A Collaborative Care Model for Identification and Intervention of alcohol use in Primary Health- and Community-based settings

Eveline Beckers & Ali Faridoon, KU Leuven

Promotor: Prof. Dr. Bert Aertgeerts, KU Leuven

Co-promotor: Prof. Dr. Mieke Vermandere, KU Leuven

Department of Public health and primary Care

Contact: mieke.vermandere@kuleuven.be

Master of Family Medicine

Masterproef Huisartsgeneeskunde
Academiejaar: 2020 – 2023

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Preface

We're so grateful for our temporary adoption in the PINO-family. Despite the COVID-19 pandemic, we have experienced a very warm welcome and spend a fantastic enriching time in this family.

The PINO-family was funded by Dr. Leo Pas and Prof. Dr. Cathy Matheï: two warm-hearted, caring and loving parents, who would do everything for their child to raise it properly. Like in every family however, there were ups and downs, and this PINO-family faced some difficult times. Way too early, Prof. Dr. Cathy Matheï, the mother of PINO, has left the family. After a short and intense but unwinnable fight, she passed away far too young and left a great void for the people who loved and respected her.

It was so fascinating and instructive to be educated by the dedicated father, Dr. Leo Pas. Given his experience in different development projects, national and international, we learned a lot about the tasks as a parent-researcher. With that passion, he instructed how we could contribute to the development of his child, the PINO project. Unfortunately, because of some troubling time and health problems, puberty created a distance between father and child. So Leo made the hard decision to entrust his child to the foster parents whom he trusted the most: Prof. Dr. Bert Aertgeerts (BA) and Prof. Dr. Mieke Vermandere (MV).

There could have been no better foster father than Prof. Dr. Aertgeerts. He took care of the development of PINO as it was his own child. We would like to thank him for introducing us in the PINO-family and for being there, whenever we needed advice. As a caring father and teacher, he guided us and made sure we followed the right path. We're so grateful for his kindness and confidence. Prof. Dr. Vermandere has been the loveliest foster mother a person can wish for. She makes sure everyone is feeling comfortable with her warm personality. We learned so much from her experience in qualitative research. It boosted the PINO-child's development and took it to the next level. Despite the unstable and shaky phase of puberty, it was thanks to her teaching that this child came of age and graduated as a successful adult.

To keep an eye on us as well as to support us, Bram Pussig was like a big brother to us. As an older member of the PINO-family and a PhD-student in biomedical science, he had a lot of experience to learn from. We really want to thank him for his everlasting accessibility, guidance and patience. He has finished his great role in the development of PINO (and his PhD) with glance. He can proudly call himself a doctor in the biomedical sciences. We wish him the best of luck and will watch his career with great interest. Thank you big brother Bram!

We thank all our 18 enthusiastic participants for their time and efforts as well as their willingness to share their valuable experiences and opinions. Our appreciation also goes to *WGZ de Ridderbuurt* for their participation in the focus groups.

Last but not least, we would like to thank our own families and friends for their non-stop support and understanding even in the toughest of times. Thank you for your eternal love and compassion throughout this entire period.

We sincerely thank all above mentioned without whom this never would have been possible.

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Abstract

Hazardous and harmful alcohol use are one of the leading risk factors for population health. To reduce the harm caused by problematic drinking in our society, a multi-level approach is necessary with engagement of all possible professions surrounding the patient. Early identification and brief intervention (EIBI) is proven to be effective to tackle problematic alcohol use. Widespread screening in society could create more awareness in the population and prevent detrimental consequences. Collaborative care is an effective strategy for increasing the delivery of evidence-based intervention in complex settings. The aim of the present study was to investigate the current lacks and needs according to first-line workers to improve collaboration in identification and intervention of problematic alcohol use in primary health- and community-based settings.

Four heterogeneous focus group sessions were conducted (3 online, 1 live). The focus groups were recorded and transcribed at verbatim. Stakeholders were recruited from different health- and community-based services in the surrounding of Leuven (Belgium) (N = 18). A purposive sampling strategy was followed. The analysis was performed using ATLAS.ti and was based on the QUAGOL-protocol.

Five main themes were identified from the focus group data: 1) goal-oriented referral; 2) interdisciplinary communication; 3) the GP (general practitioner); 4) identification; and 5) network. These findings suggest supportive elements for a collaborative care model for identification and intervention of problematic alcohol use. According to the focus groups, all first-line workers should be able to recognize problematic drinking behaviour and create awareness in people, although some participants indicated missing knowledge and skills in first-line workers. The GP as a confidant was indicated as the central contact point and a constant factor in the process of awareness and motivation. Participants stressed the lack of an elaborated step-by-step approach and an overview of the local caregivers as well as a better understanding of their task description. Communication upon referral is realised preferably by telephone, but for the follow-up process opinions were diverse.

Collaboration between first-line workers to tackle problematic alcohol use is missing. A collaborative care model with a social map and clear task division is needed to foster this cooperation. The GP as a confidant and a constant in the process, is best placed to facilitate a successful patient-focused and goal-oriented referral, but accessibility of mental health services should be simplified. Further research is needed to evaluate the development and implementation of a collaborative care model in primary health- and community-based settings.

Summary in Dutch

Overmatig en schadelijk alcoholgebruik behoren tot de grootste risicofactoren voor de bevolkingsgezondheid. Om de schade door problematisch alcoholgebruik in onze maatschappij te beperken, is er nood aan een benadering op verschillende niveaus met het betrekken van alle mogelijke beroepsgroepen die rond de patiënt staan. Het is aangetoond dat het vroeg opsporen van problematisch alcoholgebruik gevolgd door een korte interventie (Early Identification and Brief Intervention (EIBI)) effectief is om het probleem aan te pakken. Om meer inzicht te creëren bij de bevolking en om schadelijke gevolgen te voorkomen, is wijdverspreide screening nodig in de maatschappij. Samenwerkingszorg (Collaborative care) is een effectieve manier om de implementatie van onderbouwde interventies te bevorderen in complexe situaties. Het doel van deze studie was om de huidige gebreken en noden bij eerstelijnswerkers te onderzoeken om samenwerking te bevorderen bij het opsporen en het aanpakken van problematisch alcoholgebruik in de eerstelijnsgezondheidzorg en gemeenschapsdiensten.

Er vonden vier heterogene focusgroepen plaats (3 online, 1 live). De focusgroepen werden audiovisueel opgenomen en woordelijk uitgeschreven. Vertegenwoordigers werden gerekruteerd uit verschillende gezondheids- en gemeenschapsdiensten in de omgeving van Leuven (Belgie) (N=18) en een doelgerichte rekrutering van de steekproef werd toegepast. De analyse werd uitgevoerd volgens het QUAGOL-protocol in het programma ATLAS.ti.

Vijf hoofdthema's kwamen naar voor in de focusgroepen: 1) doelgerichte verwijzing; 2) interdisciplinaire communicatie; 3) de huisarts; 4) de identificatie; en 5) het netwerk. Deze bevindingen beschrijven ondersteunende elementen voor het ontwikkelen van een collaboratief zorgmodel rond het opsporen en aanpakken van problematisch alcoholgebruik. Volgens de focusgroepen zouden alle eerstelijnswerkers in staat moeten zijn om problematisch drankgebruik te herkennen en inzicht te creëren bij mensen, hoewel sommige deelnemers het gebrek aan kennis en vaardigheden in deze groep opmerkten. De huisarts, als vertrouwenspersoon, werd aangeduid als centraal aanspreekpunt en een constante factor in het proces van bewustwording en motivatie. Deelnemers benadrukten het gebrek aan een goed uitgewerkt stappenplan en een duidelijk overzicht van de lokale zorgverleners alsook een goed begrip van hun takenpakket. Communicatie bij doorverwijzing gebeurt bij voorkeur telefonisch, maar voor het opvolgproces waren de meningen verdeeld.

Samenwerking tussen eerstelijnswerkers om problematisch alcoholgebruik aan te pakken ontbreekt. Een collaboratief zorgmodel met een sociale kaart en duidelijke taakverdeling is nodig om deze samenwerking te bevorderen. De huisarts, als vertrouwenspersoon en constante in het proces, is het best geplaatst om een succesvolle patiënt-gefocuste en doelgerichte doorverwijzing te faciliteren, maar de toegang tot de geestelijke gezondheidszorg zou laagdrempeliger moeten. Verder onderzoek is nodig om de ontwikkeling en implementatie van een collaboratief zorgmodel in de eerstelijns- gezondheidszorg en gemeenschapsdiensten te evalueren.

List of abbreviations

ACHG	Academisch Centrum voor Huisartsgeneeskunde
CAW	Centrum Algemeen Welzijnswerk
COM-B	The COM-B model of behaviour change suggests that capability (C), opportunity (O) and motivation (M) are essential for any behaviour (B) to change
COREQ	COnsolidated framework for REporting Qualitative studies
EIBI	Early Identification and Brief Intervention
E-Health	The use of information and communications technology in support of health and health-related fields [WHO]
EMD	Elektronisch Medisch Dossier
ELP	Eerstelijnspsycholoog (first-line psychologist)
FG	Focus Group
GGZ	Geestelijke Gezondheidszorg (Secondary Mental Health Care)
GDPR	General Data Protection Regulation
GP	General Practitioner
HIV	Human Immunodeficiency Virus
KU Leuven	Katholieke Universiteit van Leuven (Catholic University of Leuven)
PC	Primary Care
PINO	Primary care Implementation project to scale up early identification and brief interventions for reducing alcohol related Negative Outcomes at community level
SBI	Screening and Brief Intervention (in this context specifically focussed on alcohol)
SBIRT	Screening, Brief Intervention and Referral to Treatment
SUD	Substance Use Disorders
TDF	Theoretical Domains Framework
WHO	World Health Organisation
WGC	WijkGezondheidsCentrum (Community Health Center)

First-line workers: in this study this comprises both primary health care and community-based services

1 Introduction

The burden of alcohol use on health and society is significant. Globally, harmful use of alcohol is related to the death of 3 million people annually (5.3% of all deaths in 2016)[1]. Alcohol consumption significantly affects the risk of more than 200 physical and mental disorders (i.e., liver diseases, cancers, infectious diseases (HIV, tuberculosis) and noncommunicable diseases). Besides these health risks, alcohol-related harm exceeds the individual as it also causes harm to a person's environment (i.e., relational, social, professional domain) and the whole society as a consequence, resulting in an immense economic loss worldwide[1][2]. Unhealthy alcohol use forms a broad spectrum from hazardous use (exceeding the guidelines, but no harms), harmful use (harm caused by excessive alcohol use) through alcohol dependence (showing recurrent withdrawal symptoms upon cessation) [3][4][5]. The prevalence of risky alcohol use in Belgian adults was 14.4%, in 2018[6]. Only 12.8% of persons with an alcohol use problem in Belgium sought help in the year after the problem started and 61% in later years. The average delay in care for problematic alcohol use is 18 years[7].

