Accessing treatment for problem alcohol users: Why the delay?

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Executive summary

Introduction

In England, it is estimated that a quarter of people drink to harmful and hazardous levels with the highest prevalence amongst men, young people and the homeless (Alcohol Needs Assessment Research Project, 2005). It is suggested that only one in fourteen of the in-need alcohol dependent population are accessing treatment each year (Calling Time, 2008).

In Gloucestershire, alcohol users[1] take an average of thirteen years longer than drug users to initially recognise their alcohol use as a problem and twelve years longer to access treatment from their first use of alcohol (Gloucestershire DAAT Database, 2005). This suggests that problem alcohol users experience a set of treatment barriers that are specific to alcohol use. Research into the treatment pathway for alcohol users has elicited multi-factorial results.

These factors broadly fall into four categories:

- social influence,
- personal attitudes and beliefs,
- psychosocial and physical health influences,
- treatment factors.

Saunders et al (2006) propose a framework for understanding the processes involved in seeking alcohol treatment which identifies four steps which include problem recognition, making the decision that change is necessary, deciding that professional help is needed and then finally seeking professional help and keeping appointments.

Current study

Whilst the academic literature identifies a number of general factors relating to treatment seeking barriers, little in-depth research has been carried out focussing specifically on why people delay seeking treatment. Within Gloucestershire, little is known about the delay into treatment or the differences between those who eventually seek treatment and those who do not. By increasing understanding it may be possible to develop interventions to shorten the delay into treatment for those who are in need.

The aim of the current pilot study was to inform alcohol treatment service development by exploring the reasons why individuals may delay treatment seeking for problematic alcohol use. Semi-structured interviews were conducted with nineteen adult alcohol users recruited from a variety of agencies in Gloucestershire. Interviews were subjected to formal thematic analysis to identify common themes and consider the importance of the issues raised with reference to extracts of the interview text.

[1] A variety of terms are used interchangeably to describe individuals with alcohol concerns, these are purely descriptive and not reflective of any formal categorisation of severity.

Results
Four main themes emerged from the data analysis around the central issue of delay: (1) social influence, (2) psychological influence, (3) situational influence, and (4) access barriers. Each of these had several subthemes, which acted as either 'delay influences' (factors that increased the delay in seeking treatment) or 'recognition influences' (factors that alerted the individual to the need to change their drinking behaviour and seek treatment. For the most part, the presence of 'delay influences' (e.g. pro-drinking social network) and the absence of 'recognition influences' (e.g. health consequences) appeared to impede the pathway into treatment seeking.

Discussion
The analysis revealed two main categories of influence on participants drinking behaviour and their movement towards seeking and accessing treatment. 'Delay influences' represent the factors that perpetuate ambivalence towards change and 'recognition influences' enhance the acknowledgement of problem drinking and the steps to seeking help.

The analysis facilitated a review of the treatment-seeking model proposed by Saunders et al (2006). A more complex representation is presented which is contrary to a stepwise model of treatment seeking. Notably, acceptance of an alcohol problem and acknowledgement of the need to change seemed to be a phase that lasted well beyond the onset of treatment seeking behaviour. The four main themes seemed to have varying relevance across the different phases. Specifically, social influence and situational factors played a role throughout whereas psychological influences were more pervasive once the individual starts to become aware of their alcohol problem. Treatment barriers were more apparent once they were fully aware of their problem and started to accept that they needed to change.

Implications and recommendations
The findings have a range of implications for local treatment agencies and recommendations for service improvements. Firstly, the importance of increasing awareness amongst staff working in all capacities with problem alcohol users was apparent. Staff should play a role in highlighting 'recognition influences' to clients. Early intervention services and routine screening are crucial in the detection of alcohol concerns and should be balanced with tailored aftercare and relapse prevention.

Considering the needs of those with dual dependencies and focussing on the underlying and maintaining factors of drinking (e.g. emotional aspects) are vital to long-term treatment success. Promoting services as having a dual focus may alter the perceptions and the reported stigma associated with traditional drug services.

Future research
Further work is needed to explore the differences between those individuals who access treatment compared to those who do not; especially in terms of the types of treatment people choose and the perceived barriers involved. More in depth knowledge longitudinal work is needed to examine the

experiences of those with dual diagnoses and/or dual dependencies, with a view to informing treatment interventions for this complex population.

Prospective research which follows individuals through their help seeking pathway starting at problem recognition including exploration of both baseline and subsequent predictors of help seeking is fundamental for increasing understanding. Additionally, collaborative projects with drug and alcohol staff exploring the types of interventions that can be implemented and evaluating their effectiveness.

Key Recommendations

- **Psychosocial Influences**
  - More attention to underlying factors of drinking. Referral onto more specialist mental health services if appropriate.
  - Aftercare involving family/partners.
  - When advertising services, alert individuals to ‘recognition influences’.
  - Assess situational factors.

- **Access barriers/Service experiences**
  - Flexible approach to treatment and aftercare.
  - Alcohol screening.
  - First episodes of care should be positive experiences.
  - Implement intervention initiatives.
  - Relapse prevention work in prisons.
  - Presentation of services as having a dual focus, drugs and alcohol.
  - Inter-agency care planning.

- **Training Issues**
  - Increased awareness of services/support by all staff working in the alcohol field.
  - Better identification and referral.
  - Comprehensive training.
  - Development of community based detox programmes.
  - Training to staff to recognise treatment barriers.
  - Use the treatment seeking pathway model to inform training.

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1.0 Introduction

1.1 National perspective

Data from the Health Survey for England (2005) suggests the number of hazardous and harmful drinkers to be approximately 10 million, an increase in comparison to previous figures. Overall, it is estimated that about a quarter (26%) of the people in England drink to harmful and hazardous levels, with four percent being alcohol dependent. The highest prevalence of drinking is found amongst men, young people and the homeless (Alcohol Needs Assessment Research Project, 2005).

The annual cost of alcohol misuse in England is estimated to be approximately twenty billion pounds when the cost of hospital admissions, alcohol treatment services, alcohol related crimes and lost working days are considered. The Alcohol Harm Reduction Strategy for England (Cabinet Office, 2004) sets out the Government's strategy for tackling the harms and costs of alcohol misuse in England based on a detailed analysis of the key issues and the current situation. The strategy document identifies four key areas of Government focus in order to reduce alcohol-related harm:

1. Better education and communication
2. Improving health and treatment services
3. Combating alcohol-related crime and disorder
4. Working with the alcohol industry

Improving health and treatment services for problem alcohol users is one of the key priorities for the Government. The Alcohol Needs Assessment Research Project (ANARP) suggests that there is a large gap between the need for alcohol treatment and access to treatment, with only one in eighteen alcohol dependent individuals accessing specialist alcohol treatment nationally each year (ANARP, 2004). There remains a perception amongst problem alcohol users that treatment services are difficult to access due to lengthy waiting lists and waiting times (ANARP, 2005).

