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ALCOHOL USE DISORDER IN PRIMARY CARES: HOW TO INTEGRATE BRIEF INTERVENTIONS AND CONTINUOUS CARE?

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SUMMARY

Background: *In Belgium, 82% of the population consumes alcohol occasionally while 10% consume in a way that can be seen as problematic. On a European level, only 8% of the people who can be characterized as having Alcohol Use Disorder (AUD) would have consulted professional assistance in the past year. In this context, the KCE (Belgian Health Care Knowledge Centre) has addressed multiple recommendations to health professionals to reduce the "treatment gap" concerning the patients' care: (1) encourage screening and preventative interventions, (2) promote the acquirement of communicational and relational competences (3) develop collaborations between professionals. The objective of this article is to better understand their functioning.*

Method: *We format a non-systematic literature review concerning these recommendations.*

Results: *The implementation of these Brief Interventions programs in primary care is relevant due to the moderately positive impact on the frequency and quantity of alcohol consumption but both the quality of the therapeutic relationship and collaboration with the care network would optimize Brief Interventions. The quality of the therapeutic relationship alone appears to have an impact on therapeutic outcome.*

Conclusion: *Training concerning patient-professional relationship is necessary to maximize the effectiveness of BIs.*

Key words: *Alcohol Use Disorder - Brief Interventions - therapeutic relationship - primary cares - continuous care*

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INTRODUCTION

Alcohol abuse is the origin of more than 200 illnesses and infections (World Health Organization 2014). In Belgium, 82% of the population consumes alcohol occasionally while 10% consume in a way that can be seen as problematic (Mistiaen et al. 2015). On a European level, only 10% of the people who can be characterized as having Alcohol Use Disorder (AUD) receive treatment (Wolstenholme et al. 2012). In addition, 8% would have consulted professional assistance in the past year (Alonso et al. 2004).

Subsequently, the KCE (Belgian Health Care Knowledge Centre) has addressed multiple recommendations to health professionals and politicians in order to reduce the "treatment gap" concerning the patients' care (Mistiaen et al. 2015). The main recommendations given out to healthcare providers and training institutions are:

- encourage screening and preventative interventions;
- promote the acquirement of communicational and relational competences concerning that certain population;
- develop collaborations between professionals (Mistiaen et al. 2015).

The objective of this article is to format a literature review concerning the previously mentioned recommendations in order to better understand their functioning.

NON-SYSTEMATIC LITERATURE REVIEW

The recommendations of the KCE given out to health professionals mainly target primary care (Mistiaen et al. 2015) as it consists of an organizational framework that allows a bigger number of access to care in order to reach a universal sanitary coverage (Ngo et al. 2013). Additionally, the primary health care promotes collaboration between different care handlers (Anderson et al. 2017).

AUD screening

The OMS encourages AUD testing in primary health care (WHO 2014). However, there is no established consensus concerning a systematic pattern for screening. Certain authors strongly recommend routine screening (universal testing) (Coulton et al. 2017) or in specific situations that involve comorbidities (depression, anxiety, insomnia, hypertension) (Rehm et al. 2015, 2016). Other authors tend to privilege "opportunity" screening in order to avoid a rupture in the therapeutic relationship (Kaner et al. 2009, Ketterer et al. 2014). Therefore, some professionals tend to delay screening with the intention of waiting for a more appropriate moment like; during medicine prescription, absence certificates, presence of physical wounds or social dysfunction (Ketterer et al. 2014).

Concerning the material used for screening, short questionnaires, such as AUDIT-C tend to be universally used (Aertgeerts et al. 2001; Beich et al. 2002; Anderson et al. 2017).

Brief interventions (BI)

Once AUD is detected, the BI consist of delivering appropriate treatment and advice in order to sensitize patients on the negative effects of alcohol and motivate

them towards diminishing their alcohol intake (Anderson et al. 2017). The Brief interventions of AUD are short sessions of five to ten minutes (Kaner et al. 2009, Anderson et al. 2017) during which clear and structured advice is given to the patient in order to empower one to change their maladaptive habits (Bien et al. 1993). Heterogeneity is a concern in BI (Kaner et al. 2009). Subsequently, it presents certain variability in the context of intervention in the target population, within the development of the therapist and in a theoretical framework that underlines the intervention (Kaner et al. 2009). Regardless of their diversity, the common ground between these BI can be represented by the letters "F R A M E S" which stand for Feedback, Responsibility, Advice, Menu, Empathy and Self-efficacy (Bien et al. 1993).

