KCE REPORT 258Cs

Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

SYNTHESIS

REDUCTION OF THE TREATMENT GAP FOR PROBLEMATIC ALCOHOL USE IN BELGIUM

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HEALTH SERVICES RESEARCH

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REDUCTION OF THE TREATMENT GAP FOR PROBLEMATIC ALCOHOL USE IN BELGIUM

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FOREWORD

Why do so few people with a problematic alcohol use seek/receive treatment? This is the question the KCE got from the FPS Public Health in 2014. A straightforward question. After some thorough analysis and research, we would easily formulate an equally straightforward answer. This assignment seemed right up our alley, or is there a catch?

The first problem is the question itself: its formulation, but also its interpretation. “Problematic alcohol use” is often perceived as alcohol addiction, which implies a number of preconceptions and the social stigmatization that comes with it. “So few” then sounds like an accusation. And the term “treatment” finishes the job. As often the case in our society, problems quickly and almost automatically become medical ones.

If indeed we were dealing with a mere medical issue, we only had to get a good idea of the problem’s causes, take our pick in the available therapeutic arsenal and finally deliver an action plan to the policymakers in the Finance Tower, Victor Horta Place and Tervurenlaan.

As often in our *Health Services Research* projects, things were a bit more complicated. Firstly we had to deconstruct the question and reinterpret it according to the current insights. This led us beyond the strict boundaries of healthcare, risking losing our way in the maze of all implied dimensions. We did not expect to get away with recommending a simple pill or a therapy. But the apparently straightforward question could only be answered from a *health in all policies* point of view. Or how to get the voice of public health heard amidst economic interests and how cultural aspects are not necessarily aligned. But will the voice of public health be strong enough to be heard?

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KEY MESSAGES

- The treatment gap for problematic alcohol use is a considerable problem
- Causal and other factors for the treatment gap can be identified in the patients themselves, the care providers, the organisation of care and at a general social level
- There is plenty of evidence from national and international research about the origins of the treatment gap and effective interventions for reducing it
- In order to reduce the treatment gap, numerous measures need to be taken simultaneously at all levels

SYNTHESIS

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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.[1] The Belgian health survey[2] 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.[3] A Belgian study[4] 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 Psychinfo 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 synthetize 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 Delhi-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. PROBLEMATIC ALCOHOL USE: WIDESPREAD AND RARELY TREATED

The purpose of this study was to examine what mechanisms exist to explain the treatment gap in the case of problematic alcohol use and what measures can be taken to reduce it.

More specifically, consideration was given to the barriers/facilitators for people with problematic alcohol use in seeking help, as well as to factors to do with care providers and the organisation of care and factors at a more social level.

At all levels, ways of improving the situation were sought.

To this end, three studies were conducted:

- A study of the literature (both international and specific to Belgium)
- A qualitative study with interviews and focus groups
- A Delphi study of the acceptability and relative priority of measures

In all three methods, consideration was given to people with problematic alcohol use themselves, care providers and policy-makers.

The scientific report [5] describes in detail the methods used in each study.

2.1. The extent of problematic alcohol use

The use of alcoholic drinks is widespread in our own and other societies. In European countries, 89% of men and 82% of women aged 15-64 years consume alcohol [6], and the average daily consumption is about three standard glasses per day in most European countries [7]. In Belgium, 82% of the population (aged 15 and older) consume alcohol, and 14% of the population drink alcohol every day [2].

According to the World Health Organization, alcohol consumption is a factor in more than 200 disease and injury conditions (World Health Organization 2014). It is also an important determinant of mortality: 1 in 7 deaths in men and 1 in 13 deaths in women are alcohol-related [6].

There are various definitions and standards in use concerning when the consumption of alcohol is regarded as problematic.

In the Belgian health survey [2], the CAGE questionnaire was used for this purpose: if there were two or more positive answers to the following four questions, the use of alcohol was regarded as problematic:

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

According to this standard, 10% of the Belgian population had a problematic alcohol use [2].

The World Health Organization uses the term 'excessive alcohol use' for more than 14 glasses per week for women or more than 21 for men. According to this standard, 4.6% of the Belgian population use alcohol excessively [2].