Models of Care (MoCAM, 2006) provides best practice guidelines for the provision of treatment for alcohol misusers, which highlights the importance of accessibility, equality, integrated care and evidence based treatment. The aim is to ensure availability of a range of treatment intensities to meet the diverse needs of alcohol users. It proposes a tiered framework for the provision of services[2]:

- **Tier 1** – low intensity services that identify the extent and severity of an individual's drinking. Typically including advice and brief interventions to reduce alcohol related harm. A range of generic services may deliver these, for example, General Hospitals, where the focus is not on alcohol treatment,

[2] Only tiers 3 and 4 are defined as being structured treatment for alcohol users.

- **Tier 2** – open access facilities and outreach services where alcohol-specific advice and support is provided, for example, arrest referral schemes,
- **Tier 3** – typically community based specialist alcohol treatment, for example, specialist prescribing,
- **Tier 4** – specialist inpatient treatment or residential rehabilitation, for example, inpatient detoxification.

1.2 Local perspective

The Gloucestershire Alcohol strategy 2006-2009 (County Alcohol Strategy Group, 2006) sets out the key priorities and objectives locally. This document is intended to focus the efforts of individuals and organisations within the county to ensure the long-term reduction of alcohol related harm. A key element of this policy is monitoring and reviewing the objectives to ensure that progress is made.

A recent report from the South West Public Health Observatory highlights the current situation with regards to alcohol harm and areas of unmet need in the South West (Calling Time, 2008). This 'blueprint for joint action' estimates that only one in fourteen of the 'in-need' alcohol-dependent population is currently accessing treatment each year. Whilst this suggests an improvement in the treatment figures compared to previous years (one in eighteen, ANARP, 2005) unmet needs are still substantial. It also acknowledges that alcohol use is common among illicit drug users in drug treatment services. Data is beginning to be collected for those currently accessing specialist alcohol treatments in the South West to inform strategy developments.

In Gloucestershire, the current average gap between an alcohol user recognising their alcohol use as problematic and accessing a treatment service is seven years (Gloucestershire DAAT Database, 2005). It is a similar length of time for illicit drug use. However, alcohol users take an average of thirteen years longer to initially recognise their alcohol use as a problem and twelve years longer to access treatment from their first use of alcohol (Gloucestershire DAAT Database, 2005).

Some of this variance may be explained by the different physical, social and cultural effects that alcohol may have for an individual in comparison to those of common illicit drugs such as heroin, cocaine or amphetamine. However, there also appears to be significant barriers to accessing services that are more specific to alcohol usage among problem alcohol users.

1.3 Academic literature

1.3.1 Predictors of help seeking for alcohol dependency

The majority of research investigating the predictors of alcohol treatment seeking has focused on the difference between problem drinkers who access treatment and those with less help seeking history. Studies have suggested that the pathway into treatment for problem alcohol users is multi-factorial. These factors broadly fall into four categories:

(a) Social influences

Social networks and spouses have both been found to strongly influence the help seeking behaviour of the problem drinker. Although the mere presence of a social network does not by itself influence help seeking behaviour (Hajema et al, 1999; George & Tucker, 1996), the attitudes towards drinking and help seeking within the network do. Individuals who perceived having encouragement to drink from their social network and less encouragement to seek help have been found to be less likely to be treatment seekers (George & Tucker, 1996). Families and spouses have also been identified as being particularly influential. The findings of a recent qualitative study suggest that accumulating problems related to drinking, especially with family relationships, in conjunction with a trigger event or influence from the family tended to result in help seeking (Orford et al, 2006). This is supported by cross sectional research that found that greater psychosocial dysfunction in the domain of interpersonal relationships predicts treatment seeking (Tucker & Gladsjo, 1993; Tucker, 1995). Spouse stressors also predict poorer functioning and help seeking (Brennan et al, 1994), although not being married also seems to be a predictor of help seeking and treatment utilisation (Ogborne and DeWit, 1999; Kirchner et al, 2000).

(b) Personal attitudes and beliefs

Perhaps not surprisingly, individuals who indicate that they want to handle problems on their own without professional help have been found to be less likely to seek help than those who do not hold such beliefs (Cunningham et al, 1993; Tucker, 1995; Tucker et al, 2004; Saunders et al, 2006). This also seems to be the case for individuals who felt that their alcohol problem was not serious enough to warrant help seeking (Tucker et al, 2004) and those that did not consider themselves as having an alcohol problem (Cunningham et al, 1993). Conversely, the recognition that individuals are unable to quit on their own is a predictor of help seeking (Tucker, 1995). For some individuals, these anti-help seeking beliefs may reflect the fact that drinking is not significantly interfering with other aspects of their life (see psychosocial and physical health influences). For others it may be because they are unwilling to recognise and accept the reality of their drinking behaviour and their inability to control it (Grant, 1997). Additionally, perceived stigmatisation of their alcohol problem has been identified as a significant barrier to help seeking among problem drinkers (Grant, 1997).

(c) *Psychosocial and physical health influences*

The recognition that problem drinking has had a deleterious impact on an individuals' psychological health and social environment is also associated with help seeking. Help seekers and treatment users are more likely to report greater drinking related psychosocial problems in their lives than those displaying less help seeking behaviour (Tucker & Gladsjo, 1993; Tucker, 1995; George & Tucker, 1996; Hajema et al, 1999). In a population sample of Canadian drinkers, the number of life areas where alcohol was perceived to have caused harm was found to be the strongest predictor of help seeking (Ogborne & DeWit, 1999). Likewise, having lower emotional distress was a predictor of not seeking help (Saunders et al, 2006). Evidence from a qualitative study by Thom (1987) suggests that for many problem drinkers, the

motivation for seeking help is to alleviate these psychosocial problems in their lives rather than directly changing their drinking behaviour. In addition to psychosocial factors, physical health problems perceived to be as a result of drinking are also predictive of help seeking (Hajema et al, 1999; Orford et al, 2006).

(d) Treatment factors
At a closer proximity to accessing a support service, treatment related beliefs and barriers seem to be less predictive of help seeking than person related barriers (Saunders et al, 2006). The treatment factor that best predicts help seeking is belief or confidence in the effectiveness of the treatment or support on offer from treatment providers (Grant, 1997; Tucker et al, 2004; Saunders et al, 2006). Other treatment related factors such as lack of access to services or lack of financial resources seem to be much less important (Grant, 1997; Tucker et al, 2004). Interestingly, alcohol dependence levels and drinking practices are not generally found to predict entry into treatment services (Tucker & Gladsjo, 1993; Tucker, 1995; George & Tucker, 1996; Tucker et al, 2004). A study by the charity Turning Point looking at treatment delays found that there were a number of barriers to treatment from waiting for initial assessments, poor information access, lack of GP knowledge and further delays accessing treatment following assessment (Turning Point, 2003).

