the literature shows that GPs are not at ease with this topic. There is sometimes some disinterest, some difficulties to overcome, a lack of knowledge concerning existing tools (as Short Brief Intervention), management possibilities and resources in the health system, as found in the Up To Date study, but also in other Belgian studies.<sup>49, 109, 111, 112</sup>

These expectations concerning the role played by other professionals (i.e. considering that other professionals have to manage the problem) can also be interpreted as a lack of willingness to manage this kind of patient for several reasons (moral judgement, fear of burn-out, lack of interest, etc.). It underlines the need to have some procedures and active communication and collaboration between professionals to try to help patients with AUP.

A coordinator (go-between) might be capable of bridging existing gaps between professionals, while respecting the patient's autonomy.

In order to promote a multidisciplinary approach inside the company in dealing with alcohol and other drug problems, it was recommended that the management of these problems by the OP involve a close collaboration with the prevention advisor in charge of psychosocial aspects and with the Human Resources department.<sup>114</sup>



#### 4.3.3.3 Attitude

The professionals' attitude towards AUP is also an important issue. By considering AUP a (chronic) health issue, a more or less positive behaviour is generated towards the individuals concerned. By contrast, considering the topic as a moral failure can lead to a refusal of its management or thinking of it as a private issue, which they don't have to deal with. Similar results were found in studies concerning Belgian GPs.<sup>47, 109, 112</sup>

A consensus emerged to place the GP in a central place to detect and adequately refer patients with AUP. However, a recent study demonstrated that GPs' behaviour on that topic is more "attitudinally" than "normatively" driven.<sup>109</sup> This gap between the expected role and what GPs really do is of the utmost importance; a pilot study should consider ways to reduce it in the following areas: information, training, motivation, and incentives.

Also in the Up To Date study, the significant effect of OPs' attitudes to their approach when treating employee substance abuse was remarkable. This is in line with a review by Skinner et al. who concluded that 'a wide range of factors influence health professionals' responses to Alcohol and Other Drugs (AOD) issues – one important factor is their attitude towards AOD-related work'<sup>168</sup>.

#### 4.3.3.4 Patient denial

Patient denial was also frequently mentioned by the professionals; however, this word has different meanings. Ontologically, it supposes awareness of a phenomenon, without acceptance of it. We found that what professionals call denial is sometimes a person's lack of awareness of the danger or of a harmful behaviour. This can occur when the professional's intervention precedes the second step of the above-mentioned process, when alcohol consumption doesn't (yet) have harmful consequences. Patients and professionals are then at different levels of AUP awareness, and this constitutes a main barrier for treatment uptake, making change difficult. This denial was also reported as a barrier to intervention for professionals in the Filee and Van Leeuwen studies.<sup>47, 112</sup>

A clear difference was found between specialised and non-specialised professionals. The first consider that the management should evolve at the patient's pace, from his/her initial demand to interventions on more complex aspects of his/her behaviour. The latter are more likely to consider that AUP

should be central in the management, and tend to use a "frontal" approach, more or less successfully, depending on their relational and communication skills. At this stage, "denial" is often evoked; it represents the gap between the third and the fourth steps, between willingness to mitigate the consequences and global awareness of AUP as a key point of the problem.

#### 4.3.4 Society and health system

##### 4.3.4.1 Social denial

Denial as a concept should also be considered in terms of the social perception (or vision) of alcohol. Alcohol use, legal sales and advertising are common and widely accepted in Belgium. Some restrictions on sales and advertisement are included in the 2013 convention between the producers, the catering sector, the consumers' representatives, and the Ministry of Health<sup>160</sup>. However, 24/7 access to alcohol was experienced as far too easy, creating an insuperable barrier to all the interviewed parties. A pressure to share in alcohol consumption is felt in society (e.g. to celebrate events), without any attention to the consequences of alcohol use. Numerous professionals and experts underlined the ambiguity in Belgian society and among authorities. Alcohol is not seen as a major topic in public health, and little is done to inform the public about its potential harmfulness. In fact, alcohol consumption is associated with positive values such as pleasure or sociability, also underlined by alcohol advertising.<sup>112</sup> Some professionals mentioned a possible collusion between public authorities and lobbies from the brewing industry. However, reducing the treatment gap means acting at various levels, including that of society and politics, as described in the discussion section of the literature review.

Both the lack of general information (there is a thin line between alcohol use and addiction; AUP is an illness), which leads to incomprehension in society, and the lack of public initiatives to warn about alcohol use are felt as barriers. The budget for prevention initiatives remains very small in comparison with the amount of taxes collected by the government. Recently, Rubio-Valeria et al elaborated on the predominance of the medical model in society, which prioritises disease treatment rather than prevention.<sup>38</sup> A lack of implementation of preventive actions is thus observed.





The availability of low-threshold, free and online help would make it easier for people to seek help. According to some interviewed professionals, more incentives (personnel, money) could facilitate the management of AUP.

#### 4.3.4.2 Stigma

The analysis appears to show that the stigma issue has three different faces. We found:

1. Social stigma, the way alcohol and AUP is generally perceived;
2. Personal stigma, which corresponds to shame and negative self-image of the individual with AUP;
3. Professional stigma, the stigmatising attitude of the professionals regarding patients with AUP. It is a difficult concept for the relevant parties to get to grips with.

Regarding *stigma-reducing interventions*, Livingstone *et al* (2012) distinguished different types of stigma: self-stigma as experienced by the patient himself, social stigma as imposed by people in society and structural stigma as experienced by professionals towards types of patients.<sup>82</sup> In our study the three types were mixed up by the participants with taboo and denial. In the analysis social stigma as well as self-stigma showed up, but it cannot be claimed that the difference between the two types can be sufficiently identified. With regard to interventions to reduce stigmatising attitudes, information campaigns would be welcomed, according to the professionals interviewed, although there is a lack of evidence in the literature concerning their efficacy.

If alcohol benefits from a positive image, the opposite happens with AUP; compared with people suffering from other, substance-unrelated mental disorders, people with AUP are at particular risk of structural discrimination.<sup>36</sup> This stigma is brought about by an image of an alcoholic tramp, a lack of willingness, etc. The pervasiveness of this perception is part of the treatment gap, as reported by the individuals concerned, who have difficulties in accepting this negative identity of themselves, and in acknowledging their consumption problem. This perception is shared by some health professionals, who consider AUP as a consequence of moral weakness. It seems that this negative image is maintained among professionals because of a lack of relevant knowledge about the various kinds of AUP. A potential improvement on this point is conceivable.

Continuous medical education should allow for a better understanding of the roots and the complexity of the problem, and a move in the continuum from a moral judgement to a skilled approach to the degree of the patient's awareness of harmfulness of consumption, and the practical ways to tackle it.

The Up To Date study recommends investing in the training and communication skills of OPs regarding alcohol and drug problems of employees because multiple studies have underlined the importance of education and training as a way to facilitate a positive attitude towards substance abuse among OPs as well.<sup>114, 168</sup>

In the same vein, adequate information among the general population about the potential harmfulness of alcohol, and the long-term consequences of AUP (e.g. chronic disease), should help change people's mind-sets about alcohol and its social acceptance.

Numerous people we interviewed underlined the better acceptance of a (chronic) illness rather than an "alcoholic" status. A reduction in social stigma is therefore all the more important since they expressed the need for support rather than judgement to allow them to take the step towards treatment. This opinion was shared by various professionals, who considered empathy and a positive approach as essential to starting treatment.

Reducing the stigma is also an alternative to psychiatry, especially for individuals without comorbidity. Both patients and professionals were mainly in favour of a management of AUP outside of psychiatric wards. This environment contributes to a negative social labelling of patients who don't suffer psychiatric comorbidities. Ambulatory consultations, or admission to a general hospital ward for withdrawal, were considered as valuable alternatives, sometimes in collaboration with psychiatrists. The French-speaking experts considered that AUP was rarely a matter for psychiatric advice, but for primary care or peer support groups management (e.g. AA).

