

Rassegne

Analysis of the obstacles related to treatment entry, adherence and drop-out among alcoholic patients

Analisi degli ostacoli all'ingresso, il rispetto e l'abbandono di trattamento tra gli utenti di alcol

MÁRCIA FONSI ELBREDER¹, DORISDAIA CARVALHO DE HUMEREZ², RONALDO LARANJEIRA¹

¹Federal University of São Paulo (UNIFESP), Brazil

²Guarulhos University (UNG), Brazil

SUMMARY. Alcoholism is a complex syndrome involving social, psychological and individual factors in addition to a series of obstacles regarding treatment entry, adherence, and drop-out. These obstacles contribute negatively to both clinical evolution and prognosis of the patients, affecting their quality of life and raising the social costs. This is a bibliographical study in which we address this theme as well as other experiences observed in our daily practice in the Alcohol and Drug Research Unit (UNIAD) based at the Federal University of São Paulo (UNIFESP). The analysis of the obstacles related to treatment entry, attendance, and drop-out among alcoholic patients shows that systemic, social, cultural, and individual factors are all involved, including the structural ones. Women have more obstacles compared to men, and what is thought to be a barrier to one patient may be a factor motivating another patient to search for help. We conclude that several factors at different levels exist that prevent the patient from overcoming these treatment obstacles.

KEY WORDS: barriers, treatment, gender, chemical dependence.

RIASSUNTO. L'alcolismo è una sindrome complessa che coinvolge fattori sociali, psicologici e individuali, oltre a una serie di ostacoli di trattamento in materia di ingresso, aderenza e drop-out. Questi ostacoli contribuiscono negativamente all'evoluzione clinica e alla prognosi dei pazienti, prognosi che interessa la qualità della loro vita e determina aumenti dei costi sociali. Il presente studio affronta questo tema, così come altre esperienze osservate nella nostra pratica quotidiana nella unità di ricerca alcol e droghe (UNIAD) presso l'Università Federale di San Paolo (UNIFESP). L'analisi degli ostacoli correlati al trattamento tra i pazienti alcolisti dimostra che sono coinvolti fattori sistemici, sociali, culturali. Le donne hanno maggiori difficoltà rispetto agli uomini. Diversi fattori impediscono al paziente di superare questi ostacoli del trattamento.

PAROLE CHIAVE: ostacoli, trattamento, genere, dipendenza chimica.

INTRODUCTION

There are few studies addressing the patient's access to treatment and as a result the evidence on treatment obstacles is rather inconclusive, although the reasons and barriers contributing to this are

known to differ between women and men, particularly, between the patients.

It is clear that any treatment program can only be effective if the patient attends the sessions for a given period of time necessary to promote positive changes (1). Also, the treatment can be considered effective

E-mail: mcfonsi@uol.com.br

when the patient's adherence is successfully kept as much time as possible (2).

Adherence is defined as a dichotomic variable related to a certain number of sessions (3) treatment with a specific number of days (4) or a continuous measure related to time spent as months in treatment (5).

Studies have reported that the majority of patients reach significant improvement at the third month of treatment (6), whereas others report that outpatient treatment should be last between 3-6 months, including continuous evaluation of the individual needs of each patient (7).

Research studies point that the rates of treatment retention are, in general, higher among patients with acute diseases compared to those with chronic illnesses (8), and the latter's adherence tends to decrease after six months of treatment (9).

The problem of treatment drop-out is usually seen within the context of chronic diseases such as the alcoholism, which requires long-term treatments, and it is not uncommon to find drop-out rates above 50% even in the first month of treatment (10).

In the face of what has been exposed, this study aims to describe and analyse the possible obstacles regarding treatment entry, adherence, and drop-out among male and female patients who, according to ICD-10 criteria, suffer from alcohol dependence.

METHODS

The methodology consisted of reviewing the bibliographic material related to this theme as well as the clinical experiences observed in our daily practice in the Research Alcohol and Drug Unit (UNIAD).

The data collected from our daily clinical practice were organised for further analysis.

RESULTS

We pointed out the importance of presenting some data obtained at the Alcohol and Drugs Research Unit of the Federal University of São Paulo (UNIFESP) in order to allow a comprehension of the environment from which these data were gathered.