1.3.2 Co-morbid substance use and mental health problems
Individuals with alcohol concerns often present with multiple problems, in particular drug misuse or mental health concerns (Calling Time, 2008). Evidence suggests that alcohol is the most commonly used substance by people with mental health concerns, e.g. 50% of psychiatric admissions and 30% of outpatients (Royal College of Psychiatrists, 2004). It is important to understand these relationships, as comorbidity may be difficult to manage by cross-referral to psychiatric and alcohol misuse services (Weaver et al, 2003).

There is also a growing evidence base to support the idea that there are differential predictors of treatment effectiveness for alcohol users versus drug users (Walton et al, 2003). This may be useful in developing alternative approaches to treatment and relapse prevention. A “one-size fits all” approach seems unlikely to yield optimal outcomes and it is an oversimplification to define treatment outcomes as ‘success’ or ‘failure’ (Gossop et al, 2003).

1.3.3 The treatment seeking pathway
The influence of others in the social environment, the attitudes and beliefs of the individual regarding the need to access treatment for alcohol dependency and the effectiveness of that treatment, and the perception that drinking is causing damage in their lives are all identified as important predictors of help seeking behaviour. However, a major criticism of most previous research in this area is that help or treatment seeking is invariably categorised as a dichotomous variable (Saunders et al, 2006). It is probably more realistic to regard help seeking as a more complex and fractured process where the predicting factors impose differential influences. Saunders et al (1993; 1996; 2006) describe a treatment seeking process model that identifies four steps starting from the development of problem drinking to seeking professional

help. They suggest that the first three steps towards treatment access are determined by the individual's acceptance that they need help. These steps are described as problem recognition, making the decision that change is needed and making the decision that professional help is required. The fourth step is the behavioural process of actually seeking professional help and keeping an appointment. Cognitive processes of denial and stigma are described as being of particular relevance at the first two steps, and treatment related factors, such as belief in the need for treatment and treatment effectiveness and knowledge about treatment availability, are said to be more relevant to the latter two steps. Individuals who seek self-help options such as Alcoholics Anonymous and resolve their problems are regarded as not needing to progress to step four.

1.4 Current study

The academic literatures as well as the national and local perspectives identify a number of general factors relating to the reasons why alcohol users delay seeking treatment. However, little in-depth research has been carried out focusing specifically on the issue of delay. Within Gloucestershire, little is known about the perceived barriers to access and the difference between those who eventually seek treatment and those who do not. By increasing understanding it may be possible to develop interventions that will shorten the delay between recognition of an alcohol problem and subsequently accessing help. This study was supported by a grant from the Alcohol Education Research Council and identified the following aim.

1.4.1 Aim

To inform alcohol treatment service development by exploring the factors that delay the recognition of problem drinking and the reasons why individuals delay seeking treatment for problematic alcohol use.

2. Method

2.1 Design

A qualitative study was conducted using semi-structured interviews.

2.1.1 Participants

A total number of 19 interviews were conducted with alcohol users who were both accessing and not accessing alcohol treatment services in Gloucestershire. Treatment was defined as involving a structured intervention with an individual care plan. All participants were over 18 years old, and had primary dependence concerns with alcohol. However, individuals with a history of using drugs were not excluded and just over half (52%) were using or had previously used drugs.

2.1.2 Recruitment

Participants were recruited from a variety of housing organisations and alcohol services in Gloucestershire, including Gloucestershire Drug and Alcohol Service, Gloucestershire Emergency Accommodation Resource, English Churches Housing Group, Stonham Housing and Alcoholics

Anonymous. Generally, participants had accessed the full range of statutory and non-statutory agencies within the county. An initial information session was set up with agency managers to establish agreement to recruit. Staff members were then provided with information leaflets providing details of the research and what their participation would involve. Service providers were asked to distribute leaflets to potential participants that were interested in taking part. The contact number for the research team was provided to allow interested participants to make contact if they wished to take part, so that an interview could be arranged. In addition to this, the researcher who was conducting the interviews spent time at a day centre talking to individuals about the research, to recruit participants to take part in an interview. This procedure took a 'here and now' approach which allowed for the interviews to take place at the time of recruitment. Some participants were recruited through snowball sampling, whereby previous interviewees informed others about the research.

2.1.3 Data Gathering

An interview schedule was used for all interviews to aid the researcher in exploring the issues of interest. The interviewer gave participants the opportunity to raise and discuss issues that were important to them, with reference to their own individual experiences and where possible give specific examples. Interview schedules were based on the Saunders et al (1993, 1996) model of the treatment seeking process with questions tailored to the two different groups of participants; those accessing alcohol treatment services and those not accessing alcohol treatment services .

Two research interviewers were present at each interview and participants were required to give written consent to participate in the interview. With the participants' consent, interviews were audio tape-recorded and detailed notes were taken. Verbatim transcription was carried out for those sections of the interview that were directly related to the interview questions and detailed notes were included about the remaining content.

2.1.4 Analysis

Transcripts of the interviews were subjected to thematic analysis, beginning with detailed coding of sections of the transcripts, proceeding at a later stage to more selective coding. This results in identifying common themes from the interviews and considers the frequency that these themes occur to build an overview of the important issues for this population, highlighting the themes with reference to extracts of the interview text.

2.2 Ethical Considerations

The Alcohol Education Research Council reviewed ethical considerations and approval for this research was granted. Consent was also obtained from all agencies where recruitment took place.

Ethical considerations included:

- Informing participants of the research and emphasising that participation was entirely voluntary

- Gaining written informed consent to take part in the interview, to have interviews audio tape-recorded and to have any information used in a subsequent report about the project
- Explaining that participants had the right to withdraw from the research at any time without explanation
- Explaining that any data would be treated confidentiality and any identifiable information would be anonymised
- Participants were informed of researcher's duty of care to inform the relevant people if issues of personal safety or the safety of others arose
- Debriefing participants at the end of the interview

Specific ethical considerations:

- Participants were reassured that no identifiable information would be passed directly onto alcohol treatment services or key workers
- Participants were not approached directly to take part in this study. Instead participants were informed about the research by services or previous participants that had already taken part in an interview and could then volunteer themselves to take part in an interview
- Some individuals reported drug use, which has legal and ethical implications. However, the researchers were assured that the participants involved were all drug free at the time of interview or receiving appropriate drug treatment. Moreover, participants were asked explicitly about alcohol use and treatment delay, not drug use.
- For those interviews that were conducted on a 'here and now' basis every effort was made to gain informed consent. Prior information about the project was available to all participants who were approached in this way. The interviewers emphasised the participants' right to withdraw from the study at any time and provided details of how to do this.
- If participants felt distressed when talking about their alcohol use and issues associated with it, they were given an information booklet detailing contact numbers of several alcohol services in Gloucestershire. Participants were also given a contact number for the research team, if they had any questions or concerns about the interview or the research.

3. Results

Four main themes emerged from the data analysis each with several subthemes. The majority of subthemes acted as 'delay influences'; factors that appeared to increase the delay in seeking treatment among participants. Some subthemes, though, acted as 'recognition influences'; factors that appeared to alert the individual to the need to change their drinking habits and seek treatment. However, there were some exceptions; 'delay influences' for some participants sometimes acted as 'recognition influences' for others. This is discussed in more detail in the relevant sections.