The professionals stressed the importance of multidisciplinary management. The main reason for this is that AUP has consequences at different levels: medical, psychological, and social. But it can also be driven by a desire to share the heavy burden of managing this problem. It is significant that GPs are seen by numerous professionals as the ideal coordinator of such management, while GPs themselves were less convinced when interviewed.<sup>109</sup>



### 4.3.5 Limitations of the study

#### 4.3.5.1 Use of DSM-5 as a reference

Our data, gathered from professionals and patients, suggest that all of them spoke about the severe kind of Alcohol Use Disorder, according to the three levels of the DSM-5 definition (mild, moderate and severe) despite the fact that researchers used the term “alcohol use problems” (AUP) during the interviews, which encompasses the three levels of AUP. This can be explained by two reasons, which are not mutually exclusive. This can be explained by two reasons, which are not mutually exclusive.

The first one is the lack of knowledge of disease description among some field professionals, the consequence of which could be a lack of screening and early detection of AUP by first-line professionals. The absence of a clear distinction between the various kinds of problematic use of alcohol was suggested in previous studies among Belgian GPs.<sup>109</sup>

Furthermore, results showed the terminology problem cannot only be reduced to the definition of AUP. Some words like “awareness”, “denial”, “treatment” or “stigma” can also have different meanings from one professional to another. This contributes to different interpretations and actions among professionals. Therefore, the description of the reality by the researchers should take into account this polysemy.

The second one is that some professionals have some difficulties with, or refuse, the use of such classification, somewhat criticised for its epistemological choices, even by psychiatrists who have collaborated with previous versions<sup>169, 170</sup>. The main reproach is the medicalisation of everyday behaviours. The issue of defining a pathological phenomenon in itself cannot be avoided; the primary choice made in favour of the normative definition from DSM-5 set aside some epistemological questions that remain in psychiatry or related domains. This can contribute to an undue prominence of the lack of knowledge among the professionals.

This trend to reduce AUP to the severe kind of AUP has had an impact on the recruitment of individuals with AUP. Actually, as these people were contacted mainly through health professionals, the latter tend to remember the most intoxicated ones, going through a long process. So, a bias seems to exist concerning AUP interviewees. Those going through a “lighter process” can successfully resolve their AUP without any professional

intervention (so experiencing only the three or four first steps described in the “individual’s trajectory” section). Therefore, we were not able to recruit these patients. Other elements would be found upon interviewing them, providing a broader comprehension of the phenomenon.

Also, findings showed that there is not just one treatment gap for the interviewed AUP individuals. Even if we suppose that it is partly linked to their specificities (most intoxicated individuals), what it underlines is that even if the person is looking for professional help in the beginning, the same treatment gap problem can occur several times in the event of relapses. This is sometimes enhanced by bad past experiences, which cause individuals not to want the same kind of help (it seems particularly strong for those managed in psychiatric wards).

In that way, reducing the “treatment gap” notion to just the first one seems to be irrelevant when confronting those with AUP experiences, but also from professionals’ experiences.

#### 4.3.5.2 Interviewing guide

The interviewing guide for individuals with an AUP that was elaborated by the research team in close collaboration with the KCE was based on a series of open questions posed in an interrogatory fashion, directing the focus to the theme in question. The interviewees were asked to answer questions on particular biographical details related to the treatment gap. This approach inevitably led to a process of *a posteriori* rationalisation, and significant episodes were selected by the participants. This kind of intellectual process can be affected by memory bias and distortion of the past; the long-term process of AUP for some obviously favoured these biases. Those with low socioeconomic status seemed to have more trouble analysing their memories, as expected by the interviewers. As a consequence, the interviewing guide was better suited to those who are better educated, who were more familiar with the topics addressed and the intellectual work expected; they provided more material for analysis.

Alternative methodological choices could have reduced these biases, but were more complex and would have taken more time. Biographical narrative, based on the individuals’ day-to-day experience (life-story interview) would have provided more freedom of speech, a less filtered discourse, and less discriminating data from a sociological point of view. A focus on individuals not yet in treatment would have given first-hand



opinions on the treatment gap, but the time constraints and the recruitment difficulties made it impossible. This could be considered for future research on the topic.

#### 4.4 Conclusions

Numerous facilitators and barriers were retrieved in this study, which can explain the various levels of the treatment gap for AUP. They are summarised in a text box below the conclusions. Several lines of improvement can be suggested from the results.

Although awareness of an AUP among the individual concerned is mainly a personal issue, it seems that more information is needed among the general population about alcohol-related problems. More funding for information campaigns is needed. The individual's relatives, whose importance was underlined, can also benefit from these measures. More information will be part of reducing social denial of AUP.

Once a person starts seeking help, practical and financial barriers can still be present; measures to lower the threshold for help should be considered:

helplines, directories of primary care help centres or peer groups, enhanced funding by social security, increased availability of specialised centres.

On the work floor, the coverage of the CLA 100 should be extended to the public health sector. Reintegration in the workplace should be a priority for those who achieve sufficient improvement and are able to work safely.

Knowledge on the topic, and the skills to manage it properly should be enhanced, mainly among primary care and first-line professionals, including those who are not specialised in addiction, but are in close contact with the general population. Tailored interventions should be defined for the various types of professionals, from detection and referral for those who are not qualified to manage the problem, to proper management for those who might address it. This would be part of the multidisciplinary management of AUP. Psychiatric management should be limited to patients with severe AUP and/or psychiatric co-morbidity.

Attitudes among professionals are to be considered. In order to change the stigma among health professionals, contact-based training and education programs targeting students and professionals should be proposed.

**Table 12 – Barriers and Facilitators to reducing treatment gap (summary)**

Category of actors	Barriers to seeking help	Facilitators to seeking help
<b>Persons with AUP</b>	<ul style="list-style-type: none"><li>- Not aware of an alcohol use problem</li><li>- Belief in own ability to stop drinking</li><li>- Alcohol is a way to escape, to resolve problems</li><li>- Maintaining quality of social life (no consequences/ problems because of alcohol use)</li><li>- Lack of energy and/or time</li><li>- Don't know where to go for advice</li><li>- The feeling of shame</li><li>- The feeling of losing control over life</li><li>- The feeling of losing face</li><li>- Fear of admission to a hospital (having children to care for)</li><li>- Fear of permanent abstinence</li><li>- Alcohol is part of professional life (workplace culture)</li><li>- Afraid of losing social network</li></ul>	<ul style="list-style-type: none"><li>- Awareness of the problem</li><li>- Serious consequences for life as cues to action (at work, in personal life, problems with law)</li><li>- Acceptance (to make a complete mental switch)</li><li>- Magic moment or last stream awareness</li><li>- Life accident (e.g. suicide attempt)</li><li>- Clear signals from family members</li><li>- Take advantage of a kind of 'sensitive period'</li><li>- Understanding of professionals: cautious and comprehensive approach; good atmosphere; confrontation with addiction; information about consequences; take guilt feeling away and set up goals in accordance with patient (incl. choice of treatment type)</li></ul>





- No empathy from professional advisors
- Feeling judged by professionals
- Bad experiences in the past
- Lack of knowledge concerning availability of care
- Organisational problems: admittance procedures; practical distance; costs of help
- Fearing dismissal at work

#### Relatives

- Relatives' remarks too early (no desire to change)
- Close environment is part of the problem
- Family habits
- Relatives do not know what to do
- Trying to maintain a normal family life

Relatives' intervention can advance acceptance and awareness  
 Relatives encourage person to consult professional  
 Relatives can give physicians relevant information about alcohol consumption  
 Family support

