# “Up To Date”

## **U**se of psychoactive substances in adults: **P**revention and **T**reatment by general practitioners and **O**ccupational physicians; **DAT**a retri**E**val

Final report

Book 2

March 2015

# “Up To Date”

## Use of psychoactive substances in adults: Prevention and Treatment by general practitioners and Occupational physicians; DATa retriEval


**UNIVERSITE DE LIEGE**

Marc VANMEERBEEK

Philippe MAIRIAUX

André LEMAÎTRE

Marc ANSSEAU

Frédéric KETTERER

Danièle PIRENNE

Isabelle DEMARET

**SCIENTIFIC INSTITUTE OF PUBLIC HEALTH**

Viviane VAN CASTEREN

Nicole BOFFIN

Jérôme ANTOINE

**UNIVERSITEIT ANTWERPEN**

Roy REMMEN

Lieve PEREMANS

Geert DOM

Kathleen VAN ROYEN

Lynda SYMONS

**KATHOLIEKE UNIVERSITEIT LEUVEN**

Lode GODDERIS

Marie-Claire LAMBRECHTS

**VERENIGING VOOR ALKOHOL- EN ANDERE DRUGPROBLEMEN vzw**

Marie-Claire LAMBRECHTS

General coordination: Pr Marc VANMEERBEEK, ULg

marc.vanmeerbeek@ulg.ac.be


Final report

Book 2

March 2015

# Table of contents

**WHAT FACTORS DETERMINE BELGIAN GENERAL PRACTITIONERS' APPROACHES TO DETECTING AND MANAGING SUBSTANCE ABUSE? A QUALITATIVE STUDY BASED ON THE I-CHANGE MODEL** ..... **10**

**ABSTRACT** ..... **11**

**Background** ..... **11**
**Methods** ..... **11**
**Results** ..... **11**
**Conclusions** ..... **11**

**BACKGROUND** ..... **13**

**METHODS** ..... **13**

**Conceptual model** ..... **13**
**Data collection** ..... **15**
*Sampling procedure* ..... *15*
**Interviewing procedure** ..... **15**
**Analyses** ..... **15**

**RESULTS** ..... **16**

**Predisposing factors: the influence of practice location** ..... **16**
**Awareness factors: abuse management requires specific and nonspecific skills** ..... **17**
**Motivation factors: GPs' personal representations influence management** ..... **18**
**Intention state: GPs also proceed through a motivational process** ..... **20**
**Ability factors (and barriers): one cannot handle this alone** ..... **20**

**DISCUSSION** ..... **21**

**Major results** ..... **21**
**GPs' representations of substance abuse** ..... **21**
**Training** ..... **22**
**Collaboration** ..... **22**
**Strengths and limitations** ..... **22**

**CONCLUSIONS** ..... **23**

*Ethical approval* ..... *23*
*Competing interests* ..... *23*
*Authors' contributions* ..... *23*
*Acknowledgement* ..... *23*
*Funding* ..... *24*

**REFERENCES** ..... **24**

*Supplementary Material: Interview guide* ..... *27*

**SUBSTANCE ABUSE MANAGEMENT BY BELGIAN GPS: OPINIONS AND INFLUENCING FACTORS. A QUANTITATIVE STUDY** ..... **28**

INTRODUCTION ..... **29**

METHODS ..... 30
Questionnaire ..... 30
Analysis ..... 31
RESULTS ..... 31
Respondents' characteristics ..... 31
Study findings ..... 32
*Definition of substance abuse, according to the GPs* ..... 32
*Attitude of GPs towards substance abuse management* ..... 33
*Place of GPs in a multidisciplinary management of substance abuse* ..... 33
*Support for GPs* ..... 33
Predictors of GPs' engagement in substance abuse management. Multivariate analysis ..... 34
*Predictors of GPs' engagement in alcohol abuse management* ..... 34
*Predictors of GPs' engagement in hypnotics and tranquillisers abuse management* ..... 34
*Predictors of GPs' engagement in cannabis abuse management* ..... 35
*Predictors of GPs' engagement in other illegal drugs abuse management* ..... 35
DISCUSSION ..... 36
Major results ..... 36
*Different representations of the substances* ..... 36
*Motivational factors* ..... 36
*Knowledge* ..... 37
*Support* ..... 37
*Training* ..... 37
Limits ..... 37
CONCLUSION ..... 38
REFERENCES ..... 38
**THE APPROACH TAKEN TO SUBSTANCE ABUSE BY OCCUPATIONAL PHYSICIANS: A QUALITATIVE STUDY ON INFLUENCING FACTORS** ..... 40
**ABSTRACT** ..... 41
**Objective** ..... 41
**Methods** ..... 41
**Results** ..... 41
**Conclusions** ..... 41
**BACKGROUND** ..... 41
**METHODS** ..... 42
**Conceptual model** ..... 42
**Participants** ..... 43
**Data collection and analysis** ..... 44
**RESULTS** ..... 45
**Specific work context of OPs: an important predisposing and facilitating factor** ..... 45
**Awareness: knowledge and problems in job performance as cue to action** ..... 47

**The importance of motivational factors of OPs, especially attitudes** ..... **48**
**Intention whether to act or not is influenced by barriers and ability factors** ..... **49**

**DISCUSSION** ..... **50**
**Importance of a supportive alcohol and drug policy** ..... **50**
**Health promotion on the work floor** ..... **50**
**Attitude: "a little thing that makes a big difference"** ..... **51**
**Focus on skills and motivational interviewing** ..... **51**
**Need for evidence-based directives and short-term interventions** ..... **51**
**Time as a key obstacle** ..... **52**
**Limitations** ..... **52**
**Conclusions** ..... **52**
**References** ..... **53**

**WHAT FACTORS DETERMINE THE APPROACH OF SUBSTANCE ABUSE OF EMPLOYEES BY OCCUPATIONAL PHYSICIANS? AN ONLINE-SURVEY BASED ON THE I-CHANGE MODEL** ..... **59**

**BACKGROUND** ..... **60**

**METHODS** ..... **60**

**RESULTS** ..... **60**

**CONCLUSIONS** ..... **61**

**MIRRORED VIEW** ..... **62**

**INTRODUCTION** ..... **63**

**METHOD** ..... **63**
**The nominal group technique** ..... **63**
**Selection and invitation of participants** ..... **64**
**Organisation of a NGT meeting** ..... **64**
**Results** ..... **67**
*Recruitment process* ..... *67*
*Participant's expectations about GPs* ..... *68*
*Most important themes selected by the participants for GPs* ..... *69*
*Expectations about OPs* ..... *72*
**Discussion** ..... **75**
*Process* ..... *75*
*Main findings for GPs* ..... *75*
*Main findings for OPs* ..... *76*
*Strengths and weaknesses* ..... *76*
**Conclusion** ..... **76**
**References** ..... **77**
**More references on the nominal group technique** ..... **78**
**Appendix 1: Code structure for GPs** ..... **79**
**Appendix 2: code structure for OPs** ..... **81**