3.1 Social influence

The influence of drinking dependent spouses, friends and acquaintances was often reported to exacerbate drinking. However, levels of contact with family seemed to help many individuals recognise what they are or could be missing

if they continued to drink problematically, and in some cases, helped them recognise their familial responsibilities.

3.1.1 Partner's influence

Having a partner who was also a problem drinker generally appeared to make it much more difficult to seek help and acted as a strong delay influence.

"we've talked about it (change) for the last couple of years really, and it just never seems to work out. [….] because we both lead each other astray" participant 6

"Ended my relationship, we used to drag each other down, had an "addictive relationship"" participant 2

For those with non-drinking dependent partners, the threat of separation as a result of problematic drinking behaviour and their partners' pro-change influence acted generally as a recognition factor.

"Wife is cracking up with it, lost her job, …don't want to ruin this marriage through drink," participant 10

However, treatment seeking inspired by a non-drinking partner did not always correspond with acceptance of problem drinking:

"My wife knew I had a problem and said do I want to do anything about it, I said yes, if I'd said no she would have been out of the door […] I went to AA for about 18 months, but I went to save my marriage, not because I recognised that I had a problem." participant 16

3.1.2 Cultural factors/Pressure to conform

Social pressure had both positive and negative influences on the participants with regard to their drinking levels and intention to seek help. Some individuals found that subscribing to a drinking 'culture' exerted influence on their early and continued drinking habits:

"Back home, erm, it's a social thing, everyone does it, they look at you strange if you don't drink […] I'm stuck between two camps, I've got my social group who don't drink, er I've got my family down here who do drink." participant 11

"With my family being quite involved with alcohol they didn't see there were any problem with it" participant 10

A more direct influence of the social environment on drinking habits was experienced by some participants. They often found themselves in situations where there was strong peer pressure to drink, for several because of their occupation, for others just due to general pressure from the people around them. This then encouraged them to continue drinking problematically and further established a drinking norm:

“You would be considered a wimp if you couldn't down a pint at the pub. The more you downed, the more credibility you got.” participant 14

“I used to find it fun. I would drink at work too, because people knew I would drink, they would dare me to drink loads.” participant 17

There was also perceived pressure from friends to drink socially. Some individuals were concerned that not socialising might have a negative impact on their friendships and were anxious that telling their friends they had a drinking problem could also be detrimental:

“I couldn't tell people I had a drink problem, I couldn't stay in, people think you're a stick in the mud.” participant 10

“And if friends came round they would want to join me in a drink. And that became my life […] Friends don't really want anything to do with someone who can't go out at night.” participant 12

Many found that their attempts to drink socially resulted in them consuming excessive amounts and struggling to control their behaviour. Being around friends or being involved in social activities provided them with opportunities to drink. These opportunities tended to act against the individual in recognising their problem drinking and reinforced a drinking norm:

“It's the weekends, especially if my football team's playing, tend to go out more, go and watch the game, and end up drinking more.” participant 10

“Every meeting was held in the mess after work, every sporting event had a beer tent…everything revolved around the bar really.” participant 12

For some, drinking socially became too problematic and so they stuck to drinking at home:

“I would drink six to eight pints every evening. I began to find that I wasn't welcome in places after a while so I stopped going out and just drank at home.” participant 19

3.1.3 Family influence

Family responsibilities and the threat of losing access to family members, especially children, seemed to act as a strong recognition influence of problematic drinking.

“Due to me drinking I’m not allowed to see them (children). Me last wife said if I remain sober the door is always open.” participant 1

“When I realised I was gonna, me and her were gunna have to part […] then I was going to lose my kids, erm, everything I was, you know, um, so I spent a hell of a lot of time reflecting […]I have a young boy of 18 who I don’t see that often…erm and I’ve also got three daughters and two grand kids and again if I’m drinking I don’t see them.” participant 14

Responsibilities to children and others also seemed to motivate some participants to change their drinking habits:

"I needed to stop…it put my life in danger, my sons as well... decision was made for my son, had to save my life and his." participant 7

"About 10 years ago I recognised that I had a problem, as after my wife died I realised that I had no real social life and a child to look after on my own […] I've got very high blood pressure now, I've got right upper quadrant pains so I know my liver isn't good. I want to be around to bring my children up." participant 12

3.2 Psychological factors

There were a number of factors intrinsic to the individual that seemed to inhibit help seeking. These mostly affected participants' acceptance of their drinking problem and acceptance that they needed to change. These factors seemed to be of greater importance during the early part of the treatment seeking sequence. They ranged from an explicit awareness of using alcohol as a coping method to denial that they had a drinking problem and a general ambivalence about needing to stop.

3.2.1 "Took all the problems away"

Some participants described using alcohol for dealing with problems in their lives or dealing with problems that had arisen from their problem drinking. Some identified specific 'trigger' events in their past that led them to drinking and recognised that they had used alcohol to help them forget about these past experiences. Using alcohol as a "vanishing cream" and to "blank out" problems enabled the participants to continue with their drinking lifestyle as a way of coping with any emotional distress. For some, however, this led them into a drinking cycle that was difficult to break. Two individuals described getting into a catch-22 where they found themselves drinking to help them deal with their anxieties about drinking:

"Oh I, I knew for a while my drinking was a problem but I just drank more to not worry about that problem. That was what I was just doing with every single problem you know." participant 18

"As friends didn't drink here, had to hide it. I felt horrendously guilty and ashamed about hiding it so would drink more to get rid of those feelings." participant 11

3.2.2 Denial

Not facing up to the reality of their drink problem acted as an important delay influence. Generally, most participants described that it took them a relatively long time to accept that they had a drinking problem and even longer to acknowledge what they needed to do to deal with it. However, many individuals had sought help for their drinking before they fully accepted what they needed to do about it:

"I accessed GDAS um a couple of years ago and I just didn't feel it was the right time for me, um, and I just, I, I knew I had to do something but I didn't want to do any, I didn't want to face up to it." participant 11

Some individuals struggled to admit they needed help even after deciding that it is the best course of action for them:

"I didn't want to admit for ages that I had a problem with drink. I wanted to be able to carry on. My key-worker doesn't want me drinking now. I've reached a point now where I know I need to give up and get out, even though I don't like to admit it." participant 17

3.2.3 "Not decided to stop drinking yet"

Another main delay factor to seeking help was not having made the decision to stop drinking. Many individuals found they had felt ambivalent about needing to make a change to their drinking habit and only reported a general feeling that they should stop drinking. One participant described this as a "loose, ephemeral feeling" but found that months would pass before he took any action. It seemed that a lack of sufficient recognition influences regarding their problematic drinking affected their perception of the importance of stopping drinking. For some this was due to a lack of worry about their problem; for others due to their contentedness with drinking:

"I didn't worry about my problem for years, I didn't worry about thinking about it and so I had no plans as to how to change." participant 19