The Alcohol and Drugs Research Unit (UNIAD) was established in 1994 and operates as an outpatient clinic linked to the Department of Psychiatry of the Federal University of São Paulo. In order to facilitate the treatment retention and fulfill the patients' specific needs, UNIAD was subdivided into outpatient treatment services (alcohol, cannabis, cocaine/crack, adolescence, and ADHD).

The outpatient treatment service for alcohol abuse is run by nurses, physicians, psychologists who screen the patients, record socio-demographic data, investigate pattern and frequency of alcohol consumption as well as previous and current therapeutic interventions, perform differential diagnosis between alcohol abuse and alcohol dependence according to the International Classification of Diseases (ICD-10), elucidate physical, psychological, and social problems resulting from alcohol usage, observe physical signs and symptoms of alcohol withdrawal syndrome (AWS), and evaluate the need for alcohol detoxification with specific medications.

The "Short Alcohol Dependence Data" (SADD) questionnaire has been routinely applied to those patients entering this service, being validated for use in Brazil by Jorge & Masur (11).

After the outpatient alcohol detoxification, which usually lasts about 2-4 weeks, laboratory exams were ordered and the patients were referred to auxiliary services if necessary.

Next, the patients not only received individual care from psychologists, with a varying number of sessions according to the needs of each patient, but also medical evaluation when they presented some comorbid psychiatric symptoms.

The goals of the therapeutic groups were to provide education about alcohol dependence; to listen to doubts and clarify them; to motivate the patient to remain abstinent and follow the treatment; to use of lapse/relapses prevention techniques, focuses on the re-adaptation to family, social, and occupational life, creation of a new identity without alcohol, and approaches to prevent lapses or relapses.

There were specific groups for alcoholic women and men presenting clinical problems and cognitive deficit.

The patients might continue their psychological and psychiatric follow-up concomitantly to their therapy so that they could attend the appointments more than once a week according to their treatment plan. In addition, we had a family group to support their relatives.

ANALYSING THE OBSTACLES

The analysis of the obstacles regarding treatment entry, adherence, and drop-out among alcohol users shows that there are multiple factors impeding the patient to overcome these barriers and remain in the treatment. These obstacles were classified as follows: 1) systemic; 2) socio-cultural and individual, and 3) structural.

Analysis of the obstacles related to treatment entry, adherence and drop-out among alcoholic patients

SYSTEMIC OBSTACLES

These are barriers that interfere with and impede the development of services aimed at fulfilling the patients' needs. Both male and female patients should overcome the following systemic barriers.

Gender inequality regarding power

Despite the greater political and occupational participation in the then traditionally male activities, women still are target of some cultural and structural factors contributing to this power inequality. Low participation in political parties and governmental organisations further reinforces the trend towards maintaining such activities under male control. As a result, women are underrepresented in society and cannot take part in all public policy decision-making processes (12).

Lack of information on certain populations

There are few studies on African, Asian, and South American populations. Even today, women are not included in the official statistics on psychoactive substance use in countries where they have, due to cultural reasons, an inferior status to that of men (13).

Decreased supply and demand for specialised treatment

Several studies show that alcoholic women are more likely to seek non-specialised health services compared to men, but this behaviour has been changing in the last few years as women are increasingly searching for specialised treatment (14).

Poor primary healthcare

The primary care remains ineffective and the practitioners from other areas often do not have the skills necessary to identify the actual reasons users have for seeking help, some physicians are reluctant to diagnose a disorder they do not know how to treat (15).

Qualification of healthcare professionals

Formal education of professionals is limited, especially with regard to offering adequate care and management for patients who have problems with or are addicted to alcohol and this is one of the most crucial needs in our current healthcare system (16).

SOCIO-CULTURAL AND INDIVIDUAL OBSTACLES

Both male and female patients should overcome the socio-cultural obstacles, but alcoholic women are more

likely than men to face greater social-cultural demands regarding their attitudes and behaviours if they are not considered suitable for the female gender role.