#### Professionals

##### Barriers to detection

- Psychiatric comorbidities
- Cognitive impairment (e.g. Korsakoff's dementia)
- Lack of knowledge on AUP
- Professionals don't feel entitled to talk about AUP
- Professionals do not bring up the topic
- They think other professionals have to detect the problem
- Experiencing difficulties discussing AUP
- Lack of time
- Professional's own alcohol use

##### Facilitators to detection

- Physical symptoms/biological tests
- Injuries, behavioural and personal problems, panic attack
- Signals of decrease in performing (at home, at work, etc.)
- Continual medical education on the topic
- Relational skills
- Professionals consider AUP as a part of their job
- To have a kind of tolerance for such patients
- Professionals consider they have to take care of patients, rather than cure them
- To have some time for discussion
- Using screening tools (e.g. AUDIT)
- Using information tools (folders, anonymous online help)
- Having access to support structures
- Availability of websites and forums
- Short delays for a first consultation
- Having direct access to neutral places
- Showing interest in the topic
- Feeling responsible for detection
- Consider addiction as an illness



Barriers to intervention		Facilitators to intervention	
<ul style="list-style-type: none"> <li>- AUP management is difficult and time consuming for professionals</li> <li>- Considering the patient as an actor rather than a victim of his/her AUP</li> <li>- Not feeling at ease with patients with AUP</li> <li>- Alcohol seems necessary in life (balance), as a coping mechanism</li> <li>- Experiencing multi-problems (more than AUP)</li> <li>- Alcohol addiction treated as an isolated problem</li> <li>- Mistrust between professionals</li> <li>- Lack of collaboration</li> <li>- Lack of time (emergency room)</li> <li>- Long waiting lists</li> <li>- Lack of knowledge (medical/moral model)</li> <li>- Inappropriate attitudes from professionals (professional's stigma)</li> <li>- Lack of willingness of patient</li> <li>- Low self-esteem of patient</li> </ul>		<ul style="list-style-type: none"> <li>- To start with patient's demand (not necessary focused on alcohol)</li> <li>- To have a clear signal from each other (both individuals with AUP and professionals)</li> <li>- Motivational interviewing and brief intervention</li> <li>- Cognitive behaviour therapy</li> <li>- To build a confident and supportive relationship</li> <li>- To consider AUP as a disease</li> <li>- To start with person's demand</li> <li>- Sustainable objectives, defined in accordance with the patient</li> <li>- Multidisciplinary networking</li> <li>- Comprehensive approach</li> <li>- Concrete alcohol and drug policy at work (cf. Collective Labour Agreement 100)</li> <li>- Integrated care services</li> <li>- Treating AUP as a disease</li> <li>- Knowing that alcohol problem is tip of iceberg</li> </ul>	
Societal level	Barriers to seeking help	Facilitators to seeking help	
	<ul style="list-style-type: none"> <li>- Culture in Belgium</li> <li>- Availability of alcohol</li> <li>- Social pressure to drink alcohol</li> <li>- Not a real topic in public health</li> <li>- Lack of public initiatives</li> <li>- Lack of information</li> </ul>	<ul style="list-style-type: none"> <li>- Changing people's mindset</li> <li>- Reducing attractiveness of alcohol</li> </ul>	
	<ul style="list-style-type: none"> <li>- Ambiguity of policy</li> <li>- Lack of political willingness</li> <li>- 24/7 access to alcohol</li> <li>- General alcohol image</li> <li>- Social problems</li> </ul>	<ul style="list-style-type: none"> <li>- Global alcohol plan</li> <li>- An elaborated alcohol and drug policy (cf. Collective Labour Agreement 100)</li> <li>- Reduce accessibility of alcohol</li> <li>- Public campaigns</li> <li>- Availability of low-threshold, free and online help</li> <li>- Interface between people and individuals with AUP</li> </ul>	



## 5 DELPHI PROCESS AMONG STAKEHOLDERS': CONSULTATION ON THE POSSIBLE RECOMMENDATIONS TO REDUCE THE TREATMENT GAP

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This project aims to analyze explanations for the treatment gap in alcohol misuse and to find ways and interventions, including facilitators and barriers in applying these, to improve the treatment rate of people with problematic alcohol use in Belgium. In the previous chapters we analyzed the scientific evidence on contributing factors to the treatment gap and interventions aiming at reducing it and performed interviews with practitioners, experts and patients. We were therefore able to propose ways to intervene in order to improve the situation.

We decided to conduct then a Delphi survey in order to measure acceptability and feasibility of proposed interventions among experts and stakeholders and in order to bring needed nuances on it. For more practical development or implications of the proposals, we foresaw to discuss further with the Delphi participants a short list of 'consensual' proposals issued from the scheduled 2 questionnaire-rounds during a closing meeting in October 2015.

### 5.1 Methodology

Delphi surveys could aim at different goals or have several designs<sup>b</sup>. It could be defined (among other) as a systematic collection and aggregation tool of informed judgment from a group of experts on specific questions and issues" (Hasson, 2011<sup>171</sup>, p. 1696). We used it here as "*a method for structuring a group communication process*" more than as a method to produce strict consensus<sup>172</sup>. We foresaw to administrate this online Modified Delphi with 2 rounds questionnaires maximum, because of time constraints, with

LimeSurvey. The 'closing' round was foreseen as a final meeting gathering all the respondents' opinions to the survey.

#### 5.1.1 Participants

We invited a group of stakeholders and experts in the field of alcohol detection and treatment identified for this project. In the group, 53 valid addresses were available. The group is composed of policy makers, health practitioners' representatives, patients' representatives and health insurers.

#### 5.1.2 Data collection process

The end-product of the research will be a list of recommendations to improve the treatment gap, together with an estimation of attainable goals.

##### 5.1.2.1 First round questionnaire:

The first round questionnaire proposed a list of possible interventions based on previous steps aiming at identifying barriers/facilitators and interventions to reduce the treatment gap for problematic alcohol use. These were searched in the scientific international literature (see chapter 1) and in semi-structured interviews and focus groups among patients, professionals and experts in this field in Belgium (see chapter 2), and this, in order to better contextualize what the literature had taught us. We consider that, with such material, we have sufficient lines of action to propose for a positioning of stakeholders and experts. In other words, we consider this data as a kind of preliminary Delphi round.

The first round questionnaire was launched the 29/07/15, followed by 3 reminders at 1 week interval and closed on the 28/08/15.

<sup>b</sup> See the special issue 78 of the review 'Technological Forecasting & Social change" (2011) available at <http://www.journals.elsevier.com/technological-forecasting-and-social-change/>.



### 5.1.2.2 *Second round questionnaire*

Initially, we decided that, according to the Delphi methodology, the second round would aim at precisising priority of proposals that have reached consensus for acceptability and not for priority and test new proposals formulated by participants in open questions. All questions that have reached consensus for acceptability and priority would not be asked again in the second round.

#### **Criteria for consensus:**

A proposal was considered as acceptable if at least 80% agreed or totally agreed with the acceptability and less than 10% (totally) disagreed (or the opposite) with a total number of valid responses  $\geq 2/3$  of the respondents. Only if this criteria reached consensus, we looked at priority: if at least 85% considered that the proposal is a priority (totally or agree) with a total number of valid responses  $\geq 2/3$  of the respondents, we kept the recommendation. If it was not, we would ask for priority on the second round with yes/no answer.

### 5.1.2.3 *Final stakeholders meeting*

The final meeting aimed, after a general presentation of the findings, to discuss every proposal that did not reach the 80% acceptability and one or another particular theme that would have emerged from the comments. Finally, the panel should discuss the final generic recommendations. Four hours were foreseen for the discussion.