Early identification and brief intervention (EIBI) is a proven cost-effective method to reduce alcohol consumption among adults in primary care and emergency settings[8]. Yet, EIBI is not well integrated in standard practice of care[9][10]. Barriers to implementation of EIBI include attitudes towards alcohol use, lack of structural and organisational support, unclear role definition, fears of damaging professional-patient relationship, lack of time and competing priorities[11][12]. Implementation of EIBI is facilitated by increasing knowledge and skills by training of the EIBI-providers, as well as organisational support. For high-risk alcohol users, referral or contact with second line mental health care is needed for treatment[13]. Strengthening the communication between primary care and addiction treatment facilities is necessary to prevent reluctance to screen and intervene[11].

Community-based services, such as social care, prevention workers and health agencies, are an underexplored setting with a high potential to be effective in screening for alcohol use and reducing the burden of its overconsumption[11][14]. As first-line workers, they could reach a broad spectrum of people different from patients consulting their health care provider[15][16][17]. Young people are for example more likely to access community-based services than health services[11] and the highest prevalence of problematic alcohol use can be found in behavioral agencies[18]. Psychologists, trained in motivational enhancement and structured behavior change interventions, are well-placed to screen for alcohol use and give brief intervention. As the profession of social work is based on case management with long-term contacts with patients and collaboration with other health professions, social workers can play a big role in EIBI for alcohol drinkers[19]. Community pharmacy interventions are effective for smoking cessation and are feasible to recruit patients to alcohol screening[20].

The universal implementation of EIBI is an integral component of providing quality preventive health services[21]. Despite the flexibility of SBIRT (Screening, Brief Intervention, and Referral to Treatment) to be applied in many clinical settings, implementation of it throughout the health care and social service system is inadequate[22]. An organizational model with clear task definitions and coordination is needed to achieve a more widespread implementation of EIBI in these various settings[15]. A collaborative care model is often used as a tool to implement complex interventions in different settings. Collaborative care is a complex system level

intervention, proven to be effective in the management of medical and mental health problems[23][24][25][26]. It is based on the principles of chronic disease management as described in the chronic care model of Wagner[27][28]. Although substance use disorders (SUD), including alcohol use, have been viewed as chronic diseases, few studies focused on the implementation of a collaborative care model for SUD in primary care settings[29][19].

We conducted a focus group study to define supportive strategies for collaboration, using the collaborative care model, enhancing EIBI in primary health and community-based settings within a municipality (Leuven area, Belgium) for identification and intervention of problematic alcohol usage (not dependence).

2 Method

2.1 Study design

Four heterogeneous focus group sessions were conducted between March and October 2022. This explorative, qualitative study design was used to provide an effective means to generate a broad perspective on a topic which lacks basic information. This through moderated group interaction with relevant stakeholders sharing their views, ideas and experiences[30] . The principles of the consolidated framework for reporting qualitative studies (COREQ) were followed[31].

2.2 Participant selection

Stakeholders were recruited from different health- and community-based services that are often confronted with problematic alcohol usage and therefore can benefit from a collaborative care model to tackle this problem in the community. Relevant stakeholder groups including general practitioners, pharmacists, psychiatrists, psychologists, community workers, care providers working in addiction and rehab centres and emergency doctors were recruited in Flemish Brabant, more specifically in Leuven, Hoeilaart, Tienen, Zaventem and Hoegaarden.

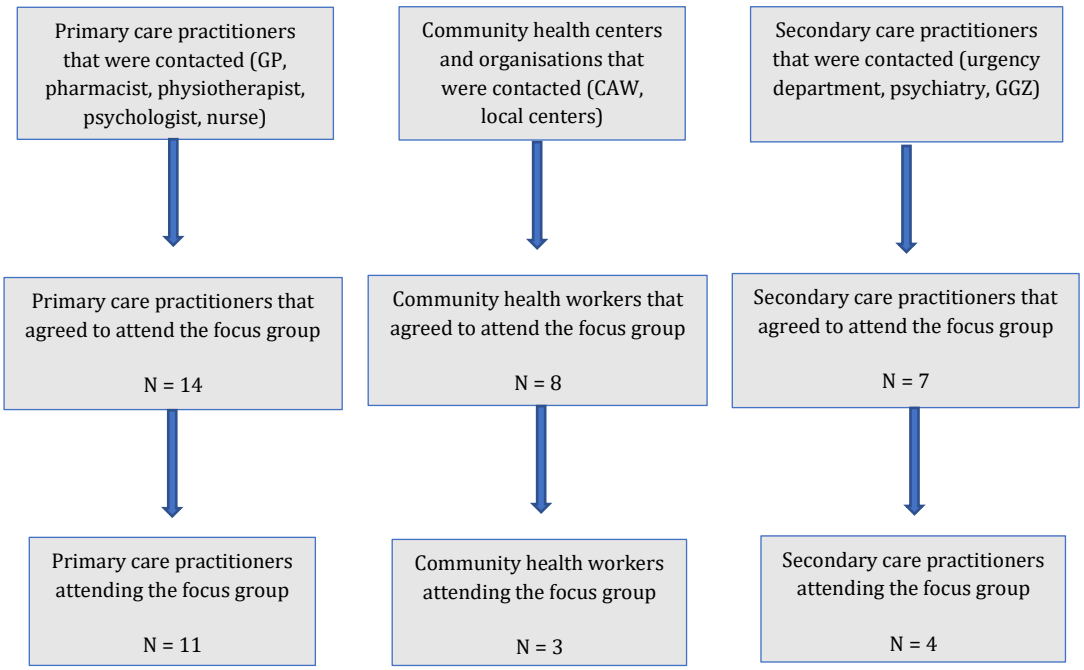


Figure 1: Participant selection

A purposive sampling strategy was followed. Diverse recruitment strategies were applied including e-mails, telephone calls and personal contacts (Figure 1). Participants were requested to take part in one focus group session. Four focus group sessions were proposed on different times and dates to reach maximum attendance and to randomly create heterogeneous groups. Each focus group consisted of at least 4 and maximum 6 participants. In total, 18 participants took part in the focus groups (Table 1). Non-participation was attributed to lack of time, no interest, or no experience in the subject.

Table 1: General data of the focus group participants

DATA OF THE FOCUS GROUP PARTICIPANTS		
SEX		
M	3	
F	15	
PROFESSION		
PHARMACIST	5	
HOLDER		1
ADJUNCT		1
TRAINEE		1
GENERAL PRACTITIONER	3	
RENTAL SUPERVISOR	1	
PHYSIOTHERAPIST	1	
PSYCHOLOGIST	1	
MOBIEL TEAM GGZ	2	
CASEMANAGER		1
PSYCHIATRIC NURSE		1
PSYCHIATRIST	1	
REGIONAL COORDINATOR CAW	1	
SOCIAL WORKER	1	
EMERGENCY PHYSICIAN	1	
NURSE	1	
TOTAL	18	

2.3 Data collection

Due to the COVID-19 pandemic, three focus groups were organised online via MS Teams (Microsoft, WA, USA). One focus group took place on-site at the community health center in Leuven (WGC De Ridderbuurt, Ierse Predikherenstraat 80, 3000 Leuven). A trained moderator (BP) guided the groups' discussion. Therefore, a guidebook was developed, based on the principles of the collaborative care model. In each focus group the same four main topics were discussed:

- a multi-professional approach to patient care,
- a structured management plan,
- scheduled patient follow-ups and
- enhanced inter-professional communication.

Two observers (AF and EB) made notes of the verbal and non-verbal expressions of the participants in the group. Additionally, video recordings were made to facilitate the analysis and at verbatim transcription.

After welcoming the participants and giving the information about the goal and the course of the group session, participants were asked to sign the informed consent file. Afterwards, a warm-up question was introduced to make the participants feel comfortable.

Then, the participants of the focus groups were presented open ended questions to enhance discussion about the four pillars of collaborative care. If needed, prime and prompt questions were integrated when more direction for the discussion was needed to obtain sufficient perspectives from the different participants about the topic. Duration of the focus group was maximum 1,5 hours. Once the four focus group sessions were conducted, the data was transcribed at verbatim to allow data analysis.

2.4 Data analysis

The discussions in the focus groups were transcribed at verbatim by one researcher (EB), based on the video-recordings and the observer notes. During this process, all identifiable data was removed and only pseudonymized data were used in the analysis. Both video recordings and observer notes were destroyed after data transcription. Two researchers (EB, AF) analysed the pseudonymized data after receiving training by an experienced professor in qualitative research (MV). The analysis was performed using ATLAS.ti in both a deductive and inductive way. The answers were summarised per group of respondents and annotated by the research team. Analysis of the transcripts was based on the principles described in the Qualitative Analysis Guide Of Leuven (QUAGOL) protocol[32]. This is a ten-step process and comprehensive method to guide qualitative data analysis. A Grounded theory perspective was applied to understand professional concerns and suggestions expressed. Codes were grouped according to consensus between researchers.

3 Results

3.1 A multi-professional approach to patient care

3.1.1 The network

The participants agreed that collaboration of the network around the patient, consisting of all the people that are close to the patient, including medical (GP, pharmacist, nurse, physiotherapist…), non-medical (social worker, rental office, CAW…) and social contacts (family, friends), is essential to guide the patient in his process of problem realisation and motivation.

That again comes down to that network, and then we are going inside, either looking at the existing network, um, okay the GP, that is a very important partner for us, also the psychiatrist if there is one, also the psychologist if there is one, so basically everyone who is there, we are going to involve in that to try to all be on the same page. (FG1, P3)

3.1.2 The confidant

According to the participants this role can be fulfilled by a variety of first line workers e.g., a rental supervisor, a district agent, a pharmacist, and psychiatrist. In general, the participants indicated the GP as important confidant and central contact point where others can refer to. Participants explained that the GP is mostly involved in multiple important life events and family circumstances of their patients which creates a strong connection.

And the second step is, if that patient then wants to seek help, that help should actually be as accessible as possible, with a person he or she trusts, and for me that would be the GP. (FG2, P2)

3.1.3 Other professionals

According to the participants, it depends on the patient's characteristics which caregivers need to be involved. Some participants mentioned the need of other professionals anyway because problematic alcohol use never is the only issue. Others emphasize that without the patient's permission, you can not refer. Awareness and motivation take time but are crucial, and this is where the key-role of the patient's network comes forth according to the participants.

So indeed, you first have all the others picking up things, planting seeds, and doing some short advice and nuh nuh nuh nuh. And then at some point, you're going to find a moment where there's motivation to really work with that. And then you start looking at, okay what would work for that patient now. Is it psychotherapy, or is it outpatient, is it an hospital admission, is it movement, is it...? (FG4, P1)

3.2 A structured management plan

3.2.1 Recognizing and addressing

There was a general agreement that every first-line worker (home assistance and rental service, physiotherapist, nurse…) that comes regularly in contact with the patient should pay attention and notice manifestations of problematic alcohol consumption. The participants highlighted that these first-line workers should be able to recognize and address the problematic alcohol usage to initiate the process of becoming aware of the problem.

...home nurses, family helpers, ..., not so much because I think they have to start asking diagnostic questions about that, but they do get very close to the people's environment and can notice there that there are manifestations of excessive alcohol consumption and may be able to ask a question about that or advise to talk to the GP about that next time. That sort of things. But actually, that applies to the whole society. (FG3, P1)

Although some argued that their trust relationship with the patient makes the conversation about alcohol use more accessible and impacting, other participants warned that it can be seen as confronting or judgemental by the patient which makes their position vulnerable. First investing in the connection and confidence is recommended in the experience of some participants. Informing caregivers without permission or knowledge of the patient is not an option as it harms the trust.