Stigma and social prejudice

The alcoholic individual is still seen in a distorted and obscure way within our society, and this places a much greater burden on women as they are supposed to behave socially better than alcoholic men. Our society finds attenuating circumstances by which a man uses alcohol (work pressure, financial or family problems), but if a woman becomes an alcoholic she is seen as a person who has broken a social taboo or wanted to draw the family's attention, among other motives. Therefore, women usually drink alone in order to avoid the social sanctions, thus initiating a cycle of shame, guilt, and stigma which makes the problem more difficult to be recognised and treated (17).

Fear of losing custody of their children

This is a real problem for women, who often delay seeking help because they fear being denounced, which would cause them to lose the custody of their children under the argument that they are incautious and consequently cannot provide appropriate care (18), on the other hand can be a motivator for women entering treatment (19).

Family support

Studies show that alcoholic women are more likely to be stimulated by their parents and children to seek treatment, whereas men are more encouraged by their spouses (20). Also, a social support network of friends is related to the maintenance of abstinence in alcoholic patients (21).

Marital status

Patients who have conflictive relationships with their spouses or partners are less likely to achieve abstinence during the early therapy and tend to relapse after treatment (22). Another study showed that women attended more treatment sessions if they had more satisfying marital relationships (23).

Motivation

It is the perception of the motivation phases (pre-contemplation, contemplation, preparation, action, and maintenance) in which the individual is inserted, including the perception of participating in the treatment. The patients follow this path non-linearly because of the in-

Fonsi Elbreder M, et al.

fluence from internal and external factors, regardless of whether they are being treated or not. Motivation plays an important role in alcoholism treatment by influencing patients to seek, complete, and comply with treatment as well as make successful long-term changes in their drinking (24).

Resistance to treatment

The motivational interviewing technique was developed to demystify certain beliefs, break the treatment resistance, facilitate changes, and help people to understand the ambivalence regarding risk factors and changes in their behaviour and attitudes they acquired over the years using psychoactive substances (25).

Relapse or lapse

By analysing the motivational phases of the patient, one can discern about the possible relapses and lapses as well as the treatment evolution. Although relapse and lapse can discourage the treatment adherence, the patient can learn from the past mistakes. In one study examining gender and the type of first relapse it was verified that relapse were more consistent for men than for women. For initial post-treatment relapses, women were more likely to have negative affects relapses, and men were more likely to have social pressure relapses (26).

Life events

Research studies point to the existence of many factors crucial for a successful treatment and certain events in the individual's life such as divorce, job loss, health problems, and accidents can cause the individual to be more susceptible to lifestyle changes, including treatment seeking. Interestingly, these factors differ between genders as women have more negative experiences that may interfere with their ability to perpetuate the success of this process (27).

Ethnics

There are discrepancies regarding whether studies on alcoholism should address systematically the race/ethnic differences during outpatient treatments so that their nature and possible origins could be better understood (28). Other study reported that 31% of women had dropped out of the treatment compared to men, and black women were at higher risk of not completing therapy (29).

Psychiatric comorbidity

Compared to men, women have higher rates of mental disorders associated with the use of psychoac-

tive substances, which might make the treatment more difficult because of the existence of more than one mental disorder (30).

STRUCTURAL OBSTACLES

Similarly to the systemic obstacles, the structural ones are practical and political barriers that make the treatment access difficult and as a result can also interfere with other types of healthcare services for men and women, including the treatment of psychoactive substance dependence.

Treatment location and cost

These are important factors that interfere with the continuity of the treatment. A study evaluated the patients desires and expectations regarding their therapy and found that more women than men reported treatment closer to home (31).

Waiting list

Because the patient should be attended as quickly as possible, the waiting list can also be a barrier to treatment entry as the patient may become discouraged from seeking help. Study reported that women waited significantly longer than men before leaving the treatment waiting list (with or without treatment entry) (32).

Program characteristics

Those programs aimed at providing specific treatment for target patient populations can make treatment entry and retention easier. Exclusive treatments for women bring them benefits because of the gender-specific characteristics of such programs (33).

Support services

Users of psychoactive substances generally need a wide range of support services. Lack of connection between the key healthcare systems can be an obstacle to the appropriate care of these patients. Studies report that patients are more likely to continue their treatment when there is the integration between primary care and mental health programs (34).