**INTERNATIONAL COMPARISON** ..... **83**

**OBJECTIVE** ..... **84**

**METHODS** ..... **84**
**Literature research** ..... **84**
**Grey literature research through expert networks** ..... **84**
**RESULTS** ..... **85**
*Feasibility of routine alcohol screening in a primary care environment (1)* ..... *86*
*Effectiveness of skills-based training using the Drink-less package to increase family practitioner confidence in intervening for alcohol use disorders (2)* ..... *88*
*["Drinking less is better". Combining early identification and brief intervention for patients at risk] (3)* ..... *89*
*Engaging the reluctant GP in care of the opiate misuser: Pilot study of change-orientated reflective listening (CORL).(4)* ..... *90*
*Cannabis use and the GP: brief motivational intervention increases clinical enquiry by GPs in a pilot study (5)* ..... *91*
*Encouraging GP alcohol intervention: Pilot study of change-orientated reflective listening (CORL). (6)* ..... *92*
**DISCUSSION** ..... **92**
**Methods used** ..... **92**
*Personal involvement of the GPs* ..... *92*
*Specific tools* ..... *93*
*Public health involvement* ..... *93*
*Incentives* ..... *93*
**Outcomes** ..... **93**
*Motivation of the GPs* ..... *93*
*Organizational factors* ..... *94*
**CONCLUSIONS** ..... **94**
**REFERENCES** ..... **96**
**VALORISATIEFASE. BESCHRIJVING EN RESULTATEN** ..... **97**
A. INLEIDING ..... **98**
B. BELANG VAN VALORISATIE ..... **98**
C. METHODE ..... **100**
Kenmerken LSI ..... **100**
D. VALORISATIEPROCES ..... **101**
Huisartsen ..... **101**
*Organisatie* ..... *101*
*Deelnemende LOKs – GLEMs* ..... *102*
*Toelichting resultaten en toetsing* ..... *102*
*Samenvatting toetsing bij huisartsen* ..... *109*
Arbeidsgeneesheren ..... **109**
*Organisatie* ..... *109*
SLOTCONFERENTIE ..... **110**

Organisatie ..... 110
Programma ..... 110
Resultaten ..... 110
*Deelnemers* ..... *110*
*Evaluatie programma en organisatie* ..... *111*
*Discussieronde* ..... *111*
***Procesevaluatie*** ..... **114**

AANBEVELINGEN ..... 115

REFERENTIES ..... 116

# Part 3/1

# What factors determine Belgian general practitioners' approaches to detecting and managing substance abuse? A qualitative study based on the I-Change Model

Frederic Ketterer[1]
Linda Symons[2]
Marie-Claire Lambrechts[3]
Philippe Mairiaux[4]
Lode Godderis[3,5]
Lieve Peremans[2,6]
Roy Remmen[2]
Marc Vanmeerbeek[1]

1 Department of General Practice/Family Medicine, University of Liege
2 Department of Primary and Interdisciplinary Care, University of Antwerp
3 KU Leuven, University of Leuven, Centre for Environment and Health
4 Department of Occupational Health and Health Promotion, University of Liege
5 IDEWE, External Service for Prevention and Protection at Work
6 Department of Public Health, Vrije Universiteit Brussels

Ketterer F, Symons L, Lambrechts MC, Mairiaux P, Godderis L, Peremans L, Remmen R, Vanmeerbeek M. **What factors determine Belgian general practitioners' approaches to detecting and managing substance abuse? A qualitative study based on the I-Change Model**. BMC Fam Pract. 2014 Jun 14;15:119.

# Abstract

## Background

General practitioners (GPs) are considered to play a major role in detecting and managing substance abuse. However, little is known about how or why they decide to manage it. This study investigated the factors that influence GP behaviours with regard to the abuse of alcohol, illegal drugs, hypnotics, and tranquilisers among working Belgians.

## Methods

Twenty Belgian GPs were interviewed. De Vries' Integrated Change Model was used to guide the interviews and qualitative data analyses.

## Results

GPs perceived higher levels of substance abuse in urban locations and among lower socioeconomic groups. Guidelines, if they existed, were primarily used in Flanders. Specific training was unevenly applied but considered useful. GPs who accepted abuse management cited strong interpersonal skills and available multidisciplinary networks as facilitators.

GPs relied on their clinical common sense to detect abuse or initiate management. Specific patients' situations and their social, psychological, or professional dysfunctions were cited as cues to action.

GPs were strongly influenced by their personal representations of abuse, which included the balance between their professional responsibilities toward their patients and the patients' responsibilities in managing their own health as well the GPs' abilities to cope with unsatisfying patient outcomes without reaching professional exhaustion. GPs perceived substance abuse along a continuum ranging from a chronic disease (whose management was part of their responsibility) to a moral failing of untrustworthy people. Alcohol and cannabis were more socially acceptable than other drugs. Personal experiences of emotional burdens (including those regarding substance abuse) increased feelings of empathy or rejection toward patients.

Multidisciplinary practices and professional experiences were cited as important factors with regard to engaging GPs in substance abuse management. Time constraints and personal investments were cited as important barriers.

Satisfaction with treatment was rare.

## Conclusions

Motivational factors, including subjective beliefs not supported by the literature, were central in deciding whether to manage cases of substance abuse. A lack of theoretical knowledge and training were secondary to personal attitudes and motivation. Personal development, emotional health, self-awareness, and self-care should be taught to and

fostered among GPs to help them maintain a patient-centred focus. Health authorities should support collaborative care.

Keywords: General practitioners, Substance abuse, Attitudes of health personnel, Motivation, I-Change Model

# Background

The social and economic effects of alcohol and other drugs on society are substantial, but they largely depend on the type of drug. In 2010, alcohol use was the third leading risk factor for global disease burden [1]. Alcohol use plays a role in more than 60 major diseases and injuries. Worldwide, it results in approximately 2.5 million deaths each year [2]. Occasional or regular heavy drinking can damage health [3]. In addition, the use of illicit drugs is an important and increasing contributor to the global burden of disease [1,4]. The United Nations Office on Drugs and Crime (UNODC) estimates that between 102,000 and 247,000 drug-related deaths occurred in 2011 [5]. Cannabis is the most frequently used illegal substance in Europe [6]. Benzodiazepine abuse is a problem that remains largely unrecognised in many countries [7]. Europe has the highest average consumption of sedative-hypnotics and anxiolytics [7].

In Belgium, 10% of alcohol consumers aged 15 or older are problematic drinkers [3]. In 2008, 15% of Belgians reported having used painkillers, tranquilisers, or sleeping aids over the past two weeks. Over the past 12 months, 5% and 1.5% of the population had used cannabis and another illegal drug (e.g., MDMA, cocaine, and heroin), respectively [3].

General practitioners (GPs) are considered to play a major role in detecting and managing the problems related to substance abuse, regardless of its legality. However, previous work by Glanz, Gabbay and Deehan in the United Kingdom demonstrated that GPs view alcohol or drug misusers as undesirable patients [8-11]. Difficulty in managing and treating these patients raises concerns about the GPs' feeling of competence and their confidence [12]. Attempts to provide specific training on this topic by Strang and McCambridge showed a limited impact, particularly regarding motivational aspects; thus, a better understanding of GP views and perspectives on substance misuse and misusers is essential [13-15]. In Belgium, little is known concerning GPs' interests and attitudes toward caring for these patients or their management skills with regard to substance abuse behaviour.