Yes yes, so we do try to work on the trust relationship first, because if you start attacking right away, there's no point, we won't achieve anything. (FG1, P1)

Psychoeducation for first-line workers about problematic alcohol usage was proposed to recognize and address it correctly without harming the trust. Some participants added that education about motivational interviewing is as important as setting boundaries to their help and be wary of not giving wrong information or handling it alone.

I think that some psychoeducation about such things is always helpful for social workers who are in contact with a lot of people and can sometimes pick up on signals, and also some of that motivational interviewing, because what social workers are very quickly doing when they have picked up a signal, um, is either we look the other way or we are easily tempted to point a finger, 'that's not allowed' or [appear] controlling, or... Whereas it's useful I think, people also don't dare speak to someone about that, or to signal something because they don't know how to do that, and then I think it's useful if you're given some tips on how to do that a bit... yeah. (FG1, P2)

3.2.2 Detection

The detection of problematic alcohol drinking, as in actively questioning alcohol use without reason, seemed rather reserved for primary health care providers. The participants primarily indicated the GP and pharmacist for active screening.

In the pharmacy, participants had already experienced that exposed tools, like posters, can start the conversation about alcohol. According to some participants, another opportunity for pharmacists to question alcohol use is when giving medication that interacts with alcohol.

To take for instance the example of the GP or the pharmacist, of when people come to get medication, once indeed just the part of medication - alcohol that doesn't go together. Just mentioning that, continuing to discuss that. (FG2, P1)

At the doctor's office, a more standardised questioning should take place with every patient according to the participants. One suggested that the GP can easily make the patient reflect on it by simply asking following questions: *"How much alcohol do you drink during the week?"* or *"How many alcohol drinks did you consume last time?" (FG3, P1).* Participants mentioned that the GP can also use abnormal blood results (e.g., impaired liver function) or present symptoms to question the patient's alcohol use.

3.2.3 Brief advice

Since questioning alcohol use in people implies knowledge about the guidelines, participants found that this could easily be followed by brief advice.

Yes, all those that we have mentioned I think can do that part. If you have that knowledge, pass it on, why wouldn't you do it? (FG4, P2)

Some participants concluded that in the pharmacy it is not feasible to have an open conversation with a patient and give personal advice considering the lack of privacy. They found that the pharmacist can only give general information about the guidelines to start the reflection process in the patient.

...that I think that we as pharmacists can often hear if there is a problem and that we may also often have or can have the role to refer to the right person and not necessarily that we are going to solve it or give that person advice, but that we can reach out to the right people for them and offer the right tools to be able to solve it. That's how I see our role as pharmacists in this. (FG3, P6)

The participants agreed that the GP is best placed for the short intervention, i.e., giving information about the guidelines and the consequences of problematic alcohol use, as well as giving personal advice and support.

Some participants mentioned that people should be able to consult the first-line psychologist (ELP) when they want information about alcohol drinking from an independent healthcare provider.

Where should you refer people to as a pharmacist, as a person who comes to people's homes, then I hope that the ELP will really be at those places where a lot of people normally come to, the OCMW, or to the town hall, or to the health insurance company, so to speak, so that you can quickly go there without having to make an appointment to obtain further information. (FG2, P1)

And sometimes I think that around alcohol, where there's a taboo and where that people might go "Gee, would I have a problem or not, I'm not going to discuss that directly, because my wife is also going to see the GP soon and tie and ta"... I think that sometimes it would help that that wouldn't happen at the GP's... It can of course happen at the GP's eh, but that it should also be able to happen at such a primary care psychologist (ELP). (FG2, P1)

3.2.4 Central contact point

Although there was no clarity about to whom first-line workers should refer to after identification, the participants agreed that the GP should be the central contact point since he is an indispensable actor of the care pathway in problematic drinking. In the focus groups it was clear that the GP needs to cooperate with and strengthen the network around the patient. In absence of a GP, participants proposed to contact another available confidant caregiver in the patient's network (psychiatrist, psychologist), or to seek a motivated GP.

Yes, I think so too, in the first line, if the rest doesn't come there, then refer to the GP. (FG4, P1)

It can be, the GP is available, if there is a GP. But sometimes there is no GP. And then if there is then a psychologist or a psychiatrist, then I think as a social worker or as a care worker, then you are happy. And yes and otherwise a nurse, if there is one, that's already there too or for the family. Talk to whoever you encounter, whoever that you trust. (FG1, P4)

3.2.5 Referral

Considering the needs and characteristics of the patient, the GP is best placed to estimate and facilitate referral to secondary care according to the participants.

Yes, but to bring in external help, surely the GP is the contact person... (FG4, P4)

Participants argued that referral to a psychologist can be needed when it is difficult for the patient to talk about it, to guide him further in the mental process with reflection and motivational talking. The psychologist can also detect and treat underlying problems that maintain excessive drinking as one mentioned in the focus groups.

If it is more serious, if there is a demand for help, okay then the psychologist can be brought in along with the patient. Or when the patient is wriggling with it, but clearly doesn't, doesn't want to communicate about it or is struggling with it, yes then it might be helpful to have some conversations with someone else who has more time for this. (FG3, P1)

In the focus groups it was not clear if referral to a psychiatrist is routinely necessary for hazardous and harmful alcohol users. However, participants stated that the psychiatrist should be engaged when diagnosis and treatment of underlying psychiatric problems is needed. Some participants mentioned the possibility for a consulting function when caregivers need advice.

I also think about the consultation function for other social workers. A psychiatrist with knowledge about addiction, could be of some use. (FG1, P2)

3.3 Scheduled patient follow-ups

3.3.1 The constant follow-up

Participants agreed that the GP as confidant is best placed for follow-up of the patient. In case of long waiting times of referral, one participant confirmed that the GP continues the follow-up and the establishment of the network around the patient. Other participants acknowledged the constant role of the GP, with or without referral.

And then the GP is maybe, yes, better placed to follow that up a bit and come back to that a few times as well... (FG2, P3)

3.3.2 A goal-oriented referral

The importance of a goal-oriented referral was stressed in the focus groups. First, participants highlighted the consideration of the individual needs of the patient in that moment as well as his state of mind (realisation, motivation for referral) to set the goal. Secondly, knowledge about the regional caregivers and their working is currently lacking to determine where this goal can be achieved best. The creation of an accessible social map with clear task description was suggested to realise a more successful patient-focused referral to the right caregiver. One participant added the importance of creating correct expectations in the patient so he has confidence in the referral.

Yes, that is always tailored and looking at, yes, and what is the supply, what is the availability, what is your momentum, what is your patient? (FG4, P1)

3.3.3 More accessible referral

Referral to the psychologist is difficult according to the focus groups because of the waiting times, the cost and particularly the lack of interest in the treatment of problematic alcohol users. The same barriers are mentioned when referring to secondary mental health care, the MHC (GGZ): the administration upon registration, the long waiting times, the patient who should fit the program and the lack of trust in each other's assessment as referring caregiver, were appointed for improvement. The participants agreed that referral to secondary care should be more easily accessible.

I think that should be much easier to do, a referral, you have to trust each other as caregivers. (FG2, P1)

3.4 Enhanced interprofessional communication

3.4.1 Communication upon referral

In the focus groups it was clear that before interprofessional communication, the permission of the patient is required. In more complex cases, one participant confirmed that an (expert) advice can be requested anonymously. According to participants the patient can realise the communication for referral himself, on condition that he is willing to do so and the service is accessible enough.

But then when I think of, yes, someone who additionally needs a therapist for example, I think that is also something that you can mutually agree with your client like "Look, would you like me to make contact with that to do a sign-off, or do you prefer to do that yourself?" Some people also like to do that themselves, others don't feel so safe with it. I think that also has to do with how approachable the service is that you refer to. (FG1, P3)

At this moment, communication for referral between different caregivers is preferably realised by phone according to the participants. It is more personal and additionally, the referring person can share more context and expectations.

Yes, about complex things still preferably over the phone. If there really is someone in front of me with a question about someone wanting to get started with help in a substance abuse problem, I do like to see that framed a bit over the phone, etc. But..., because you can't put that in a letter, plus then I also don't know what are the expectations etc… (FG4, P1)

3.4.2 Feedback

Participants stressed the lack of communication and feedback after referral between health caregivers, which is essential for proper follow-up and support. Regarding the feedback in general to first-line workers, some participants emphasized that they don't need all the details, cfr. GDPR. However, limited information should be shared when it is useful for the practice of their profession.

...But for us sometimes it is interesting to know a little bit anyway because that does affect how people live or interact with the neighbours etc. But to know that in detail now, we don't need to know that. But sometimes we do want to be kept just a little bit more informed. (FG1, P1)

In view of the multidisciplinary character of the treatment of problematic alcohol use, some participants stressed the need for a digital communication platform, where the involved caregivers receive feedback automatically, such as E-Health. However, some pointed out that agreements on confidentiality will be essential and others noted the need for personal contact upon referral in complex cases. Yet, one participant didn't believe in bureaucracy at all.

So I think we really, yes, need to think about that with the different partners and the opportunity is precisely the electronic communication network... E-Health, how do we scale this up and who needs to be informed? (FG2, P2)

3.4.3 A multidisciplinary care consultation

In case of a community health center, it is simple to organise a weekly multidisciplinary consultation moment, considering the shared professional secrecy and patient population according to the experienced participants. Outside this organisation, participants noticed that a care consultation is possible but more difficult to realise because of all the different caregivers involved. The participants agreed that this multidisciplinary care consultation is only necessary in selected, complex cases to align the network around the patient.

I think that should definitely be a possibility, I don't think that should be with everyone, but I think that should be possible. And that it should be possible in an easy way, but the government has now abolished the subsidy for healthcare consultation again, so it's always a difficult one as well to get everybody around the table, nobody is paid. (FG2, P1)

4 Discussion

4.1 Summary

Our data strongly indicate the importance of a collaborative care pathway to reduce the negative impact of excessive alcohol consumption in patients presenting in primary health- and community-based settings. The four pillars of the collaborative care model were confirmed in our data: a multi-professional approach to patient care, a structured management plan, scheduled patient follow-ups and enhanced interprofessional communication. Findings suggest that enhancement of a collaborative network which consists of medical, non-medical and social contacts where everyone should be able to recognize and address the problematic alcohol usage, is desired. The GP as confidant is stated in a rather multifunctional position when it comes to detection, passing on a brief advice, estimation and facilitation of the referral, follow-up and interdisciplinary communication. Based on our results, referral should be goal-oriented and in line with the patient's consent, individual needs and the drive at the very moment, considering the regional service accessibility with clear task description, which lacks at the moment. Data suggest that the interdisciplinary communication upon referral should be realised by calling, particularly in complex situations, as it enables back and forth conversation. Internal feedback is essential for optimal follow-up, preferably via a digital communication platform, however not essential for all care providers as long as there is basic relative information.

4.2 Comparison with other research

Considering the detrimental health consequences of at-risk substance use and the existing tolerance towards alcohol drinking, research highlights engagement of all possible professions and services to create widespread awareness in people[14][19][21][33]. The guidelines concerning alcohol consumption are not well known in the population and the definition of 'problematic' alcohol use is not easy to be applied by outsiders, considering the lack of knowledge about the early symptoms of limited excessive use[34]. Making alcohol generally discussable and providing systematic screening as a standard of care for everyone are advocated to open the conversation about alcohol use and reduce the burden[14][34][35].