"I knew I had a habit but I was quite happy." participant 14

For two others at earlier points in their drinking history, lack of drive to make changes was due to the fact that they felt they were coping with their drinking lifestyle and that it was not having a deleterious impact on their 'normal' life:

"But the key thing was every person had become absolutely rock bottom in their life… none of them were actually applicable to me [...] although I knew it was problematic and it was likely to cause me some sort of illness late on in life, I was functioning quite well and I was getting promotions [...] So I was coping, so I kind of convinced myself that really I didn't have as much of a problem as probably I did" participant 12

"When I joined the airforce, it's a pretty rigid environment, y'know, not so um so many opportunities to muck around like you can in civi street, so I suppose that kept me on the straight and narrow a lot. Still drinking, and still getting into trouble, but nowhere near as much as if I had civilian clothes on." participant 16

3.2.4 Personal stigma

Shame or stigma associated with having a drinking problem was an issue for some. Experiencing these feelings seemed to make it harder for individuals to access treatment services. The desire to keep their drinking problem quiet

(because of this stigma) acted as a treatment seeking barrier and general barrier to stopping:

“There is always the chance of bumping into someone you know [at the services], especially as I taught some of the people working in the [name of department]. The stigma of going is a barrier.” participant 12

“I didn’t want to divulge my problem to my doctor, I thought he might think I was weird, or that he wouldn’t have been able to help me anyway.” participant 19

For one of these individuals, overcoming this stigma seemed to be an important part of the process of accepting his alcohol problem:

“I am brave enough now to stand up and say I do have an alcohol problem, I think that was the hardest decision. I don’t care about stigma anymore, I can’t control other peoples perceptions.” participant 12

While feeling ashamed about their drinking might have made it more difficult for some to seek treatment, for one participant it acted as a recognition influence and spurred them into seeking help:

“Feeling awful, feeling ashamed made me realise that I had a problem, I needed to change. I went to the GP and he gave me some info about the AA, but I chickened out.” participant 8

3.2.5 Lack of control

A number of participants described lacking control over their continued drinking. This often manifested as a “weakness” or a general helplessness. Several described a general incomprehension as to why they continued to drink or went back to it having abstained for a period:

“I’ve lost everything since drinking, I hate it. But I can’t help doing it and I don’t know why.” participant 3

“Booze became the master, and I became the slave.” participant 8

Lacking control seemed to allow some to justify why they had not taken steps to stop or seek help, although for a minority, recognising that they could no longer manage their drinking acted as a recognition influence:

“I am no longer in control. I’ve put my hand up and asked for help, please, before I die.” participant 12

3.3 Situational factors

The environment that many of the participants found themselves in generally seemed to make it harder for them to make steps towards stopping drinking. Finding themselves socialising with other problem drinkers on the streets, living in temporary accommodation or shelters, having drug co-dependencies and generally having little else to do were all things that seemed to impact on

treatment delay in several ways. They impeded upon participants' recognition that changes were needed. They also served to delay access to treatment services and made it very difficult to maintain any attempts to stop or sustain a treatment regimen. Fortunately, the threat of lengthening their criminal records, and therefore chances of incarceration, and the threat of poor health acted as recognition influences and seemed to encourage individuals to recognise the need to change and seek help.

3.3.1 Unsuitable living conditions

Some of the participants lived in or relied on accommodation that impeded any attempts to stop drinking and likely exacerbated their drinking. Some lived in or had experience of night shelters or sheltered housing and found this was problematic mostly because they had few other places to go during the day:

"I don't believe anyone can give up an addiction while they're in a night shelter and on the streets." participant 5

Some individuals drank 'on the streets' partly because they could no longer afford to drink in pubs and because of their housing situation. Additionally, those that were receiving drug treatment would socialise with others doing the same and collectively pick up prescriptions from the agencies. Generally, spending time with others with drinking problems made it harder for them to break out of their detrimental routine. For one individual this helped her realise that she needed to change, for another it prevented him accessing help:

"Main factor to seek treatment - realised drinking got out of hand, "get up, have cooked breakfast, get script, go street drinkin" need to do something else." participant 3

"I came close to booking into [name of residential rehabilitation place] a few yrs ago but as all my friends were doing drugs/drink it stopped me as I thought it would have made no difference when I come out into the same environment. I need to be on the outskirts to separate myself from other drinkers." participant 6

3.3.2 Drug taking

For those with drug dependencies, giving up drinking was especially difficult. Some of these individuals experienced a dependency see-saw where giving up one dependency tended to increase the use of the other and they struggled to stop both simultaneously. There was more talk of the effect that reducing their drug intake had on their drinking than the other way around:

"I ended up replacing the drugs with the drink." participant 19

"Been a heroin addict for 16 years now. And each time I go into the [treatment centre] on Subutex or Methadone I always start drinking again, madly." participant 3

Despite it appearing like the primary rehabilitation focus among some the co-dependent participants was on the ‘drugs’, several individuals commented that they felt ‘drugs’ were easier to give up than drink:

“I just thought it was drugs, but it's not, cos drugs are easier to give up,” participant 17

“It’s evil, drink’s evil, […] Worst drug out there, worst thing to come off.” participant 3

Generally, those who had tried to stop taking drugs found their drinking increased. Not only did drinking act as a method of coping generally, it provided these individuals with a way of coping with their abstinence from ‘drugs’. ‘Drugs’, therefore, acted as a major barrier to seeking help for alcohol dependency:

“I have to get off the drugs before I tackle the alcohol […] so I never got alcohol treatment” participant 6

3.3.3 Criminality

Getting into trouble with the police and spending time in prison seemed to act as a strong recognition influence for many of the participants. Several found that being caught committing a criminal act or experiencing the legal consequences of repeat offending made them realise they needed to change and even bolstered their determination to stop:

“[Next time] it’ll be crown court where they give you two or three years instead of two or three months, you know. And that’s, that’s really helped along, you know” participant 1

“I ended up in the nick last year, […] I decided I needed to change.” participant 16

Getting into legal trouble and spending time in prison also acted as a gateway into services. Several found that they were “ordered” to attend the local service after being arrested. Although accessing the local drug and alcohol service for the first time was unlikely to lead the individual to long term abstinence, becoming aware of the service seemed to increase the likelihood that they would return at a later date.