## 5.1.3 *Data collection tools*

### 5.1.3.1 *First round questionnaire*

Here are the main conclusions from the literature review and the qualitative study we used to build the first round questionnaire:

It should be valuable to intervene at societal level:

Alcohol consumption is currently still fairly highly valued in Belgium. Its festive and convivial character and the role played by alcohol in our society hardly outweigh the 'health type' arguments. Limiting alcohol consumption is not well seen by most people. The only area where such measures are accepted is that of road safety. One of the points of the European action

plan to reduce the harmful use of alcohol 2012-2020 is to strengthen the awareness of the harmful consequences of alcohol consumption and change collective behaviour rather than targeting individual behaviour, and, among others, by actions at the community and workplaces (including schools).<sup>173</sup> When alcohol becomes a problem, the perception of society is reversed. However, it is known that the problematic drug (alcohol) use results from a complex process and that the persons concerned are more victims than perpetrators. To encourage them to seek help and be part of a therapeutic approach, it is appropriate to change the attitude of the population to these people and to associate alcohol dependence with the concept of disease chronic. This change in mentality would also help the awareness of problematic consumption or risks, and support detection initiatives and empathetic attitudes from health professionals. In this way, several proposals were made to the participants of the survey about:

What information has to be given to the general public and how?

How to change the attitudes, also but not only specifically regarding 'alcohol misusing people', to improve the seeking for help behaviour and reduce the fear of judgment?

Several measures could promote a change of mentality in relation to alcohol misuse and its consequences. Some of them are proposed in the WHO Europe 2012-2020 Alcohol plan. Such measures may encourage help seeking on the part of persons with problematic alcohol use and help healthcare professionals to address the issue of 'harmful health behaviours'. Finally, such measures can be useful in supporting treatments. By regulating advertising, for example, it affects both the effectiveness of prevention measures, as well as the attitudes to alcohol consumption in general. This could encourage discussion around alcohol consumption and encourage persons with problematic alcohol use to consult and reduce the fear of feeling judged.

It should be valuable to intervene on treatment supply / healthcare organization: Detecting problems without being able to solve is a source of frustration frequently raised during interviews with health care professionals. This explains why some professionals prefer to avoid the subject because of fear of being unable to propose any solution.

It should be valuable to intervene on the professionals:



From the literature and the interviews it appeared that health care professionals seem not so well equipped to communicate about a difficult subject like problematic alcohol use. Also they lack resources such as time, depth knowledge of the subject and specific skills in communication. It is also important that the health care professionals know how to be empathetic and make patients not feel guilty. The lack of skills to detect problematic alcohol use, i.e. individuals at risk or already dependent, has also been identified.

A support for all the problems of the alcohol misusing patient would, according to the patients we met, increase the chances of effective treatment and monitoring, and would reduce the fear of the judgment. Indeed, among the obstacles to seek help reported in interviews, are the fear of being considered as a mentally-ill patient and the fear to meet people with psychiatric problems. Similarly, if a patient complains, for example, of stomach problems, it is important to discuss and address these symptoms before addressing his possible problematic alcohol use. Nevertheless, to initiate a change in behavior, especially in the field of addictions, the patient must be involved in the process: he/she must be willing to change. In order for an intervention to be effective, it is important to intervene at the right time in the motivational cycle of the patient behavior change. Motivational interviewing is a valuable tool/skill that has already been proven effective to achieve behavioral changes. It is thus a theme interesting to be investigated in the survey.

The WHO Europe alcohol plan 2012-2020 emphasizes the importance of paying health care providers for their implication<sup>173</sup>.

Screening and Brief Intervention has been recognized as efficient to help the patients. It seems to be an interesting solution to be investigated in our survey.

It should be valuable to intervene at the patient level:

Firstly, it is necessary to increase awareness of the problematic alcohol use in the affected persons. The literature indicates that websites dedicated to increase awareness of alcohol misuse are considered effective tools and appreciated by persons with problematic alcohol use. They allow everyone to learn in anonymity and possibly start a limitation / management of his drinking.

But once they become aware of their alcohol misuse, many feel they can help themselves, or think that there is no effective solution. They do not seek

for help or do not start a treatment. In this case, better information about effectiveness of the treatments could be an improvement.

Finally, for patients, the treatment of their alcohol problems is a path strewn with obstacles, including the societal context and stigma they feel victims. A series of proposals to address them have already been made in the first part of this questionnaire (intervene at the societal level). But patients also raised the issue of economic obstacles. We made several proposals to relieve this barrier.

It should be valuable to intervene at the relatives' level: According to people we interviewed in the qualitative part of the research, support from relatives and the family circle of people with alcohol misuse seems a factor favoring the search for help and initiation of a treatment.

The first draft of the first round questionnaire was submitted in French to 4 selected experts. Modifications were made according to their remarks and the questionnaire was translated in Dutch. Both new versions were again submitted to the experts. Adaptations for the language were made by the communication cell of the KCE.

The questionnaire was then put online and pretested by 6 KCE collaborators (3 French-speaking and 3 Dutch-speaking). Last adaptations were done before the launch of the survey.

The final versions of the questionnaire in French and Dutch are presented in appendix 3.

#### 5.1.3.2 *Second round questionnaire*

Because the very large number of proposals that reached consensus in the first round and the very slight differences of percentage between 'consensual' and 'non-consensual' proposals, we decided to skip the second round.

#### 5.1.3.3 *Final stakeholders meeting*

Prior to the meeting and in replacement of the announced second round questionnaire, we sent to participants of the survey a document in French and Dutch with the proposal coloured in function of their percentage of agreement for acceptability and priority (see appendices). This was just done for information purpose to give an idea of the 'strength of the consensus':



100% acceptability 100%priority  
100% acceptability >85% priority  
> 85% acceptability 100% priority  
> 85% acceptability >85% priority  
80-85% acceptability - 100% priority  
80-85% acceptability >85% priority  
<80% acceptability→ no consensus

## 5.2 Results of the Delphi process

The results of the Delphi are presented according to the structure of the questionnaire:

1. Participants of the survey
2. Interventions that could be done at societal level
3. Interventions that could be done to improve treatment supply /care organizations
4. Interventions targeting health professionals
5. Interventions targeting patients
6. Interventions targeting patients' environment

Detailed results are available in the appendices.

### 5.2.1 Participants

On the 53 people invited to participate in the Delphi process, 39 people participated in the survey and 35 questionnaires were completed in their entirety.

**Table 13 – Description of the participants in the online survey (non exclusive categories)**

	n
Patient organization	2
General Practitioners	4
Medical specialists	5
Nurses	3
Public administration (SPF, communities, regions, INAMI/RIZIV)	7
Prevention counsellor	2
Umbrella organization (VAD, Infodrogues)	3
Psychologists	3
Research center / university	4
Other	2
Field workers	22

Fourteen stakeholders participated in the meeting. All categories of participants that responded to the Delphi-questionnaire (see table above), were also present at the final meeting.