Early identification and brief intervention are cost-effective and studies report the educational value of the screening questions alone[14][35][36]. However, the implementation of SBIRT in different settings remains challenging and it is still unclear who is best placed for taking up which role[11][36]. Research already defined a number of well-described barriers to successful implementation of SBIRT among health- and community-based services, matching our findings: attitude towards alcohol use, fear of damaging trust relationships, lack of organizational and structural support, and no clear role division[11][19][21][35]. Corresponding facilitators brought forward in the focus groups were: psychoeducation in first-line workers, quick access to an organized social map and development of a stepped care pathway with clear task description.

Findings of Watkins et al. (2017) demonstrate that a collaborative care approach results in significantly more treatment and abstinence from alcohol[24]. In this study care coordinators (CC) were assigned to support and encourage patients in the CC-group with intensive guidance. Moreover, a tailored treatment plan was provided with trained caregivers as well as weekly

team meetings. This indicates the importance of continuous care with close follow-up and a clear care model.

To our knowledge, this is the first study addressing different first-line workers to explore their views and needs regarding a collaborative care pathway to tackle problematic alcohol use. Research already indicated the lack of organisational support and the challenging referrals to mental health care, but investigation of cooperation and task division between primary care and community-based settings (e.g., rental and social services) is scarce. Studies suggest the need for practice-based approaches in adaption to local circumstances which result in a more effective and sustainable implementation of interventions[37]. More research is needed to explore the local lacks and needs of the first-line professions to improve collaboration and implementation of EIBI.

4.3 Strengths and weaknesses

The strength of this study was the wide variety of professions we had included (12 different professions) despite the low number of participants (18 participants). This gave us a broad perspective from different professional experiences and opinions. This is necessary for future development of a care pathway with clear task distribution between the different caregivers. The choice of a focus group intervention was made to encourage discussion and obtain different perspectives and personal views. Furthermore, the study's research area, i.e., Leuven, is a progressive and innovative city in terms of healthcare. The presence of the Catholic University (KU) of Leuven and its Academic Centre for General Medicine (ACHG) makes this area often participating in research and up to date. Consequently, most primary caregivers in the focus groups had already taken part in another PINO-study and were informed of EIBI and alcohol, which made the discussions richer, but can create selection bias. Based on Hennink et al. our four focus group discussions were sufficient for code saturation, i.e., identification of a range of new issues[38]. In qualitative studies it is important to have different researchers to avoid subjective interpretation of the data, i.e., researcher bias. In this study, two researchers (EB and AF) analysed the obtained data separately and brought it together in consensus afterwards.

Due to the covid-pandemic the focus groups had to be organised online, except for one. This implicates inferior opportunities for discussion and interaction, e.g., poor internet connection, poor overview of participants and difficult interpretation of non-verbal expressions. Recruitment was difficult and two focus groups had to be cancelled because of participant's no show. A patient walkthrough was foreseen, but not conducted due to lack of time. Participants engaged to take part in the focus groups might have been more interested in this subject than non-participants, which fosters selection bias. Another weakness that can be noted is that only one database was used for the literature study. Although the focus of this study, i.e., problematic alcohol use, was clearly emphasized in the beginning of every focus group, the answers often concerned patients with alcohol dependence as well. This deviation from the study topic was inevitable given the continuum of alcohol use and the difficulty to distinguish the first stages of excessive alcohol use in sight. This lack of expressive signs in problematic drinking also explains the need for tools and knowledge about the guidelines in the population.

4.4 Recommendations

According to the focus groups there are missing steps in tackling problematic alcohol use before referral to secondary care is needed. A stepped care approach is recommended with development of a social map that gives a quick overview of all the regional caregivers and a clear description of their tasks to improve a goal-oriented and patient-focused referral[21]. A central contact centre could help first-line workers to select the right support for their specific patient with risky alcohol use.

To obtain a more widespread screening of individuals, psychoeducation should be embedded in training of first-line workers and a coach should be consultable in every profession's organisation to support them. When referral to secondary care is needed, this should be more accessible, given the limited availability of mental health care providers accepting referrals when problematic alcohol use is present. Communication and feedback between different caregivers should be enhanced and made easier, e.g., via a digital communication platform such as E-health.

Further research is needed to investigate the specific role of different first-line workers and the feasibility to implement EIBI in community-based settings. Implementation science, such as the COM-B-system or the TDF domains, can help to determine effective strategies to increase implementation of a collaborative care pathway in various settings[12]. Future studies should focus on development of a clear care pathway and on how collaboration can be optimised in health- and community-based services to reduce the harmful levels of alcohol consumption currently existing.

5 Conclusion

There is a lack of efficient collaboration between first-line workers for the identification and intervention of problematic alcohol use. In the focus groups it was clear that every profession that comes regularly in contact with the patient should be able to recognize and address the problematic alcohol usage, provided that they get psychoeducation and coaching. Health care providers, given their knowledge about the guidelines, are best placed for active screening and brief advice. The GP is the central contact point for all first-line workers and the constant in the process. His task it to follow-up and support the patient, strengthen his network, and estimate the need for referral. Knowledge about the role and presence of regional caregivers, e.g., via a social map, is essential to realise a goal-oriented referral. Accessibility of mental health services should be facilitated and simplified. A digital communication platform, e.g., E-Health, is proposed to facilitate interdisciplinary communication and patient follow-up. Further research is needed to evaluate the development and implementation of a collaborative care model and to analyze its effect on tackling problematic alcohol use in patients presenting in primary health- and community-based services.

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Appendix I: EC approval

Leuven, 28 October 2021

Ethics Committee
Research UZ/KU Leuven
Herestraat 49
B 3000 Leuven (Belgium)

Email : ec@uzleuven.be

dr. Mieke Vermandere

Our reference:	EudraCT-nr:	Belg. Regnr:
S62662		

Exploration for an improved collaborative care model for professional involvement reducing alcohol use related negative outcomes. (PINO – focus group study ACHG).

Modification/additional study documents

AMEND-Id: 0001

Dear colleague

The Ethics Committee Research (EC Research) of University Hospitals Leuven (UZ Leuven) has initially given a positive advice for the above mentioned protocol on 6 May 2019.

Documents/answers submitted on 2 September 2021, 7 September 2021, 26 October 2021 and 28 October 2021 have been taken into account in the evaluation of the modification.

A favourable advice for this modification was given on 28 October 2021.

The favourable advice concerns:

Protocol
Version 5 dd 20Sep2021
Informed Consent Form
ICF version 5 dd 28Sep2021 Nl
Recruitment material
Invitation letter version 4 dd 20Sep2021 Nl
Change investigator UZ Leuven
Prof. dr Catharina Matheï will be replaced by Prof. dr Mieke Vermandere

The changes in the ICF should be clearly communicated to the patient.

We would like to point out that in case of amendments to the ICF, it is strongly advised to use an ICF addendum for ongoing participants. The ICF addendum lists only the changes or new information which is more clear to the participant than an amended ICF where changes are highlighted. When enrolment is still ongoing, an amended ICF is required for new participants.

The following documents were submitted for notification:

Not applicable

EC Research confirms working in accordance with the ICH-GCP principles (International Conference on Harmonization Guidelines on Good Clinical Practice), the latest version of the Declaration of Helsinki, the Oviedo Convention on Human Rights and Biomedicine and applicable laws and regulations.

EC Research confirms that - in case of conflict of interest - involved members do not take part in the vote concerning the study.

List of members: see appendix.

Points of concern: (if applicable)

The conformity of translated documents compared to the Dutch documents, is the responsibility of the sponsor.

In case of modifications to protocol and/or clinical trial agreement for UZ Leuven, they must also be submitted to the Clinical Trial Center (CTC) of UZ Leuven.

We would like to draw your attention to the fact that EC Research expects her initial comments to be taken into account ab initio at the next submission by the same sponsor.

Studies with investigational medicinal products and certain studies with "medical devices" should be submitted by the client (PI or sponsor) to the FAMHP (Federal Agency for Medicines and Health Products).
Studies with investigational medicinal products are only allowed to be conducted, provided that the minister (FAMHP) does not state objections within legal deadlines as described in art. 13 of the Belgian law of 7/5/2004 concerning experiments on the human person.
Certain studies using medical devices are also covered by legal deadlines (KB of 17/3/2009). Please consult the FAMHP website for more information: www.fagg-afmps.be.

Research on embryos in vitro is covered by the law of May 11, 2003. Before the research project can start, such research also requires a positive advice of the Federal Committee for medical and scientific research on embryos in vitro.

Please take into account the regulations of the hospital concerning tissue management and the regulations of the law of December 19, 2008.

This favourable advice of EC Research does not imply that she will assume responsibility for the planned study. You will remain responsible for the study. In addition, you, as involved principal investigator, should ensure that your opinion as an involved researcher is reproduced in publications, reports for the government, etc. which are the result of this study. You are reminded that concerning clinical studies, any observed serious event needs to be reported immediately to the sponsor and the ethics committee, even if the causal relationship with the study is unclear.

We request you to inform us if the study will not be initiated.

Finally, we request you to report the termination (early or planned) of the study within the legal deadlines and provide the ***Clinical Study Report*** *(CSR) to EC Research.*

In case of a clinical trial (EudraCT), please be informed that the results must be published in the European Clinical Trial Register. The report of these results can be sent to the EC Research as the CSR.

Yours sincerely,



Prof. dr. Minne Casteels
Chair
Ethics Committee Research UZ Leuven

Cc:
FAMHP (Federal Agency for Medicines and Health Products)

CTC (Clinical Trial Center UZ Leuven)

Participating centres

Local Committee	*Principal investigator*	*Date advice*

Appendix II: Protocol

Protocol submission of ACGP to EC UZ Ku-Leuven

Exploration for an improved collaborative care model for professional involvement reducing alcohol use related negative outcomes. (PINO – focus group study ACHG).

General information

Protocol – full title	**Exploration for an improved collaborative care model for professional involvement reducing alcohol use related negative outcomes. (PINO – focus group study ACHG).**		
Type of application	☒ Amendment	☒ New study project	
Principal Investigator – Promotor	**Name**	**Mieke Vermandere**	
	Faculty/ Department	**Faculty of medicine / department of public health and primary care**	
	E-mail	**mieke.vermandere@kuleuven.be**	
The principal investigator is a health professional according to the Law of 10 May 2015.			☒ YES
Co-Investigator – Co-promotor	**Name**	**Bert Aertgeerts**	
	E-mail	**bert.aertgeerts@kuleuven.be**	
The co-investigator is a health professional according to the Law of 10 May 2015.			☒ YES
Sub-Investigator(s) – Student(s)	**Name**	**Bram Pussig**	
	E-mail	**bram.pussig@kuleuven.be**	
Additional information	☒ Non-commercial study ☐ Commercial study		
	☒ Monocenter research in Belgium		
External partner(s)	☒ NO		
Funding	This study is funded by the ABinbev foundation (US) (see contract).		