One individual found that a period of sobriety in prison combined with access to alcohol support had a major impact on his life:

“In some respects I’m glad, in a way, that I did actually get sent down, cos it got me dry and it allowed me to access these services which are now turning my life around.” participant 16

3.3.4 Physical and mental health
Being told about a drinking related health problem by a health professional or realising that continued drinking was having an impact on their physical and mental health seemed to act as a strong recognition influence for many of the participants. Talk about how drinking was "killing" them was common and suggested that this realisation was a primary drive to stop drinking:

"I attended the service because I was killing myself, I was fed up of being sick. I just wanted to stop drinking." participant 16

"I needed to stop…it put my life in danger" participant 7

Even less dramatic symptoms of continued drinking seemed to have a great impact on some individuals' resolve to stop drinking:

"they took a blood test and I had slight liver damage, as well, which I was like stunned" participant 3

"Had the doctor out the night before, shaking, d&v, seeing things…want to pack it in, it's not worth it." participant 10

"I have suffered so many injuries… I've definitely reached now… I sort of feel, feel…my only hope is to stop drinking" participant 14

Awareness that drink was "messing" them up seemed to motivate individuals to make changes to their drinking. Stopping completely was generally seen as the only way to deal with this:

"I need to do it now, its got to be done, it's messing me up." participant 17

"I got myself into such a mess er physically, emotionally, er that I knew there had to be a a better way of coping" participant 11

As might be anticipated, when there was an absence of health threats, it seemed that individuals were less likely to see the importance of stopping or the need to stop:

"I knew I had a habit but I was quite happy. Physically it had no effects, and I wasn't aware that it was having any mental effects." participant 14

3.4 Access barriers

3.4.1 GP barriers
Some individuals experienced GP related barriers to getting help. For some this was down to actually getting to see their GP and having sufficient time with them, whereas others found that their GP was not entirely considerate of their situation and the support they required:

"GP's would back me up with other agencies, initially didn't find them particularly sympathetic." participant 13

“Was shown the door once, 'gotta sort your self out, waste of time talking to you’” participant 7

“I wanted support, not just given drugs and sent away.” participant 2

The two individuals that indicated they found their experience with their GP satisfactory, gave the impression that their GP was not appropriately set up to provide good support:

“In all fairness to him he [GP] was pretty good but he just seemed to lack the experience.” participant 15

“When I went to my GP, I was with him for about 5 minutes, there was nowhere near enough time with him but I did get a referral for the hospital.” participant 12

3.4.2 Service barriers

Most participants had some experience of accessing the drug and alcohol services or a perception about accessing the services that acted as a barrier to getting support. These issues were fairly varied, although there was some common ground. Several individuals commented that they had the perception that both their local treatment agency and drug and alcohol service were more focused on drugs than alcohol:

“I found that it was easy to get help with drugs, but I couldn't get any help with the drinking. They all seemed to focus on the drugs” participant 17

“I don't like the fact that most people who go to [treatment agency] are drug addicts” participant 14

There were also some issues with the time of day that appointments were available and the delay between arranging an interview and attending it. Some individuals found they had a relatively long wait between contacting services, booking appointments and then attending them. As well as the time it took to get access, one individual in particular found it was quite a struggle to get the support she was after:

“I found it quite hard to get accepted onto [treatment agency]. I felt as if I have to fight it the whole way, especially the first couple of times when my regular GP referred me. It did seem a lot of waiting time from when I was referred” 15

Several individuals found attending appointments was generally a barrier and others found that the ‘opening times’ made it harder for them:

“The biggest hassle has been attending interviews in places” participant 16

“There are flexibility issues with services. They tend to be open 9-5.” participant 12

“Times they book you in to see people can be a problem.” participant 6

3.4.3 Poor information access
Once individuals had acknowledged their problematic drinking, a factor that most likely delayed participants in seeking help was a lack of awareness about available services. Many individuals commented that for a long time they simply were not aware of the services and often found out through word of mouth:

“I didn't know of any services other than AA, I didn't know any other services existed” participant 17

“Heard about the service for smack heads and drug users, didn't realise that there was help for drinkers. Found out from people on the streets” participant 4

Several participants implied that not knowing about the services acted as a barrier to accepting their drinking problem and to changing their drinking behaviour:

“It wasn’t really until the GP said to me “you have got a problem” that I even acknowledged it to anybody except myself. Whether it was because I didn’t think there was the help available, didn’t know where to get if from or what, I don’t know.” participant 15

“I was clueless as to where else to get help from so I just carried on as I was […] I wished I could stop, do something about it, but I had no idea where to go.” participant 19

4. Discussion

The analysis revealed that there were two main categories of influence on participants’ drinking behaviour and their movement towards seeking and accessing treatment. The first, described as ‘delay influences’, represent the factors that serve to perpetuate ambivalence towards changing and form barriers to both the intention to seek treatment and actual treatment access. The second category of influence refers to the factors that enhance recognition of problem drinking and what needs to be done about it. Each of the four main themes contain both delay and recognition influences on help seeking behaviour.

Other drinkers, whether friends, family, or partners, generally served to delay the individual at whatever phase in the treatment seeking sequence they were at. They symbolised normality, reinforced drinking norms, and provided a lure for continued excessive drinking respectively. However, others in the social environment also provided recognition influences based around loss. The threat of losing access to children or breaking up with a partner seemed to provide motivation to stop drinking. In some cases, however, the need to resolve the threat rather than the cause, i.e. the loss rather than the drinking, provided the most incentive, as also identified by Thom (1987). These findings

are further supported by evidence from cross sectional research that support the influence of other drinkers within the social environment (George & Tucker, 1996) and dysfunction within the domain of interpersonal relationships (Tucker & Gladsjo, 1993; Tucker, 1995) as important predictors of help seeking.

The psychological influence subthemes identified mostly served to extend the phase where the individual struggles to accept that they have a problem and that they need to change. Factors of denial, lack of control and reliance on alcohol to cope all seemed to contribute to arresting movement towards making the decision to get help. However, some participants reported a period of time where they simply did not want to stop drinking. For these individuals it seemed to be the lack of recognition influences that prevented them from considering that they needed to change. Whether through contentedness with drinking, lack of worry about drinking or perceiving that they were coping with their drinking fairly well, with few intrinsic or extrinsic indicators of problems there seemed little reason to change. Personal stigma appeared to inhibit help seeking behaviour further down the help-seeking pathway. Interestingly, for a minority of participants, some of these subthemes acted as recognition influences. Lacking control and perceiving stigma helped some to recognise the degree to which drinking had pervaded and interfered with their lives and spurred them on to seek help. Lack of control was found to act as both a delay and recognition influence in this study, has previously been identified only as a predictor of help seeking (Tucker, 1995). It seems likely that a recognition of lacking control rather than simply retrospectively identifying it as an influence is probably the important factor in aiding the individual to recognise a need to seek help. The influence of perceived stigma on delaying help seeking among the participants, however, more closely corresponds with previous research (Grant, 1997).

The lifestyle and environment that many of the participants found themselves in tended to act against help seeking behaviour and efforts to stop drinking. After problem drinking had been well established, some found themselves in accommodation, such as sheltered housing, that provided unfavourable conditions for stopping drinking. In addition, the presence of a drug dependency exacerbated the situation especially as alcohol was often used to help deal with stopping the drug habit. Both of these factors seemed to come with their own culture where spending time with others in a similar situation and daily routines provided triggers for drinking. The consequences of repeatedly getting into trouble with the law and the physical and mental consequences of prolonged excessive drinking, however, were perceived as threatening and served to help some to recognise the need to stop drinking and seek help. Getting into legal trouble also acted as a gateway to the services, where some were required to attend their local service as a condition of their rehabilitation and others reported being receptive to support during a sober period in prison. Again, the absence of recognition influences, such as health problems, inhibited the decision that change is required. Although the presence of psychosocial problems is found to be a consistent predictor of help seeking (Ogborne & DeWit, 1999; Hajema et al, 1999), more specific environmental influences such as the negative impact of drinking and

drug taking lifestyles, and the positive influence of the threat of getting into trouble with the law, do not seem to have been explored in any depth in previous research.