This study is part of the "Up to Date" research project seeking to describe the approaches of GPs and occupational physicians (OPs) to the detection and management of the abuse of alcohol, illegal drugs, hypnotics, and tranquilisers among the Belgian population and to recommend ways to promote multidisciplinary collaborative care for these patients [16]. This paper describes only the GP arm of the study; the symmetry between the GP and the OP arms limited the topic to the working Belgian population (18-65 years old).

# Methods

## Conceptual model

This qualitative survey sought to answer the following question: "What are the experiences, attitudes, perspectives, and decision-making skills of GPs with regard to the abuse of alcohol, illegal drugs, hypnotics, and tranquilisers?" The survey sought to understand GPs' points of view. The representations of substance abuse were considered a "guide to action" [17,18]; thus, GPs' opinions were used to understand how they act.

We used de Vries' model as a conceptual framework (Figure 1) [19]. The Integrated Model (I-Change Model) for explaining motivational and behavioural change was derived from the Attitude–Social influence–Self-Efficacy Model [20,21], which is an integration of Ajzen's Theory of Planned Behaviour, Bandura's Social Cognitive Theory, Prochaska's Transtheoretical Model, the Health Belief Model, and goal setting theories [22]. The I-Change Model was used to study various and complex clinical situations in patients and the behaviour of health professionals (smoking cessation, public perceptions regarding hereditary cancer, reporting of child abuse, and midwife behaviour) [19,23-25]. This broad applicability and the embedded motivational cycle guided our choice of this model.

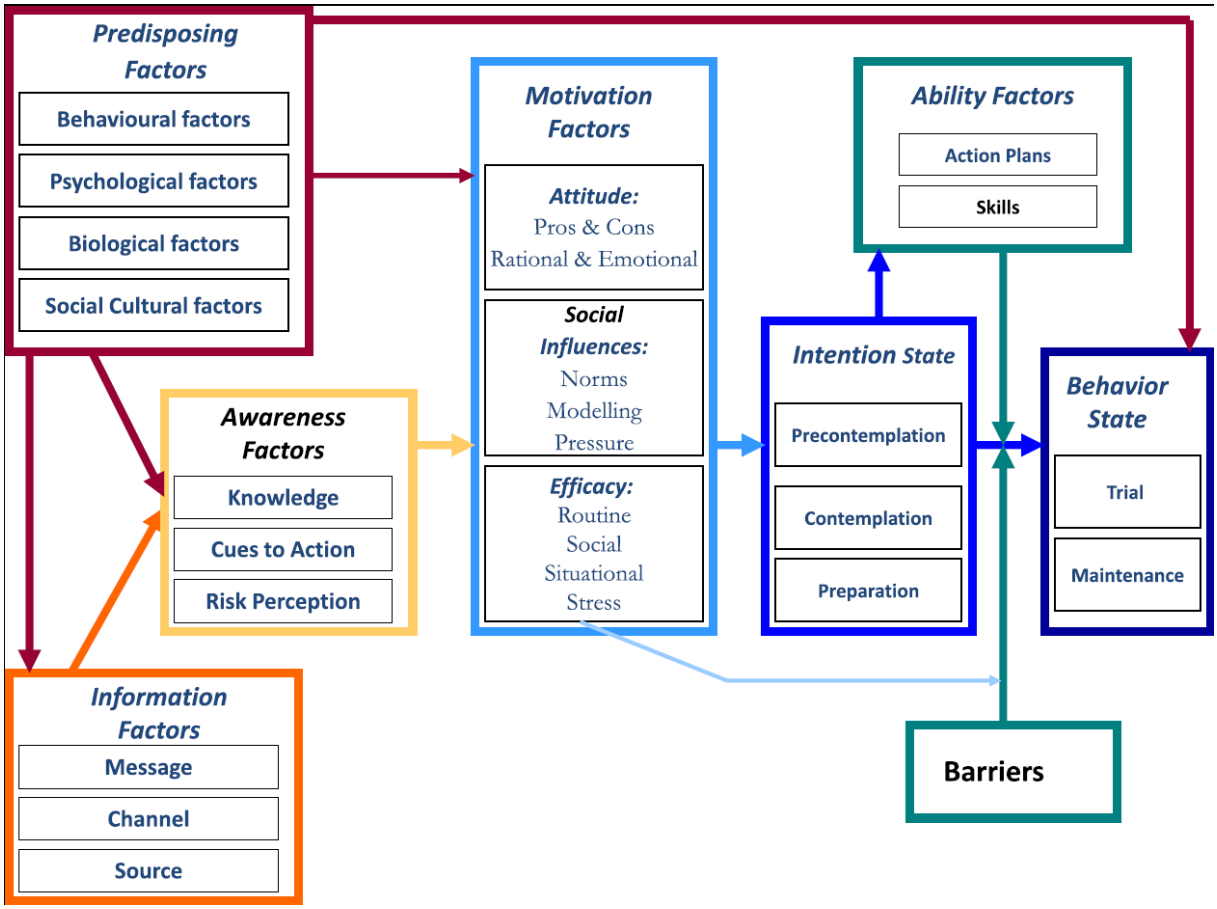



**Figure 1: The I-Change Model[19].**

Working with the I-Change model allowed us to distinguish between the factors that underlie GP decisions to care for patients with a problematic alcohol or drug use (e.g., knowledge and critical beliefs) and the factors resulting in differences between intentions and behaviours (e.g., skills). The major obstacles can be identified by deconstructing the process of intention into separate units (predisposal, awareness, information and motivational factors, abilities and barriers) and searching for the links between them. This article presents the results as a synthesis of the main results, and the results are classified according to the I-Change Model units.

# Data collection

## Sampling procedure

Chairs of the local "GP Circles" and "Local Quality Evaluation Group" of the provinces of Antwerp and Liege connected us with GPs. These recruited GPs did not necessarily possess particular expertise in substance abuse; on the contrary, GPs working in specialised abuse clinics were excluded. First, the GPs were invited to complete a short questionnaire regarding their experience in the field and their practice profile. Second, the respondents were sampled to retrieve a variety of clinical profiles based on sex, age, reported experience in substance abuse management, practice location (rural or urban), and type of practice (single or group).

Ten GPs working in the Dutch-speaking province of Antwerp and ten working in the French-speaking province of Liege were selected. Their sociodemographic characteristics are summarised in Table 1.