Background

Harmful alcohol consumption is one of the leading risk factors for poor health and death globally. About six percent of all-cause mortality in 2016 was attributable to alcohol, equivalent to 2,8 million deaths (1). In Belgium 5.85% of the total population is labelled with an alcohol use disorder in 2009 (2,3). Additionally, alcohol-related harm extends the individual harm as it also affects the burden on society, including families, communities and health systems(4). Alcohol consumption increases the social cost as it affects productivity and employability as well as causing indirect harm to the drinker and others through accidents and violence (4–6). A mayor improvement could be realised in targeting alcohol in public policy actively as use appears in Belgium the third most important risk factor responsible for Disability Years of Life after smoking and hypertension (7). The majority of alcohol-related health problems occurs in the middle-aged population, suggesting that interventions in early adulthood and middle aged population might deliver the most beneficial results (8,9).

Early detection and brief intervention (EIBI) is a proven cost-effective method to reduce the amount of heavy drinkers in primary care(10). Interestingly, the highest efficacy was observed when brief advice was delivered to non-treatment seeking, hazardous drinking, patients (11,12).

Even though EIBI is shown to be mainly effective in primary health care, implementation of EIBI by general practitioners (GPs) in the daily practice is generally lacking, diminishing its effectiveness and resulting in a mean gap in care for problematic alcohol use of 18 years (13).

Considerable effort has been given to identify barriers to explain this observation(14). Motivation of GP's to be involved is generally high, but lacking knowledge and skills are due to insufficient training or unavailability of support afterwards(14). Inadequate practice facilities (e.g. information materials, not adapted records, lack of available staff) have been indicated as contributing causes (15,16).

A clinically flexible implementation and engaging progressively primary care professionals is suggested (17). To scale-up EIBI support need to take into account personal experiences (18,19), which will evolve in particular during introduction of this strategy. Within health care centres, nurse contribution can improve screening rates while GP seem more accurate in providing advice (20). Hence, task delegation may be a way in multidisciplinary practices to reduce GP workload (21).

Acceptability to initiate discussions on alcohol was also demonstrated to be feasible by a variety of different professions (20). This includes social services , although linked to law enforcement (22,23) and pharmacies (24–29).

The efficacy of interventions in pharmacies has not been proven formally, due to lack of power or outcome data (30), but similar minimal intervention strategies for smoking have demonstrable outcomes (31). Pharmacists seem to favour medication interaction information as most feasible issue to start the dialogue (29). Ongoing support of change and skills should be part of the implementation process (32) as there is increasing awareness of the pharmacists educational potential (33). Smoking cessation strategies in Flemish pharmacies have been initiated around smoking; as a result. A limiting factor might be the need for additional room for confidential communication. These observations, taken jointly, suggest that pharmacies and social services might orient at risk patients opportunistically or more systematically to their general practitioners for advice and follow-up. Social services may well provide help for social problems underlying or favouring heavy alcohol use and support general practice in their specific area of expertise. Indeed providing 'specialist support' and 'improving collaboration' with mental health care services was indicated to be important by general practitioners in many different countries (15,17,34,35) including Flanders (16,36).

In particular collaborative care for more heavy alcohol users by mental health care is expected to improve GPs' EIBI activity in Dutch speaking general practices (37). A systematic review showed however a lack of efficacy of actual provisions for referral to mental health after screening (38).

In summary: specific attention is needed for the organisational context within primary care services and clear task definitions for all different professions potentially involved; communication with social services and mental health facilities is needed and the dialogue about care and support should be improved. Although feasibility of a variety of professionals' involvement in EIBI has been confirmed, possibilities to collaborate in care between primary care medical and paramedical professionals in direct contact with the alcohol consuming population might be useful. As this has not yet been investigated an explorative focus group study is proposed to develop a pilot strategy for collaboration within the broader Leuven area enhancing EIBI in primary health care.

Study objectives

This project aims to increase understanding about feasible tasks and collaborative care principles among primary and mental health care professionals and define professional communication principles to increase EIBI for hazardous and harmful alcohol use. This study aims to create a better understanding on the following issues:

1. What are acceptable and feasible tasks for general practitioners, social services and pharmacies to deal with hazardous and harmful alcohol use?
2. What are acceptable and feasible principles to facilitate a stepped and collaborative care approach involving different primary care providers?
3. How to assure adequate care support by mental health services for the more severe alcohol use disorders or users with co-morbid conditions?
4. How can communication between different professions about EIBI and care about alcohol use be optimised?

Research methodology

Design

An explorative, qualitative focus group study will be used. Focus groups provide an effective means to generate a fresh perspective on a topic which lacks basic information. This trough moderated group interaction with relevant stakeholders sharing their views, ideas and experiences (39). For this study, the principles of the consolidated framework for reporting qualitative studies (COREQ) were followed (40). An opportunity sample representing the different professional groups and non-professionals will constitute the study's participants. Professionals will be recruited in the broader Leuven area among local primary and secondary health care providers. Non-professionals, or patients, will be contacted through local professionals or relevant local organisations or public officers.

The study will be organised online via MS Teams (Microsoft, WA, USA) and moderated by an experienced researcher. During the focus group sessions, the moderator will guide the participants to share their perspectives and discuss task differentiation (20), improved interprofessional communication (37) and flexible stepwise implementation (17).
After analysis of the focus group data, a proposal for a collaborative care pathway will constructed. To evaluate this collaborative care model, an online member check will be organised via Formsite (Vroman Systems, Downers

Grove, IL). A member check comprises a feedback round with the participants after data analysis, improving the accuracy and credibility of qualitative findings (41). The participants will be asked to provide open-ended feedback on both the collaborative care model and the researchers' reformulation of the communication principles.

A patient centred walkthrough will allow to evaluate the usability of a system and exposing usability problems in the care process (42,43). With this walkthrough, a researcher will guide a patient through the care process. The patients will be asked to provide feedback on their experiences when following the care pathway. Based on the feedback, changes will be integrated to the collaborative care model.

Research instruments

During the focus groups, a moderator will present questions to the participants to get a better insight in the stakeholders' perspectives of the collaborative care principles for patients with hazardous, harmful of dependent use of alcohol.

1. What are the tasks of primary healthcare professionals facilitating alcohol-related early identification and brief intervention and to reduce harmful and hazardous alcohol use?
   - which tools should be used? Are these tools helpful for all care providers?
   - what are acceptable tasks for the different care providers to integrate early identification and brief intervention without affecting the professional relationship?
2. What are acceptable and manageable principles for a structured collaboration between care providers in the first line
   - what is necessary for referral of people that consume more than the acceptable weekly intake of alcohol?
   - to whom would you refer people with harmful, hazardous or dependent use of alcohol?
   - who would be responsible for an adequate follow-up of patients?
3. How should the communication between care providers be structured in order to optimise alcohol related early identification and brief intervention?
   - what do you see feasible?
   - what is necessary to accomplish this?

Participants

An opportunity sample will be selected for the focus groups and patient walkthrough.

Focus group and member check

- General practitioner
- Pharmacist
- Psychiatrist / Psychologist
- Community workers
- Care providers in working in addition and rehab centers
- Emergency doctors

Patient walkthrough

- Patient experts

Recruitment

Recruitment will be realised by the use of an online submission form sent by professional bodies holders of the original mailing list. These will be the authorised secretarial staff of the GP circle in Leuven, The Brabantse Apothekers Vereniging, The Association of Private functioning psychologists, and relevant institutions in social welfare and mental health active in the Leuven area.

Recruitment will be realised as follows:

1. Involved professions among general practitioners, pharmacists, social and mental health care workers:
- By email or telephone using regular local contacts of the Academic Center of General Practice with an equal mix of 15 GP-trainers and local GPs in different practice settings (private, solo, duo and local health centers).
- Other professional participants will be contacted through e-mail by their own professional associations (pharmacists and private practicing psychologists or through institutions where they work (hospital, welfare and community mental health /addiction centers).

2. Non-professional people can be recruited through direct invitation by their local physicians, social services, pharmacists or lay people's representation in the municipality drugs and alcohol use policy collaboration group, the 'Zorgzaam Leuven' project or 'Lazarus' project.

Inclusion and exclusion criteria

Care providers (focus group and member check):

Inclusion : We will try to approach gender equity and fair distribution of the age groups (18+) while applying following these principles:

- **working in the broader Leuven area with following characteristics:**
  - ☐ Professionals in primary and secondary level care
    - Vocationally trained general practitioners (Group & Solo practices) of which 1 GP-Trainer
    - Social workers (CAW/OCMW/mutuality)
    - Pharmacist delegates
    - Mental health care worker (CGG and Private)
    - psychiatrist
  - ☐ People not involved in primary care
    - Municipality prevention worker
    - Public insurance delegates
    - Professional with knowledge of in juridical and privacy aspects about aspects of communication and collaboration
- **Exclusion:**
  - ☐ Vocational trainees
  - Not sufficiently understanding and expressing in Dutch
  - Mayor mental disorder

Non-professional people or patients (patient walkthrough):

- **Inclusion:**
  - ☐ Living in the broader Leuven area

- ☐ Patients recruited by general practitioners
- ☐ Self-help group representatives
- ☐ Age: 18 years and older

- **Exclusion**:
  - ☐ Not sufficiently understanding and expressing in Dutch

Sample size

The Focus groups will be organised until data saturation is reached. Data saturation is interpreted as the recurrence of comparable information between groups (45). Based on previous experiences in focus group studies, we estimate to conduct 4 focus group studies with 8-10 participants each (32-40 participants in total).

For the patient walkthrough the same principle of data saturation will be followed. We estimate to conduct 8 patient walkthroughs to reach data saturation.

Participant information & Informed Consent procedure

A detailed description of the process and used terminology will be provided at start in the recruitment documentation (ANNEX I). The informed consent files are written in Dutch, as it is the native language and can be found in ANNEX II (A and B). Latter answers will be kept on a secure protected site under direct supervision of the data protection manager responsible for storage and correspondence.

The main build up is:

- Background information on how and why this research is performed and what the purpose is of this informed consent file (inform the participant)
  - Essential information for making the decision for participation
  - Practical overview of the focus group, member check and patient walkthrough
  - Privacy and use of gathered data
  - Benefits, risks, and burden of participating
  - Establishing it is a voluntary participation (participant can stop at every moment they want)
  - Costs and reimbursement
  - Main messages
  - Contact information
- The informed consent file (to sign)

Remuneration or benefits

Participating in this study will be voluntary. The participants will have no extra costs for participating with this study.

Data collection

The focus groups and patient walkthrough will be organised online using MS Teams (Microsoft, WA, USA). Video recording will be made of the focus group discussions and the patient walkthroughs using the functionalities in MS Teams. Additional security packages will be installed in MS Teams to comply with the GDPR. Recordings will be stored on a secured server from the KU Leuven. These recording will be destroyed with the necessary precaution after transcribing the focus groups and patient walkthroughs. Video recordings will be made to allow the analysis

of group dynamics and the overall atmosphere when discussing the different topics. This will be important to accentuate potential differences in perspective between the participants

Participants of the focus groups will be asked to display their first name during the discussions on their screen. This will allow the researchers to link what was said to the profession, which is important for the data analysis. During the focus groups, participants will not be asked to share their profession to allow a neutral discussion.