Moreover, 5.4% of Belgian men and 1.9% of women aged 15-64 years are 'alcohol-dependent' (Rehm et al 2012), based on the definition given in DSM IV. Drinking is also a common problem among older people: a study of 4,825 Belgian over-65s found that 10.4% were 'risk drinkers', 4.6% were 'heavy drinkers' and 5.5% were 'problem drinkers' [8].

DSM V has now been published, in which the concept of alcohol dependence is abandoned and reference is now made to 'alcohol use disorders', which may have varying degrees of severity, depending on how many of the 11 listed indicators a patient displays.
In spite of the confusing terminology, it should be clear that problematic alcohol is widespread in Belgium.

2.2. Extent of treatment of problematic alcohol use

Although cutting down on alcohol consumption and treating problematic use is effective in reducing alcohol-related problems, diseases and deaths [9, 10], relatively few people with problematic alcohol use, seek and/or receive treatment. According to an European study (including Belgium), only 8% of people with an alcohol problem had sought some form of professional help in the past year [3]; another study in six European countries found that just 10% of people with alcohol dependence were receiving treatment [11].

A recent Dutch study [12] found that 54% of people with an alcohol problem did not seek/receive any form of formal assistance within four years.

In a Belgian study [4] of people with an alcohol problem, 12.8% said they had sought help within one year of the problem starting, but 61% said they had eventually done so in the following years, with an average 'delay' of 18 years. In another Belgian study [13], it was found that 57% of patients receiving treatment from their general practitioner for substance abuse had been struggling with the issue for more than ten years.

On the other hand, there is evidence that most people with an alcohol problem are able to change their problematic behaviour without any kind of formal/professional help [12, 14-19] ; the percentages of people able to solve their problem on their own vary (from 25%[18] to 78%[12] partly depending on the severity level of the alcohol use problem in the studied population).

Although it depends a little on the angle from which the issue is considered, it is clear that many people with a problematic alcohol use seek/receive no form of formal assistance, or only do so after a long delay. It can therefore be said that there is a substantial treatment gap, i.e. a lack of help/treatment for people with a problem who may benefit from such help or treatment.

2.3. Relevance

For alcohol use disorders, depending on their severity, various treatment methods exist of proven effectiveness, such as 'simple' motivational interviewing, psychological approaches, self-help groups and drug treatments. Simply increasing the rate of treatment of people with alcohol dependence to 40% could lead to a decrease in alcohol-related mortality of 13% for men and 9% for women [6].

It is therefore of great importance to reduce the treatment gap and steer more people towards the provision of help sooner.

3. THE TREATMENT GAP: A PROBLEM WITH CAUSES AT VARIOUS LEVELS

3.1. The long and difficult road to help

As just indicated, Belgian studies show that on average, 18 years elapse before people with problematic alcohol use seek some form of formal care [4], and 57% of patients receiving treatment from their GP for substance abuse have already been struggling with the problem for more than ten years [13].

Our own qualitative study of patients has confirmed this picture of a long and difficult road to recognising and acknowledging that there is a problem and then being willing to do something about it. But many other studies from around the world have also shown that people with problematic alcohol use go through numerous alternating stages of recognition, denial, acknowledgement, shame, willingness to take action, actually doing something and so on. Among other places, this process is well described in the 'Transtheoretical stages of change model' [20]. Others [21, 22] also describe the long road and the many steps that have to be taken to become conscious and take action.

The main message seems to be that treatment/advice must be relevant to whatever stage the patient is at.

On this long road, people with problematic alcohol use experience various obstacles to recognising and acknowledging their problem, and to seeking and accepting help.

On the basis of the international and Belgian literature and of the qualitative study, the following obstacles are the most significant for patients:

- denial and lack of recognition of the problem
- thinking they can solve it themselves
- shame and self-stigma
- lack of time or financial resources for treatment
- insufficient knowledge of care provision and treatment options
- not believing that help/treatment is effective
- being afraid of losing their social network
- finding it difficult to break (bad) habits
- feeling stigmatised by care providers and by society in general
- the general social acceptance of alcohol consumption

It is unclear how significant each of these factors is: they should instead be regarded as working in combination.

Factors that help with recognition of the problem and the search for appropriate help include experiencing physical discomfort or other consequences of heavy drinking, family and friends who point out the problem and are helpful, and empathetic, non-judgemental care providers.