**Table 1: Sociodemographic characteristics of participants**

| | Sex | | Practice type | | | Experience | | | Practice location | |
|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | Individual | Group | Medical Homes | < 10 years | 10 - 30 years | > 30 years | Urban | Rural |
| Liege (French) | 6 | 4 | 5 | 2 | 3 | 2 | 5 | 3 | 5 | 5 |
| Antwerp (Dutch) | 4 | 6 | 2 | 6 | 2 | 3 | 5 | 2 | 6 | 4 |
| Total | 10 | 10 | 7 | 8 | 5 | 5 | 10 | 5 | 11 | 9 |

In Belgium, GPs work in the context of a liberal healthcare system. The fee-for-service payment system predominates. However, GPs working in one of the 100 multidisciplinary primary healthcare centres (i.e., "medical homes") are paid on a capitation basis. These centres, whose patients are bound by a contract of care, serve 3% of the population, primarily in urban and deprived areas [26].

# Interviewing procedure

Trained interviewers (FK, LS, and MV) conducted the dialogues at the GPs' practices in the second half of 2012. A semi-structured interview guide, initiated from a clinical case, based on the I-Change Model and created via consensus between the researchers, was used (Additional file 1).

The duration of the interviews was approximately 1.5 hours. All were audio recorded and transcribed with the informed consent of the respondents. Data saturation was not examined because this study was an exploratory first step for creating a questionnaire.

# Analyses

The constant comparison technique was used in this analysis, which originates from the respondents' replies verbatim. French- and Dutch-speaking researchers coded the first interviews independently using NVivo 10 software. The codebooks were then compared, discussed, and merged using an iterative consensus process in which the two teams approximated the wording of participants. The I-Change Model was used as a "sensitising concept" [27]. The codebooks were flexible until the end of the process. Both teams included bilingual researchers.

# Results

## Predisposing factors: the influence of practice location

Practice location was perceived as a strong influence on GPs' experience with substance abuse management: Urban locations, patients of low socioeconomic class, and a high proportion of migrants were associated with a higher perceived prevalence of abuse, especially illegal drugs.

> *"In general, all goes well because we remain… [in] the privileged countryside; there are very, very few (and I am not a racist) foreigners. I do not have a single drug addict among my patients. There are no secrets; we deal with people who are clever and live in satisfactory socioeconomic conditions". GP 16, Female (F), 35 year (y), French-speaking (Fr)*

Abuse was mentioned among patients with low socioeconomic level, young age, psychiatric problems, social and professional dysfunctions, private life problems, social and ethnic origin (migrants from northern Africa), unemployment, relationship problems, and child protection problems.

> *"Unfortunately, I think that more alcohol abuse occurs in less privileged environments, although in certain privileged backgrounds alcohol abuse also exists, and, in my opinion, even more so…. There is also a problem of medication abuse among families who are a little less privileged; this is the feeling that I have". GP14, Male (M), 62 y, Fr*

Some GPs cited the facilitating role of the capitation payment system because it allows extended consultation times. However, it was also thought to improve access among illegal drug and alcohol abusers, increase the referral rate from addiction treatment centres, and increase the number of addicted patients.

> *"Expertise is increasing in the medical homes because it is well known that we work in multidisciplinary teams; there is more global care, better accessibility, [and] therefore, naturally, [one cares for] people who withdraw from therapy or leave the Alpha centre etc…. The [social] workers… will maybe say to themselves… that a medical home will be more suitable because [it is a] more integrated… type of care than service providers who are on their own". GP17, M, 37 y, Fr*

In contrast, the fee-for-service system and individual practices were mentioned as being less in favour of substance abuse management. Specifically, the GPs mentioned difficulties with regard to refusing prescriptions for hypnotics and tranquilisers.

> *"If a patient only comes for a prescription, which is common because it is fee-for-service, then it is sometimes difficult to say, 'I am not going to prescribe [that drug]'. And then the patient stands there asking, 'Will I have to pay, then?' Yes, actually; but that does make it difficult, ethically speaking. In our community health centre, I simply tell them, 'I'm sorry. We can't do that'. We can easily refuse". GP 9, F, 29 y, Dutch-speaking (Nl)*

## Awareness factors: abuse management requires specific and nonspecific skills

GPs did not use peer-reviewed literature to support their practices. GPs, especially those in Flanders, mentioned the lack of guidelines regarding illicit drugs. GPs who supervised trainees in their practice more easily accessed such information.

> *"Mr. X reported that he occasionally uses cocaine. I think that is okay, but is it really okay? I would like to [review] the guideline; that [might] help me. [Then], if he comes back another time, I [would] know exactly what I should ask so that there is less guess work.... It does not have to be a novel or anything like that; something short… a consensus text, a guide… [that helps] you proceed with someone who reports [drug abuse]". GP10, F, 43 y, Nl*

The classifications of "misuse," "addiction," or "problematic use" were rarely known or used. The recommended maximum intake for alcoholic beverages by the World Health Organisation (WHO) was much better known than that for illicit drugs. Few GPs used screening tests for patients at risk, and some used the CAGE-test [28]. GPs did not consider systematic screening as part of their job, or they did not feel comfortable doing so. Only a few GPs mentioned the use of blood or urine tests.

> *"Yes. Imagine that you have come for a consultation for the first time, and you have [dysmenorrhea]. Should I ask whether you use drugs? Yes, I am somewhat reluctant to ask that of everyone as a standard question.... No, I do not do that. Maybe I should; I do not know…" GP 2, M, 51 y, Nl*

A confident relationship based on strong interpersonal skills and a patient-centred approach seemed to predict the successful management of substance abuse. Although this competency was central, it seemed to be due to the personalities of the GPs in Wallonia; specific training to encourage this behaviour rarely occurred. In Flanders, GPs more often considered communication skills training as *conditio sine qua non* to manage these types of patients. These skills included motivational interviewing, cognitive behavioural therapy, and systems thinking. GPs described patient management as a package of tailored and flexible interventions, built around shared and realistic objectives, appropriate to the real world.

> *"That depends on the objectives that you set [for] yourself: Is it to reduce risk, or is it to put an end to substance abuse? It is important to define that at the beginning". GP17, M, 37 y, Fr*

> *"Yes, the first thing is to open it [up] for discussion. They have to feel that they can discuss anything here. And that it can be discussed in a non-normative manner, now and in the future.… I frame it as a dilemma. You have to be able to come up with your own agenda. And I should not be able to determine your agenda; that is one ideal". GP 2, M, 51 y, Nl*

Important differences in training among the GPs were reported. Those who were most involved in substance abuse management had undertaken Continuous Professional Development (CPD) or network collaborations concerning this topic. Young Flemish GPs trained in communication skills specifically expressed that this training was particularly helpful for substance abuse management.

> *"You see, I guess you could say that I was trained before the war. We read a bit of theory about substance [abuse], but we did not know anything about conversational techniques.*

*And that is what you need: how you should address it with this person or that person". GP 8, M, 59 y, Nl*

The GPs discussed how their attitudes changed as a result of becoming more experienced. Starting from an idealistic or anxious point of view, feeling intrusive, with little life experience and only their education, some of them gradually moved toward a more pragmatic method of addressing abuse without antagonising the patient.