The online member check will be structured using a secured web-based format (https//:www.formsite.com).

Data analysis and theoretical perspectives

The analysis of the focus group, member check and patient walkthrough will be made on the pseudonymised NVivo files as described beneath. Pseudonymised data will be treated confidentially during the entire project and kept protected on a secure location with password protected login only for the research team. All analyses of the collected data by the research team will be made on the pseudonymised data. Answers will be analysed and summarised per group of respondents and annotated by the research team.

The extraction dataset will also contain text answers by the respondents to open questions. Such data will be treated in Nvivo to define main components. The Quagol protocol(44) will be used to analyse these open answers. Views and conditions expressed for collaborative care provision and its support will be coded using Nvivo software by two researchers independently.

A Grounded theory perspective will be applied to understand professional concerns and suggestions expressed. Codes will be grouped according to consensus between researchers.

Results of each focus group will be grouped according to professional status. After the full study, all participants will receive the resulting collaborative care proposals and suggestions to stimulate its implementation.

Data protection

Personal data will be dealt with and protected according to GDPR rules. In particular the data protection officer will supervise the pseudonymisation and log-in process of answers according to the procedure as described beneath.

Personal information of the participants, necessary for recruitment and correspondence, are recorded online with password protection, separately collected from answers to the questions. As nominative e-mails are to be used to recruit participants and to correspond with them about results this will be organised by the - independently working - data protection officer not forming part of the research group. This guarantees anonymity to the research group.

Before participating in the focus groups or patient walkthrough, prior agreement is required through a digital informed consent form (ICF, ANNEX II). Informed consent files will remain stored on a secure server of the KU Leuven.

Access to answers is protected through password protection only accessible to the researchers and stored on a secure server of the KU Leuven for five years. These data will be saved in accordance with the KU Leuven policy for five years. After this period, data will be destroyed with the necessary precaution. A copy of all the collected pseudonymised data will be saved on an external hard drive. This hard drive is secured with password protection and stored on a safe, locked, location.

Signed informed consent files will remain stored on a secure server of the KU Leuven. Paper copies will be stored on a safe, locked, location. A data protection officer will supervise the pseudonymisation and log-in process of answers according to the procedure described above. The key of pseudonymization is kept secret for all researchers involved.

Personal information of the participants, necessary for recruitment and correspondence, will be removed after completion of the study The collected data will be stored after closure of data collection on an external hard drive, protected with a password and saved on a secure location. After completing data-analysis answers will be saved in accordance with the KU Leuven policy for five years.

A copy of all the collected pseudonymised data will be saved on an external hard drive. This hard drive is secured with password protection and stored on a safe, locked, location. These data will be saved in accordance with the KU Leuven policy for five years. After this period, data will be destroyed with the necessary precaution.

Security and risk management

During the focus groups and patient walkthroughs, a sensitive topic will be discussed (alcohol use). The participants will receive a flyer guiding about risks of alcohol use (VAD guideline) and another with contact information of professionals that they can reached if they have more questions on alcohol or other issues. Latter flyer was designed by the city of Leuven and is called “Als het water aan je lippen staat… zoek hulp”. Additional information concerning the research can be directed to the promotor: Mieke Vermandere.

Ethical justification

- **Social Value**

  This research proposal provides both direct and indirect value for improving people’s health:

  Direct:
  This study will enhance and improve collaborative care and communication between care providers respecting privacy and confidentiality rules, leading to a care pathway applicable in the broader Leuven area.
  Indirect:
  The project has the potential to enhance further collaborative care protocols and consumers’ participation in care. Principles and methodology retained may also inform other chronic care development processes.

- **Scientific validity**

  1. The protocol of this study is based on Belgian(46) and international guidelines(47) for Qualitative Research. The study organises input of many different stakeholders(48), including non-professional’ participation which is increasingly a quality criterium for guideline development in care(49).

- **Fair subject selection**

  An opportunity sample has been defined including relevant professions, main institutions and non-professional representatives. Due to the wide variety of stakeholders, different approaches are proposed for the recruitment (see: recruitment).

- **Risk-benefit ratio**

  There is no risk related to participation to this consensus development protocol.

The resulting care-pathway should benefit the population by increasing access to good quality care. The care strategy promoted is a proven cost-effective method to reduce hazardous and harmful alcohol consumption at primary care level; it may enhance also care to patients that need more intensive mental care.

- **Informed consent form**

  An Informed consent will be solicited for all Delphi and nominal group participants, to be agreed upon prior to involvement into the consensus development process. Contribution of participants will be acknowledged in any publication on explicit consent (**see: participant information, informed consent procedure**).

- **Respect for participants**

  Professional associations and institutions will perform the recruitment for by sending project information online to their contacts including informed consent form and the first background enquiry form. These organisations hold authorisation of their colleagues for direct communication.

  The advantage of the chosen methodology is that participants can freely express differences in opinions. The invitation states that there are no good nor bad answers, only valid opinions. All opinions will be equally considered and retained according to predefined, agreed and scientifically recommended consensus criteria.

  Participants are allowed to refuse to answer questions that they do not want to, without justification and consequences. This will be briefed in the informed consent file online, in paper and orally repeated at start of nominal group meetings.

  Personal data will be managed according to GDPR rules (see data management).

Timeline proposed

Start date: 22/09/2021

End date: 30/12/2021

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ANNEX II. A. Informed consent:

Onderzoekers:	**Bram Pussig**
Principle investigators:	**Mieke Vermandere, Bert Aertgeerts**
Adres Onderzoekscentrum:	**Academisch Centrum Huisartsgeneeskunde (ACHG)**
	Kapucijnenvoer 33, blok H - 3000 Leuven
Sponsor:	**Katholieke Universiteit Leuven**
Financiering:	**ABInbev Foundation**
Ethisch Commissie:	**Ethische commissie onderzoek UZ/KU Leuven**

Geachte Heer/Mevrouw,

Eén kwart van de Vlaamse mannen en 10% van de Vlaamse vrouwen zou naar schatting regelmatig te veel alcohol drinken. Vroeg-detectie van dergelijk risicogebruik en kort advies in de eerstelijnszorg blijken effectief te zijn in de aanpak van dit overmatig alcoholgebruik. Momenteel krijgt ongeveer één op vijf van de overmatig alcohol drinkers een gepast advies of behandeling krijgt.

Wij willen met U nagaan hoe we deze aanpak optimaal kunnen bevorderen en ondersteunen via de samenwerking tussen beroepsgroepen op de eerste en twee lijn.

De resultaten van deze studie dienen voor het ontwikkelen van een gemeenschapsproject in Leuven om de bespreekbaarheid van alcohol gebruik te stimuleren. Hiermee willen we vroeg detectie en kort advies in de huisartsenpraktijk en actieve samenwerking met de geestelijke gezondheidszorg bevorderen.

Voordat u beslist over uw deelname vindt u op de volgende in dit document gedetailleerde informatie over de aanpak en mogelijke gevolgen voor u. Zo kan u een beslissing nemen op basis van juiste en volledige informatie.

Neem volgende informatie aandachtig door.

U kan met al uw verdere vragen terecht bij de onderzoekers waarvan de contactgegevens onderaan dit document terug te vinden zijn.

Deze studie werd goedgekeurd door de ethische comissie UZ/KU Leuven (referentienummer: S62662)

Essentiële informatie voor uw beslissing om deel te nemen:

1. **Praktisch verloop van de studie**

In dit informatieformulier worden alle onderdelen van de studie en de doelen ervan beschreven.

Verloop:

Deze focusgroep studie bevat twee onderdelen: een online focusgroep discussie met "member check" en een doorlichting met ervaringsdeskundigen.

U kunt aan een van de twee deelnemen. Voor beide wordt een evenwichtige deelname tussen mannen en vrouwen en nagestreefd. Daarnaast trachten we voor de focusgroepen ook een evenwicht te bekomen tussen de verschillende hulpverleners.

Ongeveer 40 personen worden geselecteerd om deel te nemen aan de focusgroep gesprekken verspreid over 4 focusgroepen. Voor de doorlichting met ervaringsdeskundigen zullen 8 ervaringsdeskundigen bevraagd worden.

Doel:

De studie beoogt een beter inzicht te krijgen in een samenwerkingsmodel voor eerstelijns hulpverleners dat ook gebruiksvriendelijk is voor de toekomstige patiënt. Dit door het inzamelen van meningen van personen met verschillende achtergrond.

A. **Focusgroep studie:**

Deelnemers aan de focusgroep studie worden uitgenodigd op een online groepsgesprek met andere belanghebbenden. Tijdens deze focusgroepen zullen enkele kernbegrippen van een samenwerkingsmodel besproken worden zoals:

- Welke taken kunnen eerstelijnshulpverleners, welzijnswerkers en gemeenschapsgerichte diensten opnemen om vroeg detectie en kort advies te faciliteren?
- Wat zijn aanvaardbare en haalbare principes voor een gestructureerde samenwerkingtussen verschillende eerstelijnswerkers om patiënten te begeleiden en helpen?
- Hoe kan de communicatie tussen de verschillende eerstelijnsberoepen i.v.m vroegdetectie en korte interventie bij alcoholgebruik geoptimaliseerd worden?

Er zal tijdens de focusgroepen geen aandacht gegeven worden aan de achtergrond en beroep van de deelnemers zodat iedereen zich vrij voelt om te spreken zonder barrières. Deze gegevens worden wel verzameld door de onderzoekers om tijdens de analyses ook een terugkoppeling te kunnen maken met individuele karakteristieken.

Om analyse van de focusgroepen mogelijk te maken zullen de gesprekken opgenomen worden (video). deze opnames worden na de focusgroepen uitgeschreven. Video opnames worden gemaakt om ook groepsdynamieken en expressies in kaart te brengen wat belangrijk is voor de interpretatie van de resultaten. Tijdens het uittypen zullen al de namen van de deelnemers vervangen worden door een pseudoniem om de anoniemiteit te garanderen in de daaropvolgende analyse. Ook tijdens het publiceren van de bevindingen zal enkel gebruik gemaakt worden van dit pseudoniem. De opnames van de focusgroepen worden zorgvuldig verwijderd na de analyse.

Na de analyse van de focusgroepen krijgt u als deelnemer een overzicht van de bevindingen. Via een online formulier kan u dan feedback geven op deze resultaten. Dit proces wordt een "member check" genoemd en dient ter controle voor het correct interpreteren van de resultaten door de onderzoekers. De gevens verzameld tijdens de member check worden gepseudonimiseerd vooraleer ze geanalyseerd worden.

Een focusgroep zal niet langer dan 2 uur in beslag nemen.
De member check zal ongeveer 30 minuten in beslag nemen.

B. Doorlichting met ervaringsdeskundigen

Ervaringsdeskundigen zullen na het analyseren van de focusgroepen samen met de onderzoeker door het zorgpad geloods worden om te zien of het ook gebruiksvriendelijk is voor toekomstige patiënten. Als ervaringsdeskundige zal u uitgenodigd worden op een online gesprek waar u samen met de onderzoeker het zorgpad zal doorlopen. U wordt gevraagd om uw ervaringen en bevindingen te delen over het ontworpen zorgpad. Dit gesprek zal opgenomen worden (video) om analyse mogelijk te maken. Deze opname zal met de nodige discretie verwijderd worden nadat ze uitgetyp zijn. Tijdens het uittypen zal uw naam ook vervangen worden door een synoniem om uw identiteit te beschermen. Enkel dit pseudoniem zal gebruikt worden tijdens de analyse van het gesprek en bij het publiceren van de resultaten. Dit gesprek zal niet meer dan 2 uur in beslag nemen.