3.2. Care providers experience obstacles too

The literature and the qualitative study show that care providers find it hard to identify people with problematic alcohol use, to discuss the problem and to lend a helping hand.

The main obstacles for care providers are:

- On a personal level:
  - Insufficient knowledge of problematic alcohol use and treatment methods
  - Inadequate skills to provide (initial) help
  - Lack of confidence in their own abilities in this area
  - Lack of motivation to help people with problematic alcohol use
  - Negative attitudes towards people with problematic alcohol use
  - The belief that treatment/help is ineffective
  - Fear that the carer-patient relationship will be harmed by raising the issue
  - Not seeing it as their role to do anything about problematic alcohol use

- On a more organisational level:
  - Pressure of work, lack of time and other (more important) tasks
  - Insufficient funding for this very time-consuming issue
  - Insufficient support from management to address problematic alcohol use
  - Inadequate referral possibilities for specialist help
  - Insufficient cooperation between different care providers/agencies

Factors that help care providers with identifying and addressing problematic alcohol use include a well-organised practice, continuing training and good interpersonal skills. It is also perceived as easier if the patient brings up the subject him-/herself and demonstrates motivation.

3.3. Social attitudes do not help

Extensive research shows that alcohol consumption is generally accepted in (Belgian) society and woven into the fabric of daily life. Moreover, alcohol consumption is encouraged by frequent advertisements which suggest that it is a healthy habit. As a result, problematic alcohol use often goes unnoticed, or is not noticed soon enough, and it is difficult for patients to recognise that they have a problem and can no longer participate in this common social pattern. This social attitude also ensures that treatment of problematic alcohol use is not given priority in the political agenda in general, and that there are few incentives and resources for care providers to address it.

On the other hand, there is also a negative social stigma attached to people who are drunk and alcoholics. People with problematic alcohol use are often seen in society as being to blame for their problem, and it is felt that they should sort the problem out themselves. They receive little support. This stigma is felt by the patients, making them carry on denying the problem for longer and feel a sense of shame.

4. NO EASY SOLUTIONS

Although there is no single easy solution, the literature and the qualitative study have brought to light various actions that can help reduce the treatment gap. These proposals have also been presented to stakeholders by means of a Delphi study; nearly all the proposals met with support in terms of acceptability and almost all were felt to be worth prioritising.

4.1. Helping the patient along the road

The following interventions were identified from the literature as useful for helping patients on their road to finding assistance, and can also be of therapeutic value:

- Screening and brief interventions by care providers
- On-line screening and awareness-raising programmes

Screening and brief interventions by care providers

While there may be variation in the elements of this intervention, numerous research syntheses [23-29] show that screening and brief interventions are effective in reducing alcohol consumption in people with problematic alcohol use, but not in people with alcohol dependence. It is not entirely clear whether this intervention actually leads to further treatment.

Despite this evidence, systematic screening for possible problematic alcohol use appears to be very little used; and where screening does already take place, positive screening is by no means always followed by a brief intervention. For example, in a Belgian study (Funk et al 2005) the screening rate among general practitioners was found to be just 2%. So there is still much room for improvement.

In the qualitative study, frequent reference was also made to the importance of screening and brief interventions, but also, as noted above, to the fact there are many obstacles to implementing these things.

In the Delphi study, screening and brief interventions by care providers were identified as a priority.

Online screening and awareness programmes

Systematic reviews [30-39] show that online screening and awareness-raising websites are effective at reducing alcohol consumption and contribute to better health; however, it is not clear whether they also lead to more people receiving some form of formal assistance. Such online interventions are a good alternative to screening and brief interventions by care providers, and also offer more anonymity.

Other interventions

Still other interventions were mentioned in the literature (community reinforcement and family training, interventions in the workplace, stigma-reducing interventions) that might be useful for helping the patient along the road, but the evidence for this was less clear.

In the final stakeholders meeting it was stressed that interventions always have to be tuned to the severity of the problematic alcohol use and to the stage of change of a patient.

4.2. Supporting the patient's family and friends

The qualitative study in particular highlighted the significant role of family and friends. They are often among the first to witness the onset of problematic alcohol use and can draw the patient's attention to the problem, give support and motivate him/her to seek help.