> *"For example, with a 60-year-old man with an alcohol problem… because of my age and the comfortable life that I lead, you almost feel guilty pointing fingers and saying, 'You have a problem,' you see. I cannot imagine it; I say that as well". GP 1, F, 29 y, Nl*

## Motivation factors: GPs' personal representations influence management

Personal, familial, or professional experiences of substance abuse were mentioned as influencing GPs' behaviours toward patients who exhibited these behaviours. Some GPs refused to treat these patients, whereas others cared for them with increased empathy and consideration. Personal histories, deep emotions, or emotional burdens influenced the GP's choices with regard to addressing and managing patients who abuse substances. The balance between caring for one's patients and caring for oneself seemed to directly affect GPs' behaviour.

> *"I fell into a depression then as well. I learned a lot from it personally, but I certainly use it in my daily work as well. And I think that I can sense very quickly if someone is not feeling mentally up to par; I can recognise it quickly. The personal experience makes me more sensitive, I think. It certainly plays a role". GP 3, F, 35 y, Nl*

Because substance abuse management can be challenging and stressful, the GPs said they had to identify, assess, and control their own emotions when dealing with it. With experience, certain skills are developed and additional self-care strategies are adopted. Even when their motivations (i.e., attitudes, social influence, and self-efficacy) were highly positive, the fear of not being able to personally or emotionally cope might cause GPs to refrain from becoming involved.

> *"Is it artificial [to find a meaning in becoming involved with these patients]… to hold on and be happy in my job, even if it does not pay dividends? Or is it therapeutically useful? Well, that is my question". GP 18, F, 32 y, Fr*

The GPs' perceived self-efficacy depended on positive physician-patient relationships, confidence in their own skills, and positive emotions. Time constraints and personal involvement were cited as important barriers for managing patients who required more time, especially when the chances for success are limited.

> *"No. That is not very easy for me. It is a sort of intimacy, like when you are talking about sex. Or… it has a normative character… or something like, "How dare you ask me that?"… I think that I project that onto the patient. I do not know whether the patient thinks that. Perhaps the patient thinks that it is a normal medical question". GP 2, M, 51 y, Nl*

When treating addicted patients face-to-face, two attitudes emerged: The GPs either considered substance abuse as a chronic disease (and therefore part of their routine clinical activities) or they expressed moral judgements about these patients, highlighting their faults and responsibilities with regard to clinical and social damages, and considering them untrustworthy. This second attitude reduced GPs' willingness to manage substance abuse.

> *"I cannot stand drug addicts because they are liars, and I do not like liars; alcoholics are liars too, but the former are the worse, especially because of substitution therapies…. Drug addicts are utter and complete liars, and I believe that [caring for them is not my responsibility], it is the medical centres'". GP 19, M, 58 y, Fr*

GPs perceived a primary responsibility to manage substance abuse. Some GPs were strongly engaged in their coaching role, supporting patients with regard to accepting their responsibilities and providing strength to allow them to face life's difficulties.

> *"When [I] treat an alcoholic who drinks and knocks someone over, I feel personally responsible…". GP 11, M, 51 y, Fr*

Some GPs also reported having a positive attitude with regard to this aspect of their job. In fact, many said that these responsibilities are what being a GP is all about.

> *"I always find it rewarding [to see] an alcoholic who is no longer dependent, who moves forward in life, who is more autonomous than before, who has a better quality of life in the broad sense. It is his life, it is his quality of life; but I think that if I, at any given moment, have been able to help him to reach this autonomy, well, that is good. […] I think that this is our role as doctors". GP 13, M, 43 y, Fr*

However, satisfaction with regard to dealing with addicted patients was rare. Substance abuse was described as a complex problem that requires long-term, staged follow-up assessments that proceed at the patient's pace and are associated with many relapses without any outcome certainties. GPs often considered abstinence to be a long-term goal. Negative past experiences gave some GPs a feeling of impotence.

> *"There is weariness with regard to morally supporting people. We must accept (and the patients must also accept) that we may not be able to cure them, but that we are there to help them…. It is difficult to unceasingly return [to] a problem that one cannot solve; it is not very rewarding on a medical level; it is easier to cure people…" GP 12, F, 55 y, Fr*

Some GPs considered the use of all illegal drugs as abuse, whereas others considered this use as abuse only when it affected the patient's health or social life. Cannabis was often tolerated for recreational use and was considered common among young people. Alcohol was much more socially acceptable than other substances; moreover, alcoholism was easier to address than psychotropic drug abuse. Some GPs were more tolerant of psychotropic drug abuse (particularly among elderly people), whereas others considered it to be a growing problem, and some of them felt partly responsible for initiating psychotropic treatment among patients looking for help with critical life events.

## Intention state: GPs also proceed through a motivational process

The GPs were concerned about possible breakdowns in the therapeutic relationship; therefore, they often delayed the beginning of interventions until they perceived an opportunity to discuss the abuse with their patient. After the problem was broached, the patients were made aware that the GP's door was open for additional dialogue. This behaviour was part of the contemplation stage.

During the preparation stage, the GPs sought opportunities to broach the subject with the patient, for example, when both parties had sufficient time and when the context was appropriate (i.e., not during mourning or immediately following job loss, divorce, and so on).

> *"Sometimes you ask about [the drug abuse], and you know that they are lying. Then you know, [now] is certainly not the time to go into any depth because the patient does not want to hear about it.... Then you just leave it alone for a while. In many cases, these are the types of patients who will be back. You just know that". GP 1, F, 29 y, Nl*

GPs relied on their clinical competence, and various reasons were used as opportunities to broach the problem of abuse, including repeated requests for sickness-absence certificates or drug prescriptions, physical stigmas and symptoms of acute trauma, social malfunctioning reported by either the patient (sometimes) or his or her relatives (more often), or simple intuition (i.e., a "gut feeling").

> *"The family also puts pressure on us, especially the parents. There are parents who beg us to do something, really; and then we initially see the parents 3-4 times before seeing the child because the latter does not want to see us at all". GP 14, M, 62 y, Fr*

## Ability factors (and barriers): one cannot handle this alone

The GPs expressed their need to collaborate with other caregivers in multidisciplinary networks, primarily for psychological and social reasons. The opportunity to collaborate easily with other professionals was perceived as an advantage of multidisciplinary teams. Some GPs asked about a place for information and peer exchange for support in case of pitfalls and feelings of impotence. Others asked for financial and organisational incentives. In group practices, electronic medical records provide the opportunity to share information and alert GPs to possible drug abuse or patients at risk for aggression.

Referrals to psychiatrists or psychologists were difficult and often too expensive for most patients. The waiting list at specialised care centres was a major concern among the GPs.

> *"If you have a patient who has been addicted for a very long time, [then it is frustrating] once you have finally gotten him motivated to go into detox, and there is nothing available. People often drop out then, you know. They say, 'I just don't care anymore' or 'I don't want it anymore' or 'I can solve my own problems'. And it is with precisely these people that you need to strike while the iron is hot, so to speak. This is the ideal time to admit someone. But then the moment is gone, and it is actually too late". GP 7, M, 39 y, Nl*

# Discussion

## Major results

A significant number of disparities exist among GPs with regard to their willingness to manage patients who abuse substances. The motivation to engage primarily depended on their personal attitudes, the available resources, and their training level. A striking feature of the analysis was that the vast majority of the statements ended up in the "attitude" portion of the I-Change Model. This portion of the model considered pros and cons that were crucial to determining the intentions and actions of substance abuse management, particularly with regard to its workability and manageability.