2. Vertrouwelijkheid en gebruik van verzamelde gegevens

Naar aanleiding van de vernieuwde privacywetgeving, EU Verordening 2016/679, werden alle nodige maatregelen genomen om de vertrouwelijkheid van de verzamelde persoonsgegevens te waarborgen. Deze wetgeving, ook gekend als 'general data protection regulation' (GDPR) zorgt voor een bescherming van persoonlijke data van de Europese burger.

De gegevens die wij verzamelen zullen gepseudonimiseerd worden en zijn enkel beschikbaar voor de betrokken onderzoekers binnen het overkoepelende onderzoek, zoals eerder beschreven. Uw persoonsgegevens zullen op geen enkel moment vrijgegeven worden aan de onderzoekers of

daarbuiten. Eventuele referenties, in artikels of toekomstige onderzoeken, zullen enkel gebeuren door middel van gecodeerde gegevens, die niet terug te brengen zijn naar u. Uw toestemming om aan deze studie deel te nemen betekent ook dat uw gecodeerde gegevens gebruikt worden voor doeleinden, zoals beschreven in dit informatieformulier. De onderzoekers zullen de verzamelde gegevens gebruiken in het kader van de studie waaraan u deelneemt. De gegenereerde data van dit onderzoek zullen bewaard worden in analogie met de KU Leuven richtlijnen voor vijf jaar. Hierna zullen ze met de nodige zorg vernietigd worden.

Indien u klachten heeft omtrent de behandeling van uw persoonlijke informatie beschikt u over het recht om een klacht in te dienen, bij de Belgische toezichthoudende instantie die verantwoordelijk is voor het handhaven van de wetgeving inzake gegevensbescherming:

Gegevensbeschermingsautoriteit (GBA)
Drukpersstraat 35,
1000 Brussel
Tel. +32 2 274 48 00
e-mail: contact(at)apd-gba.be
Website: www.gegevensbeschermingsautoriteit.be

Uw gegevens zullen worden verwerkt overeenkomstig de Europese Algemene Verordening inzake Gegevensbescherming (AVG) en de Belgische Wetgeving betreffende de bescherming van natuurlijke personen met betrekking tot de verwerking van persoonsgegevens. KU Leuven is de verwerkingsverantwoordelijke voor uw gegevens.

U hebt het recht om aan de arts-onderzoeker te vragen welke gegevens hij/zij over u heeft verzameld en waarvoor ze gebruikt worden in het kader van de studie. U hebt het recht om deze gegevens in te kijken en om verbeteringen te laten aanbrengen indien ze foutief zouden zijn.

De arts-onderzoeker is verplicht om deze verzamelde gegevens vertrouwelijk te behandelen. Dit betekent dat hij zich ertoe verbindt om uw naam nooit bekend te maken in het kader van een publicatie of een conferentie en dat hij uw gegevens zal coderen (uw identiteit zal worden vervangen door een identificatiecode in de studie) voordat hij ze doorgeeft aan de beheerder van de databank (Academisch Centrum voor Huisartsgeneeskunde, KU Leuven, Leuven).

Indien u uw toestemming tot deelname aan de studie intrekt, zullen de gecodeerde gegevens die al verzameld waren vóór uw terugtrekking, bewaard worden. Hierdoor wordt de geldigheid van de studie gegarandeerd. Er zal geen enkel nieuw gegeven aan de opdrachtgever worden doorgegeven.

Indien u vragen hebt over hoe wij uw gegevens gebruiken, dan kan u hiervoor steeds terecht bij uw arts-onderzoeker. Ook de functionaris voor gegevensbescherming van het onderzoekcentrum staan ter uwer beschikking. De contactgegevens van deze laatste zijn als volgt: privacy@kuleuven.be.

3. Voordelen, risico's en belasting van de studie

Deelname aan deze studie zal u geen direct voordeel opleveren. Wij hopen dat de resultaten bekomen uit deze studie zullen kunnen bijdragen tot een verhogen van opsporing en bespreking van risico

gebruik van alcohol in de huisartsgeneeskunde en verhoogde samenwerking binnen de eerste lijn en met de geestelijke gezondheidszorg

Er wordt niet gevraagd wordt naar persoonlijke of vertrouwelijke informatie. U bent niet verplicht om op vragen te antwoorden waar u zich oncomfortabel bij voelt of die te persoonlijk zijn. Het niet antwoorden op vragen heeft geen gevolgen voor verdere contacten of deelname aan studies.

4. Vrijwillige deelname

U hebt het recht om op elk ogenblik vragen te stellen over het verloop, de belasting en de risico's van deze studie. U hebt steeds het recht om, om welke reden dan ook, uw medewerking aan ons onderzoek op te zeggen, zonder dat u hiervoor uitleg hoeft te geven. Dit kan op elk moment, ook wanneer de studie bezig is. U zal niet geweerd worden voor deelname aan toekomstige studies. We vragen daarover de onderzoekers dan op de hoogte te brengen. Uw deelname aan deze studie kan ook worden beëindigd door de onderzoeker omwille van belangenvermenging of als gemaakte afspraken niet worden gerespecteerd.

5. Kosten en vergoedingen

Deelname aan deze studie is op vrijwillige basis. Uw deelname zal geen bijkomende kosten met zich meebrengen.

6. Rol van de ABInbev Foundation

De ABInbev Foundation is een organisatie met als doel overmatig en schadelijk alcoholgebruik in de samenleving te verlagen. Daarnaast willen ze ook het verantwoord schenken van alcoholische dranken verbeteren. Om dit doel te bereiken financieren ze verschillende wetenschappelijke onderzoeken wereldwijd. De naam van de foundation is afkomstig van het bedrijf (AB Inbev) dat middelen voorziet aan de foundation om dergelijk onderzoek te steunen. Verder heeft het bedrijf geen relatie met dit onderzoek en de onderzoeksgroep.

De AB Inbev Foundation heeft geen inbreng in het wetenschappelijk proces van de onderzoeken die wij organiseren. Als onderzoeksgroep vinden wij het ook belangrijk om autonoom te kunnen werken zodat er integer en kwalitatief onderzoek kan verrichten worden.

De gegevens die tijdens dit onderzoek verzameld worden blijven binnen de onderzoeksgroep. Er worden geen gegevens (ruw of gecodeerd) doorgestuurd naar de financierder van dit onderzoek. Uw gecodeerde gegevens worden bewaard op beveiligde servers van de KU Leuven en worden behandeld zoals eerder beschreven.

7. Om te onthouden :

- ✓ Uw deelname is vrijwillig; er kan op geen enkele manier sprake zijn van dwang. Voor deelname is uw ondertekende toestemming nodig. Ook nadat u hebt getekend, kan u de onderzoeker laten weten dat u uw deelname wilt stopzetten. De beslissing om al dan niet (verder) deel te nemen zal geen enkele negatieve invloed hebben op de relatie met de betrokken onderzoekers voor toekomstige samenwerkingen.
- ✓ De gegevens die in het kader van uw deelname worden verzameld, zijn vertrouwelijk. Bij de publicatie van de resultaten is uw anonimiteit verzekerd.
- ✓ Er zijn geen bijkomstige kosten en er is geen vergoeding voorzien bij het vervolledigen van de studie.
- ✓ Indien u extra informatie wenst, kan u altijd contact opnemen met de onderzoeker of een medewerker van zijn of haar team.

8. Contact

Voor vragen met betrekking tot de rechten als deelnemer, kunt u contact opnemen met de Ethische Commissie Onderzoek UZ/KU Leuven

Tel +3216348600).

email: ec@uzleuven.be

Voor vragen of opmerkingen met betrekking tot het onderzoek kan u zich wenden tot één van de volgende personen:

Bram Pussig
Tel.: +32 16 32 51 42
E-mail: bram.pussig@kuleuven.be

Prof. Bert Aertgeerts
Tel: +32 16 37 72 78
E-mail: bert.aertgeerts@kuleuven.be

Dr. Mieke Vermandere
Tel: +32 16 37 72 81
E-mail: mieke.vermandere@kuleuven.be

9. Verklaring van de onderzoeker

Ik ondergetekende, onderzoeker, verklaar de benodigde informatie inzake deze studie mondeling alsook schriftelijk te hebben verstrekt evenals een exemplaar van het informatiedocument aan de deelnemer te hebben verstrekt.

Ik bevestig dat geen enkele druk op de deelnemer is uitgeoefend om hem/haar te doen toestemmen tot deelname aan de studie en ik ben bereid om op alle eventuele bijkomende vragen te antwoorden.

Ik bevestig dat ik werk in overeenstemming met de ethische beginselen en de Belgische wet van 25 mei 2018 inzake privacywetgeving.

Naam, voornaam en handtekening van de onderzoeker:

ANNEX II B. Online informed consent:

Deelnemer

Voornaam:
Naam:

Ik verklaar dat ik geïnformeerd ben over de aard, het doel, de duur en de voordelen van de studie en dat ik weet wat van mij wordt verwacht. Ik heb kennisgenomen van het informatiedocument. *

- Ja
- Nee

Ik verklaar dat ik voldoende de gelegenheid heb gehad om het informatieformulier te lezen en eventuele vragen te stellen. De vragen die ik gesteld heb werden duidelijk beantwoord door de onderzoekers. *

- Ja
- Nee

Ik begrijp dat er tijdens mijn deelname aan deze studie gegevens over mij zullen worden verzameld en dat de onderzoekers de vertrouwelijkheid van deze gegevens verzekeren overeenkomstig de Belgische wetgeving ter zake. *

- Ja
- Nee

Ik wens op de hoogte gehouden te worden van de resultaten van dit onderzoek. *

- **Ja**
- **Nee**

Zelfreflectie

Met als doel mij te informeren over de mogelijkheden van een doctoraatsonderzoek, nam ik contact op met Prof. Dr. Aertgeerts in september 2020. Ik stuurde hem een e-mail met een uitgewerkt voorstel van een onderzoeksonderwerp. Doctoreren als HAIO behoorde niet tot de mogelijkheden, maar aangezien mijn onderzoeksvoorstel over verslaving ging, bood hij mij aan om in het PINO-team te stappen en daar een onderdeel als ManaMa-thesis uit te voeren. Verheugd omwille van dit unieke aanbod waarbij de ManaMa-thesis in een groter doctoraatsproject terecht kwam en enorm dankbaar omwille van de geboden kans, ging ik meteen in op het voorstel. Enerzijds was het deel uitmaken van een onderdeel in een doctoraatsproject extra interessant voor mij omdat ik op die manier zicht kon krijgen op wat een doctoraatsonderzoek allemaal inhoudt. Anderzijds was het in het begin even moeilijk om een duidelijk overzicht te krijgen van welke onderzoeken er reeds lopende waren binnen het project en wie welke rol op zich nam.