Patient-therapist relationship

Lack of empathy and confidence in the practitioner as well as doubts on the effectiveness of the treatment contribute to treatment drop-out. Studies show that

Analysis of the obstacles related to treatment entry, adherence and drop-out among alcoholic patients

patients who have strong relationship with their therapists are more likely to continue the treatment. A study on medical appointments reported that despite the fact that physicians tried to form an empathic bond with the patient, several obstacles occurred: 39.1% of physicians did not explain the problem in a clear and attentive manner; 58% of the physicians did not check the patient's level of understanding about the diagnostic information; 53% of physicians did not ask the patient about therapeutic indications; and 50% of physicians did not take into account psychiatric and psychosocial problems (35).

FINAL CONSIDERATIONS

Despite the evidence showing that gender differences do exist and have influence on treatment access, retention, and drop-out, this theme has not been enough investigated in the literature. However, one can conclude that there are numberless obstacles and these should be overcome by both patients and practitioners.

The present article was aimed at identifying the barriers faced by those alcoholic individuals who seek treatment.

Specialised treatments need to address these issues in order to avoid interferences with the treatment of chronic patients, which ends up resulting in harm to patient, disincentive for practitioner, and high health-care cost.

The treatment should be constantly evaluated and the patients should also be encouraged to be more participative in achieving their goals, expectations, and desires, for they are usually passive and just wait for the staff's decisions.

Studies on specific populations should be carried out to understand the intrinsic and/or extrinsic reasons interfering with the patient retention in treatment, thus improving the treatment plan for each patient.

REFERENCES

1. Meier PS, Donmall MC, McElduff P, Barrowclough C, Heller RF: The role of the early therapeutic alliance in predicting drug treatment dropout. *Drug Alcohol Dependence*, 2006, 83, 57-64.
2. Ashley OS, Marsden ME, Brady TM: Effectiveness of substance abuse treatment programming for women: a review. *The American Journal of Drug and Alcohol Abuse*, 2003, 29, 19-53.
3. Arfken CL, Klein C, di Menza S, Schuster CR: Gender differences in problem severity at assessment and treatment retention. *Journal of Substance Abuse Treatment*, 2001, 20, 53-57.
4. De Weert-Van Oene GH, Schippers GM, De Jong CA, Schrijvers GJ: Retention in substance dependence treatment: the relevance of in-treatment factors. *Journal of Substance Abuse Treatment*, 2001, 20, 253-261.
5. Comfort M, Kaltenbach KA: Predictors of treatment outcomes for substance-abusing women: a retrospective study. *Substance Abuse*, 2000, 21, 33-45.
6. Health Canada, Best Practices: treatment and rehabilitation for women with substance use problems (Ottawa, Minister of Public Works and Government Services, Canada, 2001). Available from <http://www.cds-sca.com>
7. National Institute on Drug Abuse (NIDA). Coping with craving. In: Therapy manuals for drug addiction. Available from <http://www.nida.nih.gov/nidahome.htm>
8. National Treatment Agency for Substance Misuse: Towards treatment effectiveness. London, National Treatment Agency for Substance Misuse, 2007.
9. Sabaté E: Adherence to long-term therapies: evidence for action. WHO, Geneva, 2003.
10. Stark MJ: Dropping out of substance abuse treatment: a clinically oriented review. *Clinical Psychology Review*, 1992, 12, 93-116.
11. Jorge MR, Masur J: The use of the short-form alcohol dependence data questionnaire (SADD) in Brazilian alcoholic patients. *British Journal of Addiction*, 1985, 80, 301-305.
12. Rogers WA: Feminism and public health ethics. *Journal of Medical Ethics*, 2006, 32, 351-354.
13. Nayak MB, Kerr W, Greenfield TK, Pillai A: Not all drinks are created equal: implications for alcohol assessment in India. *Alcohol and Alcoholism*, 2008, 43, 713-718.
14. Weisner C, Schmidt LA: Rethinking access to alcohol treatment. *Recent Developments in Alcoholism*, 2001, 15, 107-136.
15. Hearne R, Connolly A, Sheehan J: Alcohol abuse: prevalence and detection in a general hospital. *Journal of the Royal Society of Medicine*, 2002, 95, 84-87.
16. Pillon SC, Laranjeira R: Formal education and nurses' attitudes towards alcohol and alcoholism in a Brazilian sample. *São Paulo Medical Journal*, 2005, 123, 175-180.
17. Blume SB, Zilberman ML: Women: clinical aspects. In: Lowinson J, Ruiz P, Millman RB, Langrod JG (eds). *Substance abuse: a comprehensive textbook*. Lippincott Williams & Wilkins, Philadelphia, 2004.
18. Poole N, Isaac B: Apprehensions: barriers to treatment for substance – using mothers (Vancouver, Canada, British Columbia Center of Excellence for Women's Health, 2001). Available from www.bcewh.bc.ca/PDFs/apprehensions.pdf
19. Grella CE, Joshi V: Gender differences in drug treatment careers among clients in the National Drug Abuse Treatment Outcome Study. *The American Journal of Drug and Alcohol Abuse*, 1999, 25, 385-406.
20. Simão MO, Kerr-Correa F, Dalben I, Smaira SI: Alcoholic women and men: a comparative study of social and familial aspects and outcome. *Revista Brasileira de Psiquiatria*, 2002, 24, 121-129.
21. McCrady BS: To have but one true friend: implications for practice of research on alcohol use disorders and social networks. *Psychology of Addictive Behaviors*, 2004, 18, 113-121.
22. Schneider KM, Kviz FJ, Isola ML, Filstead WJ: Evaluating multiple outcomes and gender differences in alcoholism treatment. *Addictive Behaviours*, 1995, 20, 1-21.
23. Graff FS, Morgan TJ, Epstein EE, McCrady BS, Cook SM, Jensen NK, et al.: Engagement and retention in outpatient alcoholism treatment for women. *The American Journal on Addiction*, 2009, 18, 277-288.
24. Di Clemente CC, Bellino LE, Neavins TM: Motivation for change and alcoholism treatment. *Alcohol Research & Health*, 1999, 3, 86-92.
25. Miller WR, Rollnick S: *Motivational interviewing-preparing people to change addictive behavior*. Guilford Press, New York, 1991.
26. Zywiak WH, Stout RL, Trefry WB, Glasser I, Connors GJ, Mais-

