



The role of assisted self-help in services for alcohol-related disorders

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ABSTRACT

Potentially harmful substance use is common, but many affected people do not receive treatment. Brief face-to-face treatments show impact, as do strategies to assist self-help remotely, by using bibliotherapies, computers or mobile phones. Remotely delivered treatments offer more sustained and multifaceted support than brief interventions, and they show a substantial cost advantage as users increase in number. They may also build skills, confidence and treatment fidelity in providers who use them in sessions. Engagement and retention remain challenges, but electronic treatments show promise in engaging younger populations. Recruitment may be assisted by integration with community campaigns or brief opportunistic interventions. However, routine use of assisted self-help by standard services faces significant challenges. Strategies to optimize adoption are discussed.

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1. Introduction: challenges in addressing community-wide alcohol problems

Despite considerable investment in services, alcohol continues to pose a significant global health risk. In 2004, it accounted for 3.8% of deaths and 4.6% of disability-adjusted life years worldwide, with costs amounting to 1% of the gross domestic product of middle- and high-income countries (Rehm et al., 2009). Challenges in addressing alcohol-related problems are substantial—not least of which are its legal status, ubiquitous advertising (Smith & Foxcroft, 2009), and widespread approval of its use (e.g. only 21% disapproved of drinking in AIHW, 2008). While only 55% of men and 33% of women drink alcohol worldwide (Rehm et al., 2009), in many countries, drinking rates are higher. For example, 86% of Australian men aged 14 or over had at least one drink in the past year, as have 80% of women (AIHW, 2008). In the US, 58% of males and 47% of females aged 12 and over have had a drink in the previous 30 days, and an estimated 12.1 million US men (9.9% of the population) and 6.5 million women (5% of the population) fulfilled criteria for an alcohol use disorder at some time in the previous 12 months (SAMHSA, 2010). Rates of risky drinking are even greater: 31.6% of US men and 16.1% of women aged 12 or over had 5 or more drinks (\geq about 70 g ethanol) at least once in a 30-day period (SAMHSA, 2010); equating to nearly 60 million high-risk drinkers.

Currently, few affected people access treatment. In 2009, only 9.5% of US men and 7.5% of US women requiring treatment for alcohol abuse or dependence obtained specialist help (SAMHSA, 2010). Rates

were particularly low for young adults (6.4%). A contributing factor in non-receipt of treatment is that many do not think they need it. In 2004–5, only 10.4% of people with alcohol disorders thought they needed treatment (Edlund, Booth, & Feldman, 2009). The issue is even more acute in young people: in 2004–5, people aged 18–25 were less than half as likely to perceive a problem than people aged 35 or more (OR = 2.09; Edlund et al., 2009). While binge drinking in young people presents significant short-term risks (Chikritzhs, Jonas, Stockwell, Heale, & Dietze, 2001), many negative impacts of alcohol take some time to emerge.

Attending a treatment service is also perceived as incurring significant cost: In the 2009 SAMHSA survey, 40% of people who needed alcohol treatment but did not receive it cited lack of health insurance coverage as a reason (SAMHSA, 2010). Inequitable access can arise from the impact of service costs across different socioeconomic groups. Emotional costs are also a factor: 10.7% of people not using services feared their neighbors' opinions and 12.7% thought that receipt of treatment might have a negative impact on their job (SAMHSA, 2010).

A further challenge for alcohol services is that affected people are widely dispersed. In 2009, 5.4% of people in completely rural areas of the US had alcohol dependence or abuse (SAMHSA, 2010). Practitioner/population ratios typically reduce with increased remoteness (DoHA, 2008), and many people outside population centers who require alcohol treatment have to travel long distances or endure extended waiting periods before accessing treatment. Telephone counseling or videoconferencing can help specialist services overcome geographical isolation, when managing alcohol-related harms (e.g. drink-driving; Mello, Longabaugh, Baird, Nirenberg, & Woolard, 2008) or offering aftercare (Lynch et al., 2010), but such services have yet to be routinely offered.

Even if these barriers were addressed, specialist services would have difficulty supporting the numbers of affected people: staffing,

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facilities and budgets would have to increase substantially. Nor would that guarantee access to high fidelity, evidence-based treatment. Use of these treatments is highly variable across services (Knudsen, Johnson, Roman, & Oser, 2003; Miller, Sorensen, Selzer, & Brigham, 2006), and significant gaps between science and clinical practice are apparent (Lamb, Greenlick, & McCarty, 1998; Marinelli-Casey, Domier, & Rawson, 2002).

2. Approaches that may help to address gaps in treatment receipt

Suggested criteria for services that hope to reduce gaps between population needs and treatment receipt are summarized in Table 1. Specialist services alone have difficulty meeting these criteria: Supplementation with other components is needed.