Another important finding was that the topic strongly affected all GPs, but these physicians were also highly concerned about protecting themselves as individuals and professionals because managing these patients requires time and energy. The fears of exhaustion and burnout were tangible and justified a demand for support, including exchange meetings or effective and accessible collaborations with specialised care centres.

Collaborative management was a prerequisite for GPs who sought support and a desire to share expertise, especially with regard to illegal drug users. Mental health care (at least its accessibility) was depicted as insufficient. Local collaboration within multidisciplinary practices might be an interesting solution.

## GPs' representations of substance abuse

This study highlighted a great variety of behaviours linked to GPs' personal histories and reflexivity with regard to treating patients with substance abuse, and these behaviours matched attitude and self-efficacy, as motivational factors [29]. Managing a patient with substance abuse is not a neutral care procedure for GPs because it elicits moral judgments. GPs' perceptions of substance abuse were on a continuum from a chronic disease to a moral failing (for which the patient was completely responsible). The latter perception makes it difficult to trust the patient and engage in a constructive relationship to manage the problem.

Alcohol and psychotropic drugs are well known and more accepted by GPs; conversely, more reticence was expressed with regard to illegal drugs. It is not surprising that the opinions concerning these patients were more negative given the possible stereotypical views regarding substance use, as various authors have mentioned [9,13,14,30,31]. Goffman indicated that this stigmatisation leads to people spontaneously associating certain characteristics with substance abuse such as violence or untrustworthiness [32].

The various representations and social acceptability of different substances most likely depends partly on their legal status (e.g., alcohol and psychotropic drugs are more socially acceptable) and partly on their prevalence (e.g., cannabis is socially acceptable despite its illegality).

Older GPs with more professional experience tended to be more involved. Furthermore, perceptions of a clear role and defined limits with regard to their responsibilities protected GPs against feelings of frustration, disillusionment, and perceived impotence. However, attitudes can also be improved

through communication skills training, peer exchange, and support. A strong difference existed between Dutch-speaking and French-speaking GPs concerning communication skills training.

The existing literature does not completely support the differences in prevalence between practice locations revealed in the interviews [33]. The link between precarious situations and substance abuse is also controversial [31,34]. The GPs tended to share opinions with laypeople regarding substance abuse rather than acknowledging that their personal attitudes can create biases for or against particular patients.

## Training

GPs' attitudes concerning substance abuse, their perceptions of their role and their opinions concerning substance abuse as well as their lack of theoretical knowledge and training in this area are important determinants of their behaviours. The central effect of a physician's personal qualities with regard to dealing with emotions, his or her personal life history/experience, self-care, and self-awareness in treating patients has been acknowledged previously. Bombeke et al. introduced the "doctor-as-a-person" model as a key determinant in the development of patient-centred behaviour among medical students [35]. Using this concept, they referred to the 5$^{th}$ component of patient-centeredness as defined by Mead and Bower, which concerns a self-awareness of the influence of their personal qualities on the way they practice medicine [36].

Given the rich data that coincide with this "doctor-as-a-person" model, interventions that address self-reflection, coaching, or tutoring to improve self-care are advisable. Several participants suggested the need for this type of support, which can strengthen the ability factors of GPs. Specific skills are needed to maintain the delicate confidential doctor-patient relationship. Mutual respect is the appropriate attitude for helping these patients. Personal development, dealing with emotions and personal suffering, self-awareness, and self-care were submitted as key qualities that must be taught, guided, and fostered to maintain a patient-centred focus among GPs. Thus, tutorship and coaching are as important as theoretical and practical workshops in undergraduate education and continuous professional development programs, as various authors have mentioned over the past two decades [12,37-42]. Currently, these techniques are more commonly introduced in the medical curriculum of Flanders than that of Wallonia. This difference might explain why younger GPs in Flanders feel more comfortable managing patients with substance abuse.

## Collaboration

Addiction is a complex phenomenon that, according to WHO's definition of health, includes medical, social, and psychological aspects [43]. Collaborative care, which is an essential ability factor, is underdeveloped due to the limited accessibility of mental health care and social assistance facilities.

## Strengths and limitations

This qualitative exploratory study preliminarily analysed the determinants of GPs' involvement in substance abuse management from the GPs' points of view. This study cannot provide reliable information regarding influences at the macro-social level (e.g., the organisation of the healthcare system). Moreover, this study was conducted within a purposive sample with a limited number of participants.

This inductive phase should now be followed by a deductive phase. A quantitative survey will be conducted to measure the importance and prevalence of determinants of substance abuse management. The results might contribute to the implementation of policies that aim to support current practices. De Vries' I-Change Model provided us with a complementary and continuous approach between the current qualitative portion and the upcoming quantitative portion of this study.

# Conclusions

This exploratory study highlighted major aspects of addiction management in the general practices of two Belgian provinces. The personal determinants of behaviour are most likely homogenous in culturally similar western nations.

Improving GP practice is often depicted as a matter of training or developing new tools to help physicians. Guidelines and implementation tools are of limited interest for those who do not favour personal involvement. Our study showed that GPs do not act as a homogeneous group. GP behaviours are strongly influenced by their opinions of substance abuse. Moral judgments and various fears were present in the therapeutic relationship. This point should be accounted for in the initial training of physicians. Support workshops and groups aiming to exchange best practices in a safe environment should also be considered for those who treat patients with substance abuse. This practice will help to break the isolation of GPs and reduce the risk of developing burnout, which is frequent among these professionals [44-46].

Improving substance abuse management in primary care is also a matter of policy as well as improving clinical competencies, as has been depicted for other mental health problems [47].

## Ethical approval

The Ethics committees of the Universities of Antwerp and Liege approved this study (Belgian Nr: 12/41/315 for Antwerp and B707201214939 for Liege).

## Competing interests

The authors declare that there are no competing interests.

## Authors' contributions

All authors participated in the design of the study and construction of the interview guide.

FK, LS, ML and MV conducted the interviews; FK, LS and ML analysed the results with the help of LP and MV. FK drafted the manuscript. MV was the coordinator of the Up to Date research project, which includes this study. All authors read and approved the final manuscript.

## Acknowledgement

The authors warmly thank Hein De Vries for his permission to reproduce his model.

## Funding

This research was funded by the Belgian Science Policy Office (BELSPO); the Federal Public Service Health, Food Chain Safety, and Environment; and the Federal Public Service Employment, Labour, and Social Dialogue (Contract DR/00/60).