At a close proximity to treatment, experiences of accessing services were identified mostly as delay influences. GP support received mixed ratings, with support perceived as being unsympathetic or that didn't propose favourable treatment options acting as barriers to recovery. Many participants described being unaware of the alcohol treatment services that were available to them for some time. These findings are in line with the results of Turning Point (2003). When individuals were aware or had experience of the treatment services some described the expectation that they were primarily focused on drug rehabilitation and others described first hand experience of this. The inflexibility of appointments and physical access to the services also seemed to contribute to delay. On a positive note, participants who had received support from the local services (e.g. GDAS) that had helped them progress towards recovery were generally very favourable towards them. While treatment barriers are regarded as less important predictors than person related barriers in terms of help seeking (Saunders et al, 2006), the perception that the support on offer is primarily focused on drugs or a lack of awareness that there is support available can stall attempts to access treatment.

For most of the participants the presence of 'delay influences' and absence of 'recognition influences' appeared to impede the pathway to seek help for their alcohol dependency. For example, those who experienced reinforcement of a drinking norm within their social environment, who maintained the capacity to fulfil other responsibilities (e.g. being employed) and were not experiencing any noticeable medical consequences as a result of their drinking were least likely to seek treatment for their drinking. In contrast, this study suggests that for individuals who experienced an accumulation of 'recognition factors', movement down the treatment pathway is likely to be accelerated. For example, an individual who had a non-drinking social norm, was involved in criminality and acknowledged a lack of control with regards to their drinking was more likely to have entered a treatment regime to some degree.

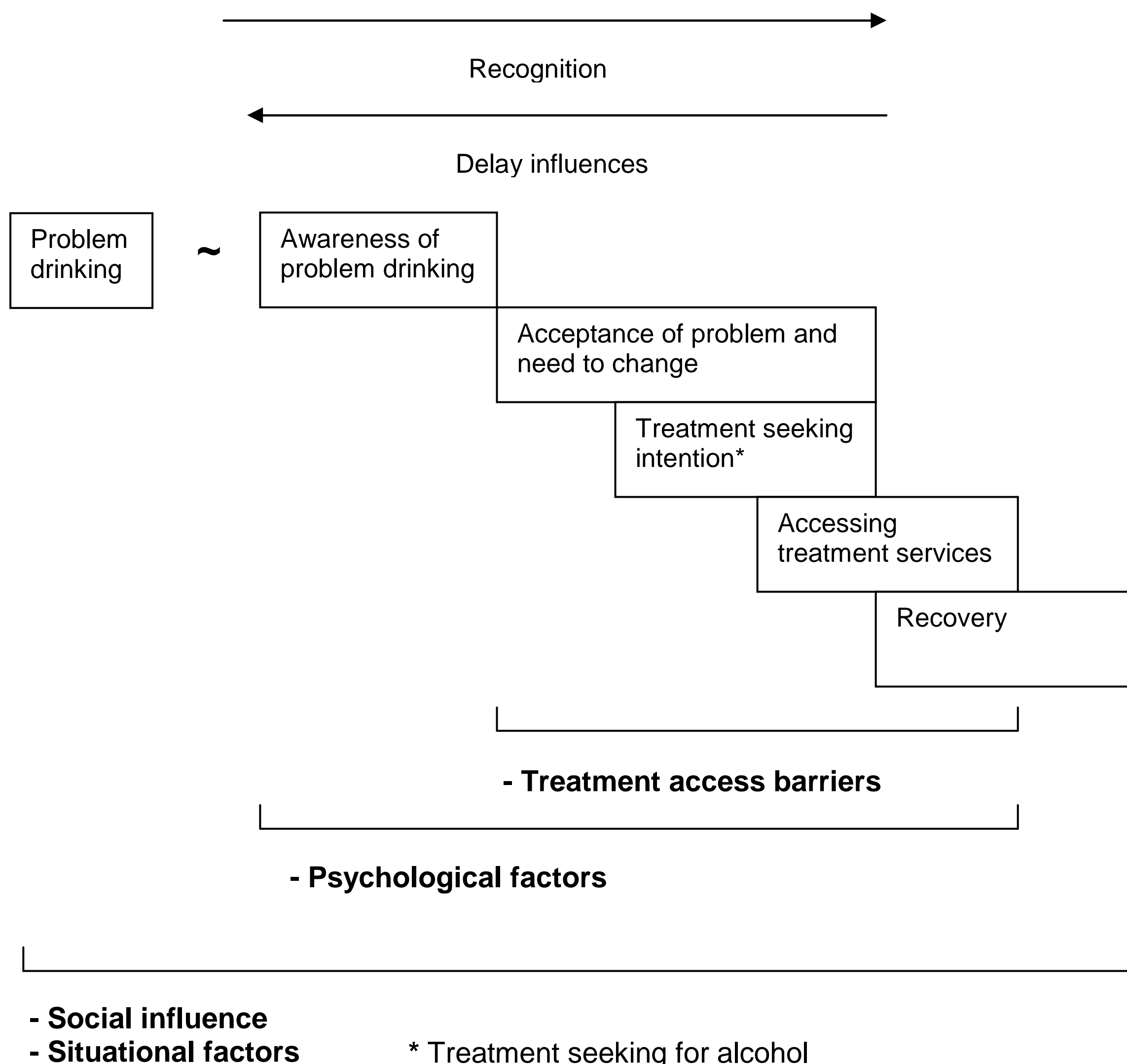
Importantly, the degree to which a 'recognition influence' or a 'delay influence' was acknowledged as such varied for each individual. For example, partners who drank generally exacerbated the drinking lifestyle (therefore acting as a 'delay influence') whereas non-drinking partners tended to aid recognition of an alcohol problem, usually by overtly encouraging help seeking. These elements have varying influence at different stages of the treatment-seeking pathway.

4.1 Treatment seeking pathway revision

While Saunders et al's (2006) treatment seeking model is a useful overview of some of the important milestones in the help seeking sequence, the picture of treatment seeking painted by our participants presents a more complex and iterative process (Figure 1). Seeking help was rarely something that only

needed to be done once and regression to previous phases in help seeking was common. Accepting there is a problem and accepting the need to change was a phase that lasted well beyond the onset of treatment seeking behaviour among our participants. Some described having the primary aim of alleviating psychosocial problems in their life and continued to report ambivalence about the need to stop drinking after seeking help. Therefore, any phase of accessing treatment should overlap with phases of acceptance and treatment seeking intention. The main themes identified have different relevance across the different phases. Social influence and situational and environmental influences seem to play a role throughout the whole sequence, from the onset of problem drinking to recovery. Psychological influences start to play a more important role once the individual is aware of problem drinking and when they start to accept that they have a problem and need help. Treatment access barriers are likely to become relevant during a phase where the individual is accepting their dependency and are particularly relevant when they seek help formally. Delay influences, therefore, inhibit progression to later phases and recognition influences accelerate advancement.