### 5.2.2 Interventions that could be done at societal level

#### 5.2.2.1 Information of the public to increase knowledge and change mentalities regarding alcohol (mis)use in general:

From the survey it appeared that the majority of the stakeholders found that a **better information for everybody** is a priority, for which the content could include:

- the norms of at risk consumption
- the risk of daily drinking, occasional drinking or binge drinking

About the content of the information on the alcohol use and its consequences, several suggestions were formulated:

- Instead of norms, it would be better to present the undeniable evolution of the "consequences" of abusing alcohol
- Present the alcohol as a drug, because it is and in consequence add namely 'the alcohol' in the communications about drug use





- Avoid moral judgment
- Make it clear that excessive alcohol consumption is harmful even for persons who are not addicted and debunk health myths (e.g. who doesn't drink has an increased risk for cardiovascular disease)

Respondents also agreed that this **information has to be spread via several channels**. Respondents pointed out that:

- 'health care channels' as well mass media channels' should be used in synergy
- Channels have to make sense – first line healthcare providers are well placed for it but need more training to do it
- Several actors have to convey the messages
- Already existing campaigns should be extended
- With great dramas (related to alcohol abuse) such as serious traffic accidents, homicide, suicide, etc. it would be useful to give messages in words and images.
- Information should also occur in at risk environments (such as festivals or places to go out)
- Information could be included in TV soaps
- Labels on alcoholic products could be used as a channel for information
- In addition respondents made several remarks:
  - Communication is a duty from the government
  - Communication strategy has to be based on innovative methodologies
  - Regarding the form of the information:
    - It should be simple to understand with clear and simple slogans
    - It could also use humour
    - Labels on the bottles should preferably use pictograms
- Information should not be restrained to alcohol use norms and consequences but should also concern the existence of support groups (self-help or for relatives)
- Education at school could be an option
- Use App's to give correct information

### 5.2.2.2 Preventative actions

#### Alcohol supply

Our panel has retained as acceptable and as priority the reinforcement of the sanctions when alcohol is sold to young people, under the legal age. Next to our proposal, some other propositions were formulated by the respondents:

Forbid free alcohol drink

Forbid all alcohol sale in fuel stations, night shops, at workplaces, in sport clubhouses during competitions for young people

Nevertheless there was less consensus in the survey about a more strict regulation of the sale of alcohol such as on upgrading the legal age for buying all types of alcoholic drinks to 18. While there were some opponents to these proposals, it appeared during the final meeting, that it was more a question of 'feasibility' and realism of the proposals than a clear unacceptability of these. The panel underlined the importance to have a clear message, including to facilitate the control of the measure and they referred to the advice of the WHO to put the limit at 18 years. Moreover, they stressed that the age level of 18 year is very important, since there is large evidence on the damage alcohol use can cause; also they believed that we have to reason from a health point of view on not from a political viewpoint. Neighbouring countries already have a 18 year limit. The panel finally agreed on the acceptability and the importance of this proposal.

Disagreement reached also from the survey about the proposal to introduce a licensing system to be authorized to sell alcohol. After discussion in the final meeting, the panel finally agreed with the acceptability of the proposal but warned that prohibiting may induce illegal circuits of sale; circuits that also cause the loss of social control.

#### Advertising

The respondents retained also the proposal to regulate sponsoring activities, the content, the form and the volume of the advertising.

However, the panel discussed during the final meeting on the role of the authorities in the control that was not so consensual in the survey results and questions on the different ways to control. It raised from the discussion that authorities are the only suitable instance to control the advertising. It



was underlined that the jury of ethics in advertising ([Jury voor ethische praktijken inzake reclame/ Le Jury d'Ethique Publicitaire](#)) could be also involved.

#### 5.2.2.3 *Change the attitudes towards dependency*

To change the attitudes of peoples regarding alcohol dependent persons several possibilities were judged as acceptable and priority. First, information could also be useful to change the attitudes towards persons who have alcohol dependency. In this case it will concern the mechanisms that make enter someone in an alcohol dependence pattern.

Next to the information, our panel retained the following proposals:

- Identify in scientific literature the effective interventions to reduce negative attitudes towards specific populations, especially towards people with alcohol dependence
- Present alcohol dependence as a chronic disease
- Care for people with alcohol dependency not only in psychiatric wards, to avoid to consider people with alcohol dependency as 'crazy' people.

#### 5.2.2.4 *Other proposals to be done at societal level*

General comments were given during the survey about the way to intervene at societal level:

- Give the example with, e.g. organizing a successful festival or feast without alcohol
- Finance risk reducing initiatives
- Think about introducing a Belgian 'law Evin' (like in France<sup>c</sup>)
- Communicate to the population the expenditure of the damage caused by alcohol misuse
- Get concern with alcopops (premixed alcohol-soda)
- Introduce a course of citizenship education in secondary schools
- Prices:

- Fix a minimum price per alcohol unit that should be sufficiently high to have an impact on several health indicators
- Decrease price and taxes on soft drinks, including NA bier

In the final meeting, the question on 'how to decrease stigma?' was also discussed. Stakeholders agreed that decreasing the stigma could probably reduce the treatment gap quite rapidly because of the shame in persons with alcohol misuse. So it is a priority. Combined actions are necessary and further research on the field, contextualized to the Belgian society are welcome.

Simple messages could also help in changing image and reducing stigma e.g. 'problematic alcohol use is a disease', 'problematic alcohol use can effectively be treated'. Problematic alcohol use is currently too much seen as a problem of a person that is not strong enough, has not enough will power etc.

#### 5.2.2.5 *Interventions that could be done to improve treatment supply / healthcare organization*

To improve treatment supply the following proposals were retained by the panel:

##### **For the first line**

Improve the support/care of psychological/mental problems in general, and more specifically

- Increase the supply of first line psychology
- Reimburse the psychological consultations prescribed by a medical doctor
- Accelerate the access to centres for mental health when referred by a GP
- Execute the recognition of the psychotherapists

Develop a first line specialized care with GP, nurses, psychologists and social workers.

<sup>c</sup> [https://fr.wikipedia.org/wiki/Loi\\_%C3%89vin](https://fr.wikipedia.org/wiki/Loi_%C3%89vin)



In this proposal, results of the survey showed that the role of the occupational physician, internist, and worker in emergency department, gynaecologist, tabacologist and pharmacist remain less consensual. Suggested others who can contribute to this first line cited in the survey were family helpers, (street) educators, teachers, psychiatrists and ONE/Kind & Gezin.

According the comments we received directly in the survey or during the meeting, the 'refusal' of the above list of providers to implicate in first line of care might come from the formulation of the question. Indeed, a large part of them are currently second line actors. It is therefore a paradox to use them in first line.

The 'support/care (prise en charge) of the patient was also a too large notion. The panel agreed that every healthcare professional should be able to detect/screen for alcohol misuse and intervene. It is necessary to develop a culture of detection of alcohol misuse. Depending on the severity of the problematic alcohol use, a proper intervention, by the proper professional in the proper care environment should be initiated.

The role of the gynaecologist, meanwhile, is more seen in the framework of the pregnancy, not for every women.

Detect/screen patients in ED department for alcohol misuse (be conditioned by adequate financing)

#### For the second line

- Reinforce the 2<sup>nd</sup> line structures by (suggestions made by participants):
  - Increasing supply (also because if the treatment gap reduces, we will also be confronted to the need to create sufficient care environments and options, so everyone can be treated soon and no waiting lists exist)
  - Treating people in groups
  - Treating people on the long term
  - Increasing ambulant supply
  - Reinforcing mobile teams

- Bringing the patient into contact with self-help groups, such as AA
- Improving working conditions for healthcare providers
- Developing the specialism of addictology that currently doesn't exist in Belgium and that is different from psychiatry
- Develop an 'alcohol liaison function' in hospitals (with a decision/intervention power less limited. This can be improved by a co management of the internal medicine wards by addiction specialists)

#### Other suggestions/remarks:

- Work in multidisciplinary way for each patient
- Develop actions in the living environment. These actions have to be recognized by the second line providers and the authorities
- Improve supply and support for patients with a problematic alcohol use outside of the mental healthcare system
- Offer alcohol withdrawal programs at home with multidisciplinary team<sup>d</sup>

#### 5.2.3 Interventions targeting health professionals' knowledge, attitude, skills and behaviour

##### 5.2.3.1 Inform to make aware and change attitudes

Our panel agreed in the survey that the theme of alcohol and alcohol misuse should be presented

- in the local groups of medical assessment (GLEM/LOK)
- in the meeting of occupational physicians
- in the programme of the academic detailing

They also agreed that information specific to the health professionals should address as well the thresholds/norms and definitions of alcohol misuse as the risks of daily use, occasional use and binge drinking.

A respondent proposed to encourage physicians to assist to a meeting of self-help groups (by accreditation for example).