2.1. Preventive programs and regulation

Among population-based approaches to these issues are preventive interventions and regulation. Some skills-based preventative programs in schools reduce or delay substance use, although effects are relatively small and are often short-lived (Anderson, Chisholm, & Fuhr, 2009; Faggiano et al., 2008). Regulatory responses and pricing can also impact on a population's alcohol use (Johnson, 2008) and on related harms such as drink-driving (Anderson et al., 2009). However, many population-wide approaches have little or no research support (Anderson et al., 2009), and risky or problematic consumption by individuals must still be addressed.

2.2. Mutual-help groups

Mutual-help groups using 12-step and other approaches offer a partial solution. In the epic Project MATCH study, a 12-step program initially performed better than cognitive-behavioral therapy, although differential benefits had disappeared by the 3-year follow-up (Project MATCH Research Group, 1997, 1998). Effectiveness is harder to establish, especially in voluntary and anonymous groups. The nature of mutual help groups allows them to assist large numbers, regardless of financial status. Anonymity alleviates some concerns about help-seeking, and the distributed nature of groups allows meetings to be more geographically accessible than specialist services. However, the current impact of mutual-help groups on population problems remains limited. Only 11% of people with current substance-related disorders receive support from a self-help group (SAMHSA, 2010), and retention—which is correlated with successful outcomes (Fiorentine, 1999)—is only around 20% (Terra et al., 2008). Among other reported reasons for not participating or adhering to 12-step groups are a lack of identification with the method, format, membership or spiritual components, and social anxiety (Copeland, 1997; Kelly, Kahler, & Humphreys, 2010; Terra et al., 2008). Additional strategies are required, especially for people with at-risk alcohol use that has not yet had significant functional impact.

Table 1
Characteristics of services for alcohol misuse that contribute to population impact.

Required characteristics of services
Effective
Able to service large numbers
Induces perception of need
Acceptable perceived and actual costs
Engages key risk groups
Avoids inequity (SES, geographical)

2.3. Brief intervention by existing practitioners

One strategy to increase awareness and initiate change across communities uses existing points of contact (e.g. general practitioners, hospitals, workplaces), to undertake screening and brief interventions opportunistically. Most commonly, interventions comprise provision of assessment feedback and brief advice. Some use motivation interviewing (Miller & Rollnick, 1991) or add follow-up assessments (Wallace, Cutler, & Haines, 1988).

Family doctors and other health professionals represent credible sources of information and advice, are typically more widely spread than specialist services, and are accessed at least annually by many people (e.g. 88% of Australians; Knox, Harrison, Britt, & Henderson, 2008). If brief intervention is given after an injury or physical test, its relevance and impact is difficult to ignore. In samples who are not seeking treatment for alcohol problems, meta-analyses demonstrate that brief interventions have small but statistically superior effects on alcohol consumption and related outcomes than control treatments for up to 12 months (Miller & Wilbourne, 2002; Moyer, Finney, Swearingen, & Vergun, 2002). The classic Swedish study of Kristenson, Ohlin, Hulten-Nosslin, Trell, and Hood (1983), which included liver function tests at follow-up sessions, demonstrated 50% reductions in 6-year mortality rates. Brief interventions also show benefits in treatment-seeking samples (Miller & Wilbourne, 2002). In fact, it is difficult to demonstrate superior results from more extensive treatment, except in severely affected patients (Moyer et al., 2002).

Interventions by trusted practitioners have an important role in a multi-component approach to alcohol-related problems, but there are significant problems with reliance on these as the primary outreach strategy. To some extent, access remains subject to location and financial status. Applications of screening and brief intervention by practitioners are also limited by competing foci for opportunistic intervention, time pressure, self-efficacy, attitudinal and systemic issues (Nygaard, Paschall, Aasland, & Lund, 2010; Sturk et al., 2007).

2.4. Remote delivery of assisted self-help

Bibliotherapies, and automated electronic interventions (using mobile phones, computer programs or the Internet) provide highly accessible self-help support at low cost.

2.4.1. Bibliotherapy

Alcohol treatments via printed manuals, self-help books or letters have been evaluated for some 30 years. Memorable early studies (Miller, Gribskov & Mortell, 1981; Miller & Taylor, 1980; Miller, Taylor and West, 1980) were randomized controlled trials for problem drinkers, where effects of a self-help book were compared with those from adding up to 8 multi-component treatment sessions. Each found substantial reductions in alcohol consumption, but little difference between treatments.

Subsequent research continued to find strong results from bibliotherapies. Apodaca and Miller (2003) observed within-treatment improvements in alcohol outcomes from bibliotherapies, of .80 SD for media volunteers and .65 SD for people screened in health services. Differences between experimental and control conditions at Post or Follow-up were .31 SD for media volunteers and .21 SD for screened patients. There was no significant difference between bibliotherapies and more extensive treatments in either group ($d = .05$ and $-.10$ respectively).¹

Interventions using letters have had similar results to other bibliotherapies: for example, within-treatment effect sizes for multi-component postal interventions in three of our own alcohol studies,

¹ Note that there is an overlap between the studies on screened patients in the Apodaca and Miller (2003) bibliotherapy review and those in the Moyer et al. (2002) meta-analysis of brief interventions with people who were not seeking treatment.

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