Figure 1. Treatment seeking pathway



4.2 Implications for local support

The current study offers further insight into the complexity of alcohol dependence. At a local level, it highlights that reducing the harm caused by alcohol cannot be tackled independently but instead encompasses other social, situational and psychological concerns. This is also supported by current policy (e.g. Calling Time, 2008). Furthermore, these concerns can have altering influences upon individuals throughout the treatment pathway, as demonstrated by the revised treatment seeking pathway model. This has implications for staff working in alcohol treatment services in terms of being sufficiently trained to help individuals manage a complex framework of issues surrounding their alcohol use and to recognise when referral onto other agencies might be required.

For this population, treatment access barriers were present far sooner than might be expected, with individuals already being influenced by perceived barriers before treatment seeking intention had developed, which acted as a delay influence upon them. Therefore, if treatment agencies are able to foster more positive reputations this may have considerable impact upon the delay into treatment. Locally, individuals reported mixed experiences of treatment, especially in terms of community detox programmes. Accurate information provision about the process involved which addresses common problems/concerns and tailors to the individual are possible areas to target.

The findings demonstrate that once an individual has developed an awareness of their problem drinking psychological factors (e.g. denial, control) begin to influence treatment seeking. Alcohol use was alluded to as a way of coping with the emotional aspects of current and past situations or traumas. Research by Proudfoot and Teesson (2002) has also suggested that psychological distress (e.g. anxiety, depression) may be a primary treatment seeking predictor. This highlights the importance of integrated services in achieving effective treatment outcomes, particularly given that improvements in emotional management are shown to ameliorate drinking behaviour.

High levels of co-morbidity were evident in the present sample, with just over half having current or previous drug use as well as having a current dominating alcohol concern. The overall impression given was that alcohol use was harder to manage/control than drug use. Typically, if people gained more control of one substance, use of another one increased, therefore swapping one dependency for another. This highlights the importance of considering the needs of clients with dual dependencies when delivering interventions, in particular addressing the stumbling blocks that seem almost inevitable when tackling such complex dependency.

The findings clearly demonstrate the importance of early interventions in detecting alcohol misuse. Such initiatives ease accessibility and can be provided in environments that may be perceived as less stigmatising and more familiar than an alcohol service, therefore alleviating the impact of treatment access barriers. The Gloucestershire Alcohol Strategy Group has recently implemented the provision of specialist alcohol workers in Emergency

Departments. Anecdotal evidence suggests that this is contributing to raising awareness of alcohol concerns and providing early signposting and information to those presenting to Emergency Departments in Gloucestershire (Gloucestershire Alcohol Strategy Update, 2008). However, initiatives in areas such as primary care (e.g. GP surgeries) are still needed to address the scope of this dilemma within Gloucestershire.

Those individuals having most favourable treatment experiences reported that key workers demonstrated empathy and understanding by listening and responding to their concerns, whilst offering flexibility. This indicates that services would be utilised if they existed within an environment that maximised treatment outcomes, i.e. offered flexible, inter-agency stepped care. Additionally, this may facilitate an increase in referrals of those with the lowest treatment figures, e.g. young people (Calling Time, 2008). The treatment seeking pathway for these groups would suggest that they are less likely to disclose alcohol concerns possibly due to fewer 'recognition influences' (e.g. fewer indicators of harm due to alcohol). The findings can therefore offer some guidance in terms of informing assessment/screening measures for agencies at each stage of the care pathway.

Supporting individuals to address social and situational factors may play a large part in optimising treatment outcomes. The current findings serve to demonstrate the difficulties of those that have pro-drinking social networks and/or have unsuitable living circumstances. For homeless individuals, street drinking tended to ensue, partly due to a lack of other activities or boredom but also due to a social network predominated by other street drinkers. This suggests that treatment that involves partners/family members would have favourable outcomes, given that they may be crucial to sustaining progress in the long term.

The iterative nature of recognition and delay influences upon the treatment pathway highlights the importance of relapse prevention and aftercare services. The majority of individuals who present with problem drinking behaviour seem likely to have several 'lapses' before successful long-term management can be achieved. Typically individuals access more than one episode of care and sometimes more than one agency (Gloucestershire Drug and Alcohol Database, 2005). This suggests that minimising the impact of these is relatively vital within any care planning and emphasises the importance of inter-agency working, particularly for those with dual dependencies.

4.3 Recommendations for local practice

4.3.1 Psychosocial influences

- Agencies should give detailed attention to the underlying and maintaining factors of drinking, assess their relevance and refer onto more specialist mental health services if appropriate.

- Aftercare involving partners/family members offered routinely to prevent and/or support relapse.

- When promoting/advertising services directly to problem drinkers, it might be useful to alert individuals to ‘recognition influences’, e.g. the impact on their access to and relationships with children, criminal justice consequences, etc.

- Assess the impact of situational factors, e.g. housing needs.

4.3.2 Access barriers/Service experiences

- Given the complexity of this client group, services would ideally offer a flexible menu approach to treatment and aftercare, in line with stepped care, considering key worker characteristics, setting, etc.

- Alcohol screening to be part of routine practice for all healthcare staff – encouraging identification of health problems that may be associated with alcohol and alerting the individual to this.

- Putting steps in place to make initial engagement with alcohol treatment services easier and to ensure that first episodes of care are positive experiences, e.g. having dedicated alcohol treatment premises.

- Implement new early intervention initiatives and maintain existing ones, e.g. Alcohol Arrest Referral Scheme.

- Relapse prevention work in prisons - Ensure that individuals who have a drinking related background are offered support – this may be an important window of opportunity.

- Promote services as having a dual focus on alcohol and drug problems and perhaps attempt to change the perception that the clients of these services are all ‘junkies’.

- Inter-agency care planning, including non-alcohol specific agencies, e.g. housing organisations, GPs.

4.3.3 Training issues

- Increase awareness of services and types of support for all staff working in the alcohol field, e.g. support agencies, sheltered housing, etc.

- Better identification and referral amongst primary care services, e.g. GP surgeries.

- Comprehensive training for all staff working with alcohol dependent individuals - this may be the first time that someone has discussed alcohol use with a health professional.

- Development of community based detox programmes including increasing availability where possible, providing detailed information about the process and tailoring interventions.

- Training for staff to recognise treatment barriers and how to tackle them. Service users can inform this by way of regular feedback to agencies, which can be incorporated into ongoing service evaluation.

- Use of the treatment seeking pathway model to inform assessment/screening of individuals with alcohol concerns and prioritise needs/treatment outcomes.

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