<sup>d</sup> For example : <http://www.lacaho.be/partenaires-groupes-de-parole-projets/freedom-accompagnement-sevrage-a-domicile/>



However, respondents rejected the intervention that proposes a self-test to the health professional in order to increase their awareness on their own alcohol (mis)use.

This was thus discussed during the final meeting. It was reminded that it is not new that health practitioners have difficulties to talk about their own use. The panel was not convinced that such self-test could induce a reduction in the treatment gap. Also one remarked that the question was not clear and the term 'self-test' could also mean a test of their knowledge.

#### 5.2.3.2 *Improve communication with the patients*

The panel agreed on the acceptability and priority of the proposals we formulated to favour the communication with the patient by developing communication skills through their basic training and continued education.

They also agreed on giving the opportunity to bill a long consultation (45 minutes) in case of alcohol misuse (or other addictions as suggested by a panellist - provided physicians are properly trained) was also valued.

Another suggestion proposed by a panellist to facilitate the communication is to leave information folders in the waiting room that can be used as a support for the discussion (for example 'operation Boule de neige' edited by the CAL Luxembourg<sup>e</sup>).

Another respondent underlined the fact that communication has to be encouraged among all health professionals - not only physicians- and another insists that communication skills are a necessary base before any sensitization to a specific medical problem.

#### 5.2.3.3 *Increase detection/screening skills*

The respondents to our survey confirmed the need to increase detection/screening skills. Indeed, our suggestion to train following professionals to detect/screen alcohol misuse reached consensus on both acceptability and priority:

- physicians: GPs, occupational therapists, internists, gynaecologists

- healthcare workers: nurses, ED workers, psychologists, tabacologists, pharmacists (as well as physiotherapists, midwives)
- non healthcare professionals: social workers (as well as family helpers, educators, teachers, pub operators...)

While we had proposed to intervene with a large list of professionals, the panel raised that psychiatrists were not mentioned and the panel agreed during the final meeting that they should be also considered as a target for all of the proposed interventions targeting professionals, as well as all (health) care professionals.

#### 5.2.3.4 *Increase detection/screening behaviour*

In the survey, we proposed to incent a series of professionals to ask about the alcohol use of their patient.

Respondents find that it is acceptable and priority for

- physicians : GP, occupational therapists, internists, gynaecologists
- healthcare workers: nurses, ED workers, psychologists, and tabacologists (as well as physiotherapists, midwives)
- non healthcare professionals: social workers (as well as family helpers, educators, teachers, pub operators..).

Nevertheless they did not agree in the first round questionnaire that the pharmacist should investigate it with his/her clients.

It raised from the final meeting discussion, that, if it is obvious that pharmacists have a great role to play when they deliver medicines with alcohol use contraindication as well, because many pharmaceutical preparations are made on an alcohol-base, the panel mentioned that the pharmacy as it is now conceived is not appropriate to ask such questions to the clients. More discretion is required. However, the panel agreed that in theory this proposal makes sense.

<sup>e</sup> <http://www.cal-luxembourg.be/les-drogues-et-les-assuetudes/operation-boule-de-neige/>



### 5.2.3.5 *Increase skills to motivate the people who misuse alcohol to enter treatment*

We asked our panel if they found it acceptable and priority to train the professionals in motivational interviewing. They agreed for:

- physicians: GPs and occupational therapists but the consensus was weak for internists and gynaecologists
- healthcare workers: nurses, psychologists, and tabacologists but consensus was weak for ED workers, and pharmacists. They suggested that also dieticians and midwives could benefit from such training.
- non healthcare professionals: social workers (as well as family helpers)

In the comments we received we have identified that motivation of the patient to enter a treatment could be increased by:

- the type of treatment proposed: step by step, not targeting abstinence as first goal and always in collaboration with the patient
- the implication of self-help/-support group during the consultation, not only by referring the patient to an association or giving the information about it. They propose a more peer to peer approach and not a top-down one that could impair acceptability (and durability - while it is not the focus of this report) of the change in behaviour/treatment

Our panel did not reach consensus in the survey regarding the way to follow every patient, even without alcohol misuse. Indeed many of them rejected the proposal that GPs must define objectives of alcohol use in terms of limitation or reduction with every patient. They invoked in the comments the motivation of the patient, the demand, and that a systematic assessment of the alcohol use will be a sufficient first step. In the discussion during the final meeting, it was hypothesized that the absence of consensus hold to a not enough precise formulation. The panel agreed on the following rephrasing: "the GP should systematically over a period of time detect alcohol use and intervene with a graduated response according the type of alcohol use and the motivation of the patient." The topic alcohol should be more systematically discussed during the consultations.

### 5.2.3.6 *Increase Screening and Brief Intervention skills (SBI)*

Respondents of the first round questionnaire agreed that it is acceptable and priority that the proposed healthcare workers and social workers are trained in SBI, except the gynecologists and the pharmacists.

Nevertheless, respondents underlined that:

- There is a problem of knowledge about the treatment possibilities in second line;
- There is a problem of availability of specialised treatment;
- Intervention must be appropriate according to the severity of the misuse.

During the meeting, stakeholders reported that motivational interviewing and SBI should ideally be part of the basic training of every healthcare professional. Here also, the gynaecologist is particularly the right person to address alcohol use with pregnant women. But that they might be afraid to discuss alcohol use because women would feel guilty and to avoid stress during pregnancy. The pharmacists, for their part, do not work in an appropriate work environment to systematically be able to use these skills in case of alcohol misuse.

### 5.2.3.7 *Care for patients in a in a comprehensive way*

In order to approach the patient in a comprehensive way, respondents agreed in the survey that it is acceptable and priority to treat cognitive problems related to alcohol misuse. However, it is even important to also listen and treat complaints in priority, without directly focusing on misuse-related problems. Anyway they did not agree that the patients have to be treated in internal medicine wards preferably than in psychiatry. To notice that in the comments we have received, this last proposal seemed not well formulated: the problem seems to be that the treatment for misuse should not occur at hospital, except for dependency, and that when a hospitalization is needed, it should preferably be done in internal medicine or in ambulatory care.

Moreover, the discussion of the meeting indicated that treatment for problematic alcohol use varies from advice giving to intensive pharmacological treatment; the proper place of treatment largely depends on the type of treatment. Treatment and treatment's place should be





adapted in function of the level of alcohol misuse and the patient expectations. It is not necessary to oppose psychiatry to other settings but it would be better to multiply the access options and to favor/support collaborations. Yet, although some patients refrain to be treated when it is linked to psychiatry, this does not mean that all patients should be treated out of psychiatry. Cooperation is the word and the patient has to be treated at the most proper place.

#### 5.2.3.8 *Favour networks*

Respondents agreed that it is acceptable and priority to:

- Involve GPs in first line networks caring for psychological difficulties
- Provide ongoing information to the GP of reference about the treatment plan and after-care of patients treated for alcohol misuse
- Share information in the global medical file in case of treatment for alcohol misuse
- Develop care pathways for alcohol misuse

Respondents also pointed that:

- self-help/support groups should be included in the networks
- the collaboration between residential treatment team and post-cure is important

#### 5.2.3.9 *Others suggestions and considerations targeting professionals:*

Here is a summary of the comments given in the open-ended questions:

- Develop multidisciplinary support networks for health professional
- Create an 'hotline' for urgent questions of the providers
- Train nurses in addictology
- Don't forget the geriatrician: their patients have a lower threshold for an 'at risk use' and a higher risk because of the co morbidities.
- Don't forget that the alcohol is often used as a self medicine for larger medico-psycho-social reality. You cannot simply 'just' suppress alcohol use. It is therefore important to recognize the difficulties of the healthcare providers to work in a context of lack of resources (psy, nurses, training, supervisions, etc.)