It is often also relatives who report problematic alcohol use to care providers; care providers can therefore also support the patient's family and friends to encourage the patient to seek help.

4.3. Supporting the care providers

Care providers experience numerous obstacles to screening for possible problematic alcohol use and starting initial assistance.

The provision of initial and continuing training in the skills required for screening and motivational interviewing is an effective intervention, as is clear both from systematic reviews [40-45] and, to a certain extent, from Belgian empirical studies.

Specific training in the field of alcohol problems and possible interventions is also desirable, in addition to more general training in the field of addiction and mental health problems.

Work also needs to be done on care providers' perception of their role regarding problematic alcohol use: many take the view that screening and addressing problematic alcohol use are not their responsibility but someone else's; care providers thus tend to 'pass the buck' to one another.

The recent review from the European OHDIN project [45] also finds that in order to increase the rate of screening and brief interventions, it is important to implement a combination of interventions aimed at the care providers themselves, the organisation of care, and the patients.

4.4. Improving the organisation of care

Improving the organisation of care can certainly help reduce the treatment gap. This can be either at the level of individual care providers, by ensuring the ready availability of resources and protocols, or through the standard inclusion of questions on problematic alcohol use in computerised medical records. Better funding for extended consultations can also help.

It is also important for cooperation between different professionals in primary and secondary care to be improved, and for the consultation possibilities for specialised care providers to be increased and made easier. A specific alcohol consultation team in general hospitals would be a good example of this.

Increasing the number of specialised facilities also seems necessary, so that primary care workers can refer more easily and in order to keep waiting times to the minimum.

The qualitative research showed that it is also important not to organise the treatment of problematic alcohol use exclusively in a psychiatric context/facilities, because of the stigmatising effect that this can have.

The qualitative study also indicated that self-help groups such as AA are happy to be involved in the care provision process, and believe they can make an accessible contribution.

4.5. Influencing public opinion

This is perhaps the hardest part, and the evidence is also much less clear here. However, the literature suggests that educational leaflets and mass media campaigns can help change the attitude of the general public towards mental disorders in general and alcohol use disorders. If public opinion changes, this also makes it easier for care providers and family and friends to raise the issue.

The qualitative study also stressed the importance of regarding problematic alcohol use as a chronic disease, rather than as a situation that patients themselves have sought and are to blame for. Measures can also be taken in the work environment to change the image of (problematic) alcohol use.

Moreover, alcohol and positive alcohol advertising are ubiquitous, and this ensures that problematic alcohol use is less noticeable and can be used as an excuse for those involved.

4.6. Political action needed

To reduce the treatment gap successfully, measures aimed exclusively at patients, care providers or the organisation of healthcare are inadequate. All measures must fit into an overarching policy framework regarding alcohol consumption. A different image of alcohol can only arise if advertising and the sale of alcohol are more strictly regulated. An effective approach to problematic alcohol use by care providers is only possible if enough resources are made available politically.

5. IN CONCLUSION

In this study, we have found an overwhelming amount of literature, so much so that the literature search was confined exclusively to an analysis of previously published systematic reviews, and for some aspects even to reviews of reviews. A considerable number of primary studies of Belgian origin are also available.

The treatment gap is clearly a major problem, and reducing it could lead to significant health benefits, provided it is approached in the right way.

Because of the massive scientific literature, it was impossible to enter in the ‘evidence’ for each aspects in the time frame of this report. However, the extensive research makes it clear that reducing the treatment gap for problematic alcohol use is a complex matter with many contributory factors at various levels. Tackling it therefore requires a comprehensive strategy and a (simultaneous) combination of measures at all levels in order to produce real results.

There is abundant evidence about the extent of the alcohol treatment gap, the process that patients with problematic alcohol use go through, the barriers and facilitators they encounter on the path towards help and treatment, the barriers and facilitators that influence care providers in identifying and treating problematic alcohol use, social attitudes and what measures and interventions are effective and can be applied at the level of the patient, the care providers, the organisation of care and society in order to reduce the treatment gap for problematic alcohol use.