Fonsi Elbreder M, et al.

- to SA, et al.: Alcohol relapse repetition, gender, and predictive validity. *Journal of Substance Abuse Treatment*, 2006, 30, 349-353.
27. Green C, Polen MR, Dickinson DM, Lynch FL, Bennett MD: Gender differences in predictors of initiation, retention and completion in a HMO-based substance abuse treatment program. *Journal of Substance Abuse Treatment*, 2002, 23, 285-295.
 28. Johnson P, Richter L, Herbert KD, McLellan AT, Carise DA: Telescoping of drinking-related behaviors: gender, racial/ethnic and age comparisons. *Substance Use & Misuse*, 2005, 40, 1139-1151.
 29. Mammo A, Weinbaum DF: Some factors that influence dropping out from outpatients alcoholism treatment facilities. *Journal of Studies on Alcohol*, 1993, 54, 92-101.
 30. Greenfield SF, Grella CE: What is "women-focused" treatment for substance use disorders? *Psychiatric Services*, 2009, 60, 880-882.
 31. Schneider U, Kroemer-Oldbrisch T, Wedegärtner F, Cimander KF, Wetterling T: Wishes and expectations of alcoholic patients concerning their therapy. *Alcohol and Alcoholism*, 2004, 39, 2141-2145.
 32. Downey L, Rosengren DB, Donovan DM: Gender, waitlists, and outcomes for public-sector drug treatment. *Journal of Substance Abuse Treatment*, 2003, 25, 19-28.
 33. Hodgins DC, El-Guebaly N, Addington J: Treatment of substance abusers: single or mixed gender programs? *Addiction*, 1997, 92, 805-812.
 34. O'Toole TP, Strain EC, Wand G, McCaul ME, Barnhart M: Out-patient treatment entry and health care utilization after a combined medical/substance abuse intervention for hospitalized medical patients. *Journal of General Internal Medicine*, 2002, 17, 334-340.
 35. Caprara A, Rodrigues J, Montenegro BJ: Building the relationship: medical doctors and patients in the Family Medicine Programme of Ceará, Brasil. *Congress challenges of primary care-oriented health systems: innovations by educational institutions, Health Professions and Health Services, Londrina*, 2001.