### 5.2.4 *Interventions targeting patients*

#### 5.2.4.1 *Enhance the visibility of web sites dedicated to alcohol consumption*

To enhance the publicity of websites informing about information on alcohol misuse, information about possible treatment and support groups for the patients were judged as acceptable and priority by the respondents of the survey. It was not the case for the publicity of the websites offering online help.

In addition, comments on websites were related to the fact that they are not sufficient and should be a way/ a point of entry to a 'human' professional, and that they have to be controlled by authorized instances to avoid false information. It would also be valuable to develop smartphone-apps to reach young people more specifically. A way proposed by a respondent to make publicity for useful websites is to refer them on the labels of the alcoholic drinks.

Explanations and discussions in the final meeting about the strengthening of publicity for websites offering an online treatment of alcohol misuse followed the same reasoning. The panel mentioned that it is not possible to treat all patients online. Here also it depends on the level of the misuse. A mix of online and face to face should be ideal. The risks they identified are that patients do not go to 'real help' if more is needed and that it can also be used as an excuse for professionals as well ('we gave a web-link to the patient, so we have done enough') Moreover, some patients need medication and therefore a prescription. Online treatments are not enough. In addition, for example, communication, empathy and understanding are very important elements in treatment. Can these be accomplished online? Nevertheless, online treatments should be supported by the authorities to avoid that patients go to paid websites, without quality control on these. The proposal was thus finally judged as acceptable with caution.





#### 5.2.4.2 *Economic interventions to decrease the economic brake to seek for and get help*

The financial support of the treatment should be a priority for our respondents: this support could consist in better informing the patients on the costs related to the treatment, in supporting financially by the compulsory insurance (INAMI/RIZIV) as well as in forbidding to exclude costs related to the treatment of alcohol misuse from the covered treatment by private insurances.

A panellist remarked that there is already a financial support for tobacco cessation.

Another underlined that intervention of the alcoholic anonymous is free of charge.

#### 5.2.4.3 *The patient and the treatment*

The following proposals were judged acceptable and priority by our panel:

- inform patients about the efficacy of the treatments
- support self-help groups

During the final meeting, it was reminded that the support groups claim in general for their independency. But because they seem to be an important help for people (or their relatives) who have alcohol misuse, and particularly (but not only) dependency, they have to be included in the actions to reduce the treatment gap. While AA does not accept financial support, maybe other groups would appreciate working support.

#### 5.2.5 *Interventions targeting patients' environment*

The panel judged acceptable and priority interventions to inform the close social environment of the patient presenting alcohol misuse about:

- healthcare providers that could initiate a treatment,
- the possible treatments
- the difficulties related to the treatment of alcohol misuse
- the role they can play in the treatment

They also agreed

- to support support groups for relatives of patients with alcohol misuse

- to enhance publicity of websites to support relatives of patients with alcohol misuse
- to involve the relatives in the follow up of the choices of treatment

Panellists suggested in addition to propose family therapy, and to inform the patients about the proceedings to contact relatives.

### 5.3 *Final recommendations*

Finally the panel agreed on the final global recommendations presented hereunder. Detailed possibilities could be found in the proposals of the survey because all of them, except the auto testing by the health care practitioner were judged as acceptable.

To reduce treatment gap, combined and multiple actions have to be done in synergy: stigma reduction in society, training of the professionals and in particular the GPs, detection culture development. Networks have to be developed or must be made more visible.

More specifically, the panel had a consensus on these general recommendations:

At the societal level, in order to improve knowledge, change mentalities, and reduce stigma on alcohol misusers, we should improve information for:

- The public
- The (healthcare) professionals
- The patients :
  - about treatments (including efficacy)
  - about the existence of self-help groups
- The relatives :
  - about the treatment options
  - about the potential providers
  - about the existence of support groups
  - about the difficulties related to the treatment
- Simple messages have to be given
- Use several channels
- Make publicity for websites about:



- information on problematic alcohol use
  - treatment
  - self help support groups
  - relatives support groups
- At the political level:
  - Regulate advertising of alcohol products
  - Regulate distribution of alcohol products
  - Struggle against discriminatory mechanisms (insurances)
- At the level of organisation of care
  - Reinforce first and second line. Think not only of psychiatry
  - Favour networks and multidisciplinary work

Because, all health care professionals must be able to initiate discussing alcohol, consider the training of a large panel of professionals in **basic** and **continuing** education in order to improve **knowledge**, change **attitudes** and improve **skills** in :

- problematic alcohol use
- detection of problematic alcohol use
- communication
- motivational interviewing
- screening and brief intervention for problematic alcohol use
- on site-training and 'stages' with patients with problematic alcohol use should also make professionals more interested in the topic

Improve the place of the topic 'alcohol' in the practice

- Encourage professionals to talk about alcohol use and, at least, assess the patient's alcohol use
- Consider alcohol dependency as a chronic disease
- The intervention of the professionals should be adapted to the level of misuse

At the level of health insurance:

- Financially support treatments for problematic alcohol use by compulsory health insurance :

- Support self-help groups and support groups for relatives of patients with problematic alcohol use (not by financing but increasing their visibility in the healthcare system)

## 5.4 Discussion and conclusions

Globally, the results of the first round survey showed that there was a consensus on a large majority of our proposals. The stakeholders in the field agreed on the priority of a large series of actions/interventions. Apart of one or two exceptions, the non-consensual proposals were 'rejected' because of their formulation. With supplementary nuances, they were judged as acceptable by the panel. In conclusion, after the final meeting, a general consensus on all proposals with some nuances here and there was reached.

It raised from this process that to discuss such topic, clear terminology is essential. In the treatment gap we can point several terminology problems that impaired an efficient discussion and weakened the questionnaire. First, next to definitions problems we have already considered in the introduction part of the report, problematic alcohol use is a very broad concept. To collect data with the same understanding of this concept, we proposed a definition in the introduction part of the questionnaire. Nevertheless it appeared that nuances are required regarding the severity of the misuse to be able to adequately position oneself about the acceptability and the priority of the interventions proposed. Secondly, the concept of treatment remains difficult: varying from simple discussion that could already have effect to a hospitalization; there are several steps and these have to be, here also, discussed according the severity of the misuse and the motivation of the patient. Finally, it was not always clear if we were discussing on the management of alcohol misuse in general or specifically on the treatment gap. For example, legal rules about sale of alcohol and advertising have to be considered here as a mean to change the mentalities about alcohol use giving a clear message: alcohol drinking could be risky and the public authorities have to reinforce the message protecting youngest and weakest people. They should be implemented not only in order to delay the entry in the alcohol drinking behaviour or to reduce the risks of road accident or other collateral damages.



A large panel of (health) care professionals have to be considered in the actions. Some of them because they are in touch with the intimacy of the people or are close to the life place (social worker, teachers, educators...), other because of their health care mission. According to the type of contact they have with patients, they can play one or another role. Opportunities are pointed such as pregnancy, purchase/delivery of medicines, accident injuries... and therefore alcohol detection/screening should become a part of the routine of the healthcare professionals. This should contribute to talk about it early, before the problems occurs and give a signal that alcohol use is mainly not good for health.

Nevertheless, it clearly appeared in the comments and discussions that it is necessary to act conjointly, to develop a global action plan. Indeed, information for public or for specific professionals without adequate training and sufficient supply for the treatment will be useless.

The problematic of alcohol and the willing to reduce the treatment gap will be ineffective if the problem is not tackled with a multiplicity of actions at different levels, targeting different actors and carried conjointly or in short sequences. Positive experiences will reinforce self-efficacy perception of the providers and that will increase their motivation to talk about this topic. Therefore, targeting effectiveness of the treatment should also have an impact on the treatment gap.

In addition to these interventions, the place of the self-help groups should be considered. Indeed, they seem to be able to improve effectiveness of the actions according to the comments formulated in the open-ended questions.