Of course some aspects still require further investigation, such as specific measures for people with a very serious alcohol use disorder that will lead them towards treatment, as well as the effectiveness of actions aimed at reducing the stigmatisation of certain groups in society. There is also room for discussion about questions such as whether doctors should screen everyone or should only do so selectively, or whether all people with a problematic alcohol use need formal help, or may be capable of taking action themselves in some cases.

However, none of this should be used as an excuse for doing nothing and postponing action.

The question is not so much who should do what, but when the initiative will be taken at the national political level to sit down at the table with all parties concerned, and when resources will be freed up for joint comprehensive action. This does not mean that waiting for a political initiative can now be used as a pretext: measures can already be taken on a smaller scale, such as continuing training for care providers; however, smaller-scale initiatives will be beneficial and have greater effect if several well-coordinated interventions are launched simultaneously.

The problem and its causes are known and effective interventions are at hand: now is the time for action!

RECOMMENDATIONS[a]

It can be seen from the foregoing that problematic alcohol use and the reduction of the treatment gap are a multi-dimensional problem that can only be tackled by a combination of measures, taken simultaneously as far as possible. Combined measures will give synergy.

- **KCE recommends that all parties, competent authorities, policy makers, professional bodies, care organisations, patient groups and other stakeholders should sit down together as soon as possible and work on a comprehensive Belgian alcohol plan. Reducing the alcohol treatment gap should go together with policies to reduce alcohol consumption in general (regulating sales and advertising). The Minister of Health should take the lead in this. Such an national alcohol plan fits with recommendations from the World Health Organization [46, 47] and a recent resolution of the European Parliament [48].**
- **to the competent Ministers:**
  - **Launch information campaigns together with the Federal Public Service, the VAD (Flemish Association for Alcohol and Drug Problems), Infordrogues and other organisations to make people more aware of the risks and consequences of alcohol use**
    - **Make standards about acceptable alcohol use widely known**
    - **Show the consequences of excessive alcohol use**
    - **Use all types of (mass) media for the information campaigns**
    - **Set up targeted information campaigns at nightlife venues, festivals, etc.**
    - **Publicise who people can contact if they have questions about or need help with alcohol**
    - **Publicise how people can contact a self-help group**
  - **Set up contact points (phone lines, websites) that people can turn to if they have questions, and/or refer to what already exists and coordinate all initiatives in this area**
  - **Arrange an adequate financing for integrated and multidisciplinary care, both in primary and secondary care, in cohernce with the approach for people with chronic health care problems, and in such a way that care professionals can take sufficient**

[a] The KCE has sole responsibility for the recommendations.

time for those patients and in such a way that care professionals invoke easily each other expertise.

- **Expand the treatment capacity for problematic alcohol use, in primary care, in general hospitals and in specialist psychiatric services**
- **Forbid exclusion of insurance coverage because of alcohol-related problems**

- **to the care providers' training institutes:**
  - **include education and training on addiction problems, including problematic alcohol use, in the basic curriculum**
  - **include education and training on communication skills, including motivational interviewing, in the basic curriculum**
- **to the care providers' professional bodies:**
  - **organise refresher courses and training in screening and brief interventions for problematic alcohol use**
  - **inform care providers about the standards, definitions and consequences of problematic alcohol use and about the available guidelines on problematic alcohol use**
  - **include screening for possible problematic alcohol use in as many treatment protocols as possible**
  - **discuss the best way to work together with relevant professional associations and patient groups**
- **to the general practitioners (and other involved care providers):**
  - **put information leaflets about the consequences of alcohol use and options for getting help in all waiting rooms**
  - **screen for problematic alcohol use periodically**
  - **approach patients with a problematic alcohol use in a non-judgemental and empathetic way. Discuss and treat the symptoms for which the patient has made the appointment before raising the issue of problematic alcohol use**
- **to special interest organisations**

- **promote (development of) more strongly websites with information about the risks of alcohol, websites with information about treatment options for problematic alcohol use and websites to support people with problematic alcohol use more strongly**

- **to the administrators/designers of computerised patient records**
  - **include screening questions about alcohol use as mandatory**
- **to the universities and research institutions**
  - **develop research into interventions to reduce the treatment gap specifically for people with a very severe problematiclcohol use – alcohol dependence**
  - **develop research into stigma-reducing interventions**

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COLOPHON

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