The implementation of these BI programs in primary care is relevant due to the moderately positive impact on the frequency and quantity of alcohol consumption (Anderson et al. 2017, Kaner et al. 2018). However, it appears that the quality of the patient-professional relationship has a greater impact on therapeutic outcome than the content and duration of counseling (McCambridge & Kypri 2011, Platt et al. 2016). These results are in line with the literature that emphasizes the quality of the patient-practitioner relationship (Haggerty et al. 2003), as a determinant of psychotherapeutic outcome (Lambert & Barley 2001).

The literature also highlights several barriers to screening and BI, such as stigmatization of AUD (Van Boekel et al. 2013), caregiver motivation (Ketterer et al. 2014), lack of training (Lock et al. 2010, Van Boekel et al. 2013, de Timary 2014, Mistiaen et al. 2015, Anderson et al. 2017), fear of failure, fear of breaking the therapeutic bond, and lack of confidence in their ability (Beich et al. 2002). Even if AUD is detected, caregivers with low confidence in their aptitude will tend to either not intervene or use more "pragmatic" methods of care (task oriented approach) in order not to upset the patient (Van Boekel et al. 2013, Ketterer et al. 2014). Caregivers who view AUD as a moral issue rather than a chronic illness also engage less in care behaviors despite detection of the disorder (Ketterer et al. 2014). Even with these barriers, collaboration with a multidisciplinary care network can be considered as facilitators to screening and Brief Interventions (Ketterer et al. 2014).

Promote the achievement of communication and interpersonal skills

Relational and communicative difficulties are inherent in primary health care, as in the general practice for example (Lepièce et al. 2019). This appears to the case of AUD (Beich et al. 2002). As discussed in the previous section, the interpersonal factor plays a central role in screening behavior as well as the effectiveness of BI in AUD. A good patient-caregiver relationship would also make it easier for patients with AUD to seek help (Mistiaen et al. 2015). According to Ketterer et al. (2014), interpersonal and communication skills are necessary qualities in handling alcohol abuse. Nonetheless, when health care providers are interviewed, they report difficulties in establishing a good relationship with screened patients, which can be a barrier to implementing an intervention (Beich et al. 2002). One of the explanations can be their lack of training; health care professionals who report a lack of training are less engaged in care giving; their appointments with these patients are shorter, they have less personal commitment including less empathy for them (Van Boekel et al. 2013).

Develop collaborations and exchanges between care providers

The authors of the KCE report insist on the importance of working in collaboration and information exchange between the different healthcare providers (Mistiaen et al. 2015). There is a correlation between engagement in the management of AUD and investment in care networks or Continuous Professional Collaborations of development (CPD) (Ketterer et al. 2014).

An explanation of failure to implement the BIs can be the lack of collaboration between the primary health care providers and mental health services (Anderson et al. 2017). In mental health, the literature emphasizes the coordination of services (Haggerty et al. 2003); proposing multidisciplinary work that integrates medical-psycho-social care is necessary for AUD (McLellan et al. 2000, Mistiaen et al. 2015).

RESULTS

Recommendations (2) and (3) are part of the broader concept of continuity of care. This three-dimensional concept (i.e., quality of the relationship, information exchange, and coordination of care) aims to ensure appropriate and continuous care over time by implicating various participants (Haggerty et al. 2003). Continuity of care is particularly relevant in the context of chronic problems such as AUDs (Bekkering et al. 2016, Patigny et al. 2018). It is viewed by both patients (Rehm et al. 2015) and professionals as an essential characteristic of quality of care (Biringer et al. 2017) and is used as an indicator of quality of care at the integrated level (Bekkering et al. 2017).

In our initial questioning, we questioned the coordination of two care behaviors in the handling of AUD, namely BI and continuing care. Although both are relevant, they remain different in terms of temporality: on the one hand, a "cross sectional" approach and, on the other, a vision of "continuous" care. Based on our literature review, it would appear that continuity of care would play a more facilitative role for the BI. Indeed, both the quality of the therapeutic relationship (Anderson et al. 2017) and collaboration with the care network (Ketterer et al. 2014) would optimize Brief

Interventions. In addition to being an BI facilitator, the quality of the therapeutic relationship alone appears to have an impact on therapeutic outcome.

DISCUSSION

The training of primary health care actors is central in the fight against AUD. It is linked to a higher level of confidence and comfort among caregivers (Anderson et al. 2014) and helps to reduce barriers in order to access to care (Livingston et al. 2012). However, training concerning patient-professional relationship is necessary to maximize the effectiveness of BIs.

CONCLUSION

To be effective to reducing the "treatment gap" concerning the patients with AUD, the acquisition of communication and relationship skills for this population appears to be a prerequisite for the implementation of other recommendation. Future studies should focus on quantitatively assessing the influence of the issue components in the effectiveness of these interventions.

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Pierre Patigny, Nicolas Zdanowicz, Denis Jacques & Brice Lepiece all made substantial contributions to conception and design and or acquisition of data and/or analysis and/or interpretation of data.

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