### Limitations

Our approach shows several limitations. First of all, it is a semi-qualitative/quantitative approach. We decided on consensus based on statistics, but without statistical representativeness of the stakeholders. We tend to reach 'points of view representativeness'. Moreover, we carefully (and purposefully) selected our participants. In this way, voluntarily, the sample was small at start. During the process we lost a considerable number of participants: the invitation was sent to 53 person but only 35 completed the survey. Reasons for non-participation can be diverse but one of them is probably that the survey was carried during summer holidays. We gave more than one month to participate and sent 3 reminders nevertheless several people did not join the survey and we have no information on the

reason why. Then only 14 respondents have participated in the final meeting. At least 6 had intended to participate but had last minute impediment (sickness or agenda). We are not able to identify the position of the absent people regarding the proposals and do not know exactly the reason for their absence.

Secondly, because of the length of the questionnaire, we opted for a reduced scale of answer possibilities, in order to reach rapidly consensus. There were few places for nuances. More the proposals sounded very consensual regarding the choice of the stakeholders and experts surveyed, a second round could be probably have been excluded at start.

Thirdly, results showed a very large consensus. Here we can suspect a selection bias: we invited only specialized stakeholders, healthcare professionals and people interested in the topic. They were all 'alcohol health experts'. We did not invite people who had other interests in alcohol use, such as industry representatives.

Finally, we did not test the exact consensus during the meeting but everyone had received sufficient time to react in the discussion.

**The general conclusions of this Delphi process are that synergetic, combined and multiple actions are needed at societal, professional, healthcare organisation and financing levels. Professionals must adapt their intervention to their patient according his/her alcohol misuse and level of motivation. Self help and support groups have to be considered in the actions.**



## 6 CLOSING REMARKS

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Alcohol use is a widespread phenomenon in western societies and it is a significant cause of morbidity and mortality. Only a small proportion of people with a problematic alcohol use seeks or receives treatment/intervention and it appears there is a large 'treatment gap'.

In this project we aimed to find explanations for this treatment gap and to find interventions that could reduce it. We did so by combining three research approaches: a literature study, a qualitative study and a Delphi-study. The explanations found in the (international and national) literature were confirmed by the qualitative study with Belgian participants. The interventions to reduce the treatment gap described in the literature were also confirmed by the qualitative study and received a general consensus on applicability and priority in the Delphi-study. This combination of methods gives us confidence in the validity of the results we found. However, there remain many uncertainties and points for discussions; three of them are highlighted hereunder.

### 6.1 Terminology

In all three research approaches we were confronted with a multitude of terms used to describe (treatment gap for) problematic alcohol use, and the contributing factors as well as to describe interventions to solve them.

First we encountered the many terms concerning problematic alcohol use and the different ways to measure this. Different organizations, different authors or different interviewed people use different definitions and different measurement characteristics. It was not always clear to what extent the sources were talking about the same or about different things and how much overlap there was. E.g., is hazardous drinking the same as problematic alcohol use or as a mild to moderate alcohol use disorder? Consequently, we were not able to see/analyse if the treatment gap is different in size or in explaining factors for the different concepts or for the severity levels within a problem concept.

Secondly, we encountered a comparable multitude of terms regarding treatment or intervention options. Here, we had a double issue: besides unclear or overlapping terms, we had to deal with the fact that sometimes it concerned treatment/interventions towards the problematic alcohol use itself, and other times it concerned treatment/interventions towards the treatment gap. And it was also the case that some interventions were targeted to both or had effect on both: e.g. screening for problematic alcohol use is mainly to select people who could profit from some kind of intervention, but it appeared that this could have a therapeutic effect as well. This dual effect and/or aim seems to apply to all different forms of the container-term 'screening, brief interventions and referral to treatment'. Also there are semantic problems when something is called a 'treatment' or an 'intervention'; e.g. is a simple advice from a healthcare professional to reduce alcohol consumption considered 'treatment'? And what about an awareness campaign about problematic alcohol use? This prohibited us to clearly delineate interventions specifically targeting the treatment gap and to specify in detail our propositions.

Thirdly, what is exactly a treatment gap? If somebody with problematic alcohol use is screened by his GP and receives an advice to lower his alcohol consumption: did this person received treatment? And is his treatment gap solved? But what if that advice did not get into this person's mind or if he is need of more extensive interventions? Does he still have a treatment gap? Perhaps, there is no single treatment gap, but several. And maybe we could better speak of a gap in receiving 'appropriate treatment'. Moreover, the term 'treatment' has often too much the connotation of pharmacological or psychiatric interventions, causing that less extensive (but effective) interventions are not perceived as a treatment and are probably not recorded nor reimbursed.

Post hoc, if at the start of the project more focused and detailed definitions would have been chosen, we probably could have avoided some of these terminology problems and it probably could have led to more concise propositions.



## 6.2 Natural recovery

Several studies show that most people with an alcohol use problem are able to change their problematic behaviour without any kind of formal/professional help, the so called natural recovery. However, we focused our research on the treatment gap, meaning people that have a problem and could benefit from a type of treatment/intervention but do not seek/receive it. In the literature review we did not search for studies on people in which the problematic alcohol use disappears or lowers without treatment/intervention. Also our qualitative data, gathered from professionals and patients, suggest that all of them spoke about the severe kind of problematic alcohol use; and the recruited patients all had experienced a long trajectory of alcohol dependence. As a consequence, the phenomenon of natural recovery appeared in our project as a kind of 'collateral' finding. To what extent do these studies minimize the size of the treatment gap? Is the treatment gap much lower than generally assumed? Or is it the case that many of persons with natural recovery received some type of intervention (a screening, an advice, a warning, a good supportive talk, etc.) that acted as a trigger to change? Or were there other triggers (e.g. career change, new social relationships,...) on their trajectory that made them change? It is not unlikely that some type of intervention was given somewhere within a healthcare encounter, without formally being recorded and maybe in a way that the patient was unaware of it or could remember when asked about treatment received. It would be interesting to study more in depth the path those persons followed and sift out what made them change, and what in fact is the working element. At least, we think that the phenomenon of natural recovery may not be used to minimize the problem of the treatment gap and as an excuse for not acting.

## 6.3 Review of reviews

We were overwhelmed by the amount of available studies on the topic, in such a way we had to choose to limit the literature study to reviews only for the international literature and to primary studies of Belgian origin. This approach gave us good oversight in a relative short time. However, it also caused that we did not get good insight in the individual primary studies included in the reviews and the details of the study populations and intervention ingredients. Is the treatment gap larger/smaller in particular persons with problematic alcohol use? Are some interventions more

effective in particular groups? How much heterogeneity is there in interventions that were grouped under one label in a review? This review of reviews approach caused loss of practical detail, prohibiting to formulate well-defined propositions. In this way we miss precision in our proposals concerning what treatment is needed for a person according to his stage of behavioral change and to the severity of the problematic alcohol use and what tailored intervention is needed to lead him to that treatment.

An example of having too superficial results, is the role of family/relatives support in helping people to seek help. From our data, we now know only that family/relatives support is a crucial factor but we miss details on how that support could be enhanced. To know more about that analyses of primary studies are required. Also the intervention of 'mutual aid' lacks detail in how this treatment/intervention can be supported.

By limiting to reviews, each with a particular focus, we were not able to compare one intervention to another; is a specific approach more effective than another?

And it is imaginable that we missed interventions that were already studied in primary research, but were not yet included in a review.

Despite above mentioned limitations and discussion points of our project, we believe that our results are convincing and encouraging enough for different types of parties to start action. We demonstrated that there is room for improvement, but also that there are solutions. And although the treatment gap is a multi-layered and complex problem and it requires initiatives at different levels at the same time, we are trustful that the 'treatment gap' for problematic alcohol use can and will be reduced in the coming years.



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