Gezien de toen heersende COVID pandemie, gingen alle vergaderingen online door. Ondanks de afstand die was gecreëerd door COVID, voelde ik mij bij het eerste ontmoetingsgesprek al meteen welkom in de PINO-familie. Ik had de eer om in het team terecht te komen van Prof. Dr. Cathy Matheï, Prof. Dr. Mieke Vermandere, Prof. Dr. Bert Aertgeerts, Dr. Leo Pas en doctoraatstudent Bram Pussig. Vanaf dag één heb ik mij enthousiast ingezet ter realisatie van een project waar ik helemaal achter stond: het tegengaan van de schade die zelfs beperkt overmatig alcoholgebruik kan veroorzaken in de maatschappij. Des te meer gedreven was ik toen ik vernam dat Prof. Dr. Matheï eigenlijk een verslavingsarts was die zich gepassioneerd inzette voor de kwetsbare groepen in de gemeenschap. Ik keek er zo naar uit om van haar uitgebreide kennis en ervaring te leren, in de hoop om na de thesis nog verder te kunnen samenwerken. Maar het lot heeft jammer genoeg anders beslist. Prof. Dr. Matheï was blijkbaar al een tijdje aan het vechten tegen een zware ziekte. In augustus 2021 heeft ze de strijd verloren. Dit was een zware en moeilijke periode voor het PINO-team. Na het incasseren van deze zware klap kon er niet worden teruggeveerd. Ook Dr. Leo Pas kampte met ernstige gezondheidsproblemen waardoor de PINO-familie werd geherstructureerd. In de plaats van Prof. Dr. Cathy Matheï en Dr. Leo Pas, namen Prof. Dr. Aertgeerts en Prof. Dr. Vermandere de ouderschapsrol/leiding over en daarbij vond ook een zekere verandering van visie en aanpak van de thesis plaats. Waar het oorspronkelijke plan de uitvoering van een Delphi-studie beoogde, veranderde deze werkwijze naar een focusgroepstudie met de daarmee gepaard gaande aanpassingen in het ontwerp en de realisatie. Dit vroeg wat flexibiliteit van ons als onderzoekers, maar voor mij was het vooral leerrijk om op die manier de verschillende kwalitatieve onderzoeksmethoden te ontdekken.

Op donderdag vond er een wekelijks vergadermoment plaats met alle PINO-leden. Ik had het geluk om in het eerste jaar van mijn HAIO-schap in een praktijk te zijn terecht gekomen die zich soepel opstelde en die me toeliet de tijd te nemen om aanwezig te zijn op deze wekelijkse vergadering. In geval van nood of drukte echter, gaf ik voorrang aan mijn werk. Er werd achteraf een verslag rond gestuurd met de belangrijkste punten van de vergadering, zodat iedereen steeds op de hoogte was. Ik vond het toch belangrijk om aanwezig te zijn of op de hoogte te zijn van de vorderingen binnen het volledige PINO-project, omdat ik mij ook graag inzette voor het bredere project dan enkel mijn thesis. De eerste maanden heb ik ook een bijdrage geleverd aan de andere reeds lopende projecten: ik heb onder andere een e-learning doorlopen en suggesties tot aanpassingen gedaan, een aanzet gegeven voor een PINO-promotiebericht in de actua van het ICHO, meegeholpen aan de rekrutering van HAIO's en huisartsen (via mail, telefoon) voor het PINO-onderdeel met de e-learning (11 ingevulde feedbackformulieren verkregen) en vragenlijsten nagelezen. Door dit allemaal te doen, voelde ik mij nog meer deel van de

PINO-familie en werd het ook allemaal veel duidelijker waar de andere PINO-onderdelen specifiek over handelden.

Eind januari 2021 is Ali Faridoon bij het PINO-team gekomen en mochten we samenwerken aan eenzelfde onderdeel van het PINO-project voor onze ManaMa-thesis. Op dat ogenblik was door mij al heel wat opzoekingswerk gerealiseerd en was ik ook al helemaal ingewerkt in het PINO-team. Gezien deze voorsprong en wetende hoe moeilijk het initieel was geweest voor mij om de structuur van het uitgebreide PINO-web te begrijpen, heb ik meteen voorgesteld om met Ali af te spreken. In een ZOOM-meeting heb ik hem dan zo duidelijk mogelijk alle onderdelen van PINO uitgelegd en hem dit middels een schema gevisualiseerd. Omdat ik uiteraard al verder stond met het inlezen van het thesisonderwerp, werd met de promotoren afgesproken dat ik mij initieel zou focussen op het uitschrijven van de introductie en Ali op de methode.

Wat de rekrutering van de deelnemers betreft, hebben we ook enige flexibiliteit aan de dag moeten leggen. Gezien niet iedereen op dinsdag bereikbaar was, heb ik noodgedwongen tussen de consultaties en/of huisbezoeken door telefoontjes gepleegd. Gelukkig kon ik dit altijd bespreken in de praktijk en dit goed inplannen. Ali en ik hadden de beroepsgroepen onder elkaar verdeeld en indien nodig, hielpen we elkaar bij het verder zoeken en rekruteren. Gezien de COVID-pandemie was het niet eenvoudig om bereidwillige en beschikbare deelnemers te vinden. Als hulp en ter ondersteuning van het gebruik van de Nederlandse taal door Ali, had ik een draaiboek uitgeschreven voor de telefonische contacten alsook de e-mails opgesteld om uit te sturen naar alle geïnteresseerden.

Voor mij was het heel interessant om aanwezig te zijn bij de focusgroepen als observator, waarvoor ik het draaiboek had opgesteld. Zo kon ik kennis maken met deze specifieke manier van onderzoek en ook aanschouwen welke dynamiek zich afspeelt tussen de deelnemers. Ik heb zowel een online als live focusgroep meegemaakt. Dit vond ik leerrijk om toch de verschillen in interactie te zien tussen beide uitvoeringen. De beperkingen van het online gebeuren werden meteen duidelijk (non-verbale expressie, onderbreken, vlottere communicatie enz..).

Het uitschrijven van de opgenomen focusgroepen heb ik op mij genomen omdat dit geen gemakkelijke opdracht is voor iemand die de Nederlandse taal niet als moedertaal heeft. Nadien bleek ook de interpretatie van de resultaten uit de focusgroepen soms moeilijk te verlopen om dezelfde reden. Het opstellen van de codeboom is dan ook bijzonder moeizaam verlopen. Het werd meer het overlopen van mijn bevindingen en interpretaties van de resultaten dan echt een dynamisch en interactief groepswerk. Nochtans heb ik de tijd noch moeite gespaard om mijn manier van aanpak duidelijk uit te leggen, hebben we de promotoren aangesproken om ons bij te staan in het analyseproces en stond ik altijd open voor vragen. Alhoewel ik alle begrip heb voor de zware periode die Ali moe(s)t doorstaan ben ik toch wat ontgoocheld in het samenwerkingsverloop, aangezien het “samen” overleggen en het discussiëren het kwalitatieve onderzoek naar een hoger niveau kon tillen.

Maar de tijd begon te dringen en het werd mij stilletjes aan duidelijk dat ik mij de rol van manager moest aanmatigen die zorgde voor een duidelijke communicatie van de taken en het bepalen van deadlines. In overleg met de promotor werd het coderingsproces in ATLAS.ti opgedeeld zodat ieder twee focusgroepen had om de codes in aan te duiden. Het samen met Ali overlopen van mijn structuur van de analyse vond ik heel leerrijk en verhelderend. Hier merkte ik dat Ali goed is in het creëren van een algemeen overzicht met de focus op het geheel, maar minder beslagen is in de interpretatie van de details. Op basis hiervan is dan in overleg met de promotor beslist dat de discussie door Ali zou worden uitgewerkt en door mij de resultaten zouden worden uitgeschreven.

Bij het schrijven van de resultaten vond ik het moeilijk om er niet mijn eigen interpretatie aan te geven of de voor mij meest interessantste quotes uit te lichten. Dit was een heel leerzaam proces, want

dankzij het coderingsproces heb je al heel vaak stil gestaan bij de verschillende visies en door telkens terug te keren naar de focusgroepen vorm je eigenlijk automatisch wel een correct beeld van wat er in het algemeen gezegd wordt. Toch zijn ook de alleenstaande meningen niet onbelangrijk en dienen deze ook vermeld te worden, zeker in kleinschalig onderzoek. Het was natuurlijk wel een uitdaging om dit zo kort mogelijk samen te vatten. Ali heeft een mooie aanzet gegeven aan de discussie en het abstract doch door de tijdsdruk heb ik dit deel verder aangevuld, alsook de conclusie geschreven. De volledige afwerking en laatste praktische zaken heb ik eveneens grotendeels voor mijn rekening genomen.

Samenwerken met Ali heeft mij heel wat bijgebracht op cultureel vlak. Als vluchteling uit Afghanistan lichtte hij mij in over de gruwelijke gebeurtenissen die zich daar afspelen en over de zware periode die hij reeds had doorstaan, maar ook nog altijd meemaakte. Ik heb enorm veel medeleven en begrip voor zijn situatie. Daarom dat ik het ook geen probleem vond om iets meer taken op mij te nemen, zeker indien een goede kennis van het Nederlands vereist was. Ali was altijd uitgesproken dankbaar en vriendelijk, iets wat mij opviel. Ik heb vastgesteld dat het voor hem toch moeilijk was om hulp of bijkomende informatie/verduidelijking te vragen. Ondanks mijn herhaaldelijke vraagstelling of alles duidelijk was, bleek dat nadien niet het geval te zijn doch werd dit niet gemeld waardoor de voortgang haperde. Ik heb me er altijd, vol enthousiasme, voor gesmeten, van begin tot einde. We hebben ons best gedaan en ik geloof dat de thesis een mooi resultaat is geworden.

Gezien mijn interesse in de verslavingszorg, heb ik het als enorm leerrijk ervaren om in het kader van deze masterproef eens te gaan kijken naar de stadia die verslaving voorgaan. Voorkomen is nog altijd beter dan genezen. Bij de uitvoering van deze thesis vond ik het zeer boeiend om mij hierin te verdiepen en vooral om tijdens de focusgroepen de expertise en visies van ervaren mensen in het werkveld te exploreren. Het belang van een algemene bekendheid van de richtlijnen rond alcoholgebruik kwam duidelijk naar voor alsook het probleem van het heersende stigma om erover te kunnen praten. Vanuit de overheid zijn er reeds verschillende sensibiliseringacties op poten gezet, zoals de BOB-campagne en Tournée Minérale. Ondanks deze inspanningen blijft de alcoholconsumptie te hoog met de bijhorende schade op verschillende domeinen als gevolg. Ik hoop dat we met onze studie een bijdrage kunnen leveren aan het ontwikkelen van een zorgpad waar alle actoren van de eerste lijn samenwerken om deze info tot bij de mens te brengen en overmatig alcoholgebruik in een vroeger stadium op te sporen zodat erger kan worden voorkomen. Door zoveel mogelijk mensen in te schakelen, die op zoveel mogelijk momenten de patiënt kunnen inlichten over het problematisch alcoholgebruik, kan het proces van bewustwording sneller in gang gezet worden. Aan de thema's preventie en verslaving hecht ik veel belang en de conclusies die we uit deze studie hebben kunnen trekken neem ik alvast zelf zeker mee naar de praktijk.