# References

1. Lim SS, Vos T, Flaxman AD, Danaei G, Shibuya K, Adair-Rohani H, Amann M, Anderson HR, Andrews KG, Aryee M, Atkinson C, Bacchus LJ, Bahalim AN, Balakrishnan K, Balmes J, Barker-Collo S, Baxter A, Bell ML, Blore JD, Blyth F, Bonner C, Borges G, Bourne R, Boussinesq M, Brauer M, Brooks P, Bruce NG, Brunekreef B, Bryan-Hancock C, Bucello C. et al. A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet. 2012;380(9859):2224–2260. [PMC free article] [PubMed]
2. World Health Organization. Global Status Report on Alcohol and Health. Geneva; 2011.
3. Gisle L, Hesse E, Drieskens S, Demarest S, Van der Heyden J, Tafforeau J. Health Interview Survey, 2008. Brussels: Scientific Institute of Public Health; 2010.
4. Degenhardt L, Whiteford HA, Ferrari AJ, Baxter AJ, Charlson FJ, Hall WD, Freedman G, Burstein R, Johns N, Engell RE, Flaxman A, Murray CJ, Vos T. Global burden of disease attributable to illicit drug use and dependence: findings from the Global Burden of Disease Study 2010. Lancet. 2013;382(9904):1564–1574. [PubMed]
5. United Nations Office on Drugs and Crime. World Drug Report 2013. Vienna; 2013.
6. European Monitoring Centre for Drugs and Drug Addiction. Annual Report on the State of the Drugs Problem in Europe. Lisbon; 2011.
7. United Nations. Report of the International Narcotics Control Board for 2009. Vienna; 2010.
8. Glanz A. Findings of a national survey of the role of general practitioners in the treatment of opiate misuse: views on treatment. Br Med J (Clin Res Ed) 1986;293(6546):543–545. [PMC free article] [PubMed]
9. Deehan A, Taylor C, Strang J. The general practitioner, the drug misuser, and the alcohol misuser: major differences in general practitioner activity, therapeutic commitment, and 'shared care' proposals. Br J Gen Pract. 1997;47(424):705–709. [PMC free article] [PubMed]
10. Gabbay MB. Management of opiate dependence. Br J Gen Pract. 1996;46(402):50. [PMC free article] [PubMed]
11. Gabbay MB, Shiels C, van den Bos A. 'Turning the tide': influencing future GP attitudes to opiate misusers. Educ Gen Pr. 2001;12(2):144–152.
12. Deehan A, Templeton L, Taylor C, Drummond C, Strang J. Low detection rates, negative attitudes and the failure to meet the "Health of the Nation" alcohol targets: findings from a national survey of GPs in England and Wales. Drug Alcohol Rev. 1998;17(3):249–258. [PubMed]
13. Strang J, McCambridge J, Platts S, Groves P. Engaging the reluctant GP in care of the opiate misuser: pilot study of change-orientated reflective listening (CORL) Fam Pract. 2004;21(2):150–154. [PubMed]
14. McCambridge J, Platts S, Whooley D, Strang J. Encouraging GP alcohol intervention: pilot study of change-orientated reflective listening (CORL) Alcohol Alcohol. 2004;39(2):146–149. [PubMed]
15. Strang J, Hunt C, Gerada C, Marsden J. What difference does training make? A randomized trial with waiting-list control of general practitioners seeking advanced training in drug misuse. Addiction. 2007;102(10):1637–1647. [PubMed]

16. Use of alcohol, illegal drugs, hypnotics and tranquilizers in the Belgian population (UP TO DATE) [ http://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR/60]
17. Abric JC. Pratiques Sociales et Représentations. Paris: Presses Universitaires de France; 1994.
18. Creswell JW. Qualitative Inquiry and Research Design: Choosing Among Five Approaches. Thousand Oaks, CA: SAGE Publications; 2012.
19. de Vries H, Mudde A, Leijs I, Charlton A, Vartiainen E, Buijs G, Clemente MP, Storm H, Gonzalez Navarro A, Nebot M, Prins T, Kremers S. The European Smoking Prevention Framework Approach (EFSA): an example of integral prevention. Health Educ Res. 2003;18(5):611–626. [PubMed]
20. de Vries H, Dijkstra M, Kuhlman P. Self-efficacy: the third factor besides attitude and subjective norm as a predictor of behavioural intentions. Health Educ Res. 1988;3(3):273–282.
21. de Vries H, Mudde A. Predicting stage transitions for smoking cessation applying the attitude-social influence-efficacy model. Psychol Health. 1998;13(2):369–385.
22. The I-Change Model. [ http://www.maastricht-university.eu/hein.devries/interests/i-change-model] [PMC free article] [PubMed]
23. de Vries H, Mesters I, van de Steeg H, Honing C. The general public's information needs and perceptions regarding hereditary cancer: an application of the Integrated Change Model. Patient Educ Couns. 2005;56(2):154–165. [PubMed]
24. Goebbels AF, Nicholson JM, Walsh K, De Vries H. Teachers' reporting of suspected child abuse and neglect: behaviour and determinants. Health Educ Res. 2008;23(6):941–951. [PubMed]
25. Segaar D, Bolman C, Willemsen M, De Vries H. Identifying determinants of protocol adoption by midwives: a comprehensive approach. Health Educ Res. 2007;22(1):14–26. [PubMed]
26. National Institute for Health and Disability Insurance. Annual Report. Thematic Presentations/IV: Health Professionals Census; Entitlement For Practice. Brussels; 2009.
27. Bowen GA. Grounded theory and sensitizing concepts. Int J Qual Methods. 2006;5(3):1–9.
28. CAGE Questionnaire. [ http://pubs.niaaa.nih.gov/publications/inscage.htm]
29. Dale R, Barton R, Shepherd J, Burrows A, Brooke D, Adshead G. Why are doctors ambivalent about patients who misuse alcohol? BMJ. 1997;315(7118):1297–1300. [PMC free article] [PubMed]
30. Room R. Stigma, social inequality and alcohol and drug use. Drug Alcohol Rev. 2005;24(2):143–155. [PubMed]
31. Hans SL. Demographic and psychosocial characteristics of substance-abusing pregnant women. Clin Perinatol. 1999;26(1):55–74. [PubMed]
32. Goffman E. Stigmate: Les Usages Sociaux des Handicaps. Paris: Les Éditions de Minuit; 1975.
33. Schifano F. Is urbanization a risk factor for substance misuse? Curr Opin Psychiatr. 2008;21(4):391–397. [PubMed]
34. Metsch LR, Pollack HA. Welfare reform and substance abuse. Milbank Q. 2005;83(1):65–99. [PMC free article] [PubMed]
35. Bombeke K, Symons L, Debaene L, De Winter B, Schol S, Van Royen P. Help, I'm losing patient-centredness! Experiences of medical students and their teachers. Med Educ. 2010;44(7):662–673. [PubMed]
36. Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. Soc Sci Med. 2000;51(7):1087–1110. [PubMed]
37. O'Connor PG, Nyquist JG, McLellan AT. Integrating addiction medicine into graduate medical education in primary care: the time has come. Ann Intern Med. 2011;154(1):56–59. [PubMed]
38. Babor TF, Higgins-Biddle JC. Alcohol screening and brief intervention: dissemination strategies for medical practice and public health. Addiction. 2000;95(5):677–686. [PubMed]

39. Botelho RJ, Skinner HA, Williams GC, Wilson D. Patients with alcohol problems in primary care: understanding their resistance and motivating change. Prim Care. 1999;26(2):279–298. [PubMed]
40. Sandlow LJ, Dos Santos SR. Addiction medicine and continuing medical education. J Psychoactive Drugs. 1997;29(3):275–284. [PubMed]
41. Peters C, Wilson D, Bruneau A, Butt P, Hart S, Mayhew J. Alcohol risk assessment and intervention for family physicians. Project of the College of family physicians of Canada. Can Fam Physician. 1996;42:681–689. [PMC free article] [PubMed]
42. Durand MA. General practice involvement in the management of alcohol misuse: dynamics and resistances. Drug Alcohol Depend. 1994;35(3):181–189. [PubMed]
43. WHO definition of Health. [ http://www.who.int/about/definition/en/print.html]
44. Kacenelenbogen N, Offermans AM, Roland M. [Burnout of general practitioners in Belgium: societal consequences and paths to solutions] Rev Med Brux. 2011;32(4):413–423. [PubMed]
45. Lesage FX, Berjot S, Altintas E, Paty B. Burnout among occupational physicians: a threat to occupational health systems?–a nationwide cross-sectional survey. Ann Occup Hyg. 2013;57(7):913–919. [PubMed]
46. Vedsted P, Sokolowski I, Olesen F. Open access to general practice was associated with burnout among general practitioners. Int J Family Med. 2013;2013:383602. [PMC free article] [PubMed]
47. Roberts JH. Improving primary health care services for young people experiencing psychological distress and mental health problems: a personal reflection on lessons learnt from Australia and England. Prim Health Care Res Dev. 2012;13(4):318–326. [PubMed]

## Supplementary Material: Interview guide

| | |
|---|---|
| | ***GP definitions*** |
| | First, the GPs' personal definitions of substance abuse and the differences between use and abuse as well as problematic use and addiction were discussed. Then, the interview focused on a specific case from their practice. |
| | ***I-Change Model*** |
| **Facilitators and barriers** | Given this type of patient's abuse, can you tell me some of the difficult management aspects you came across?<br>What allowed you to overcome obstacles and manage this case? Conversely, what were the compromises or concessions you made to continue with management?<br>Given the cases of abuse that you managed, what would help support you better? What factors contribute to making this job easier? |
| **Skills and abilities** | Do you feel comfortable in this area?<br>Where have you learned the most about this domain? What have you learned?<br>In your opinion, what competencies does a GP need to manage this problem well? To what extent do you think that you have these competencies? Have they improved with experience?<br>What is missing in your training? How could this absence be addressed? Do you have any suggestions? |
| **Collaboration** | Are there other laypeople/professionals concerned by this problem? Who? How so? |
| **Context, Environment** | Is it important for you to know patients' employment statuses?<br>Are these elements addressed in relation to substance abuse? |
| **Attitudes** | In your opinion, what is the aim of substance abuse management? What type of results do you want to obtain?<br>Is the management of patients who engage in problematic substance use similar to that of patients with other health problems? |
| **Norms and social influences** | Did certain situations or people influence how you managed this problem?<br>How do patients influence this management? What is their role? |
| **Self-Efficacy** | Why do you decide to manage this problem? |
| | ***Miscellaneous*** |
| **Physician as a person** | To what extent does working on this problem satisfy you?<br>Do you think your personality or your life story affects your involvement in this management and its success or failure?<br>Did your behaviours or feelings concerning substance abuse develop throughout your career? |
| **Professional status** | Is the working context important? To what extent does it influence your management? |
| **End of interview** | Suppose you had the power and capacity to allow GPs to improve the management of patients with substance abuse. What would be your major ideas or measures to make this achievable? |

Part 3/2

# Substance abuse management by Belgian GPs: opinions and influencing factors. A quantitative study

Frederic Ketterer[1]
Linda Symons[2]
Marie-Claire Lambrechts[3]
Philippe Mairiaux[4]
Lode Godderis[3,5]
Lieve Peremans[2,6]
Roy Remmen[2]
Marc Vanmeerbeek[1]

1 Department of General Practice/Family Medicine, University of Liege
2 Department of Primary and Interdisciplinary Care, University of Antwerp
3 KU Leuven, University of Leuven, Centre for Environment and Health
4 Department of Occupational Health and Health Promotion, University of Liege
5 IDEWE, External Service for Prevention and Protection at Work
6 Department of Public Health, Vrije Universiteit Brussels

# Introduction

Numerous papers underline the burden of diseases related to alcohol and drug abuse. In 2012, alcohol was the third risk factor for general morbidity, with an attributable burden of 3.3 million of death [1]. According to the World Drug Report 2013, between 102,000 and 247,000 death were attributable to illegal drug abuse in 2011 [2]. In Belgium, the recurring health interview surveys measure the prevalence of this health issue; in 2008, over the past 12 months, respectively 5% and 1.5% of the population had used cannabis or another illegal drug (e.g. MDMA, cocaine, or heroin) (it is difficult to distinguish use, problematic use and abuse in this kind of survey) [3].

General practitioners (GPs) are often cited as front line actors, having a major role to play in this topic, particularly in screening and management. However, few studies are available about their knowledge and attitudes towards the topic, and none concern Belgium. A study was therefore conducted among Belgian GPs to bridge this knowledge gap about their approach and attitude toward substance abuse.

This study is part of the "Up to Date" research project seeking to describe the approaches of GPs and occupational physicians (OPs) to the detection and management of the abuse of alcohol, illegal drugs, hypnotics, and tranquilisers, among the Belgian population and to recommend ways to promote multidisciplinary collaborative care for these patients [4]. The research question was as follow: "What are the experiences, attitudes, perspectives, and decision-making skills of GPs with regard to the abuse of alcohol, illegal drugs, hypnotics, and tranquilisers?" This paper describes the quantitative part of the GP arm of the study; the symmetry between the GP and the OP arms limited the topic to the working Belgian population (18- 65 years old).

We used a phenomenological approach, starting from the GPs' point of view (opinion, representation, and practice) to understand their behaviour. For this reason, no definition of substance abuse was given in the surveys, avoiding a normative approach to the GPs' knowledge. However, the way they defined substance abuse was part of the study.

We used a mixed method, developing an exploratory protocol [5]. During the first phase, twenty GPs were interviewed, and the transcripts were analysed in a qualitative way [6]. De Vries' I-Change Model was used as a conceptual framework to design the interview guide and to classify the main results (figure 1) [7]. This model analyses the process of intention into separate units: predisposal, awareness, information and motivational factors, abilities and barriers; it proposes links between them, allowing for a deep understanding of the determinants of behaviour.

The qualitative study underlined the role of motivational factors, which are obviously important to determine the willingness to manage patients with substance abuse. Moreover, strong differences were reported between the substances: alcohol and psychotropic drug abuse being more or less accepted by GPs, while illegal drugs – except for cannabis – were generating a lower acceptance [6]. The GPs pled that these patients were complicated, time-consuming, and had a low success rate in treatment. The interview study also found other variables explaining the GPs' behaviour: practice type (the capitation payment system was described as a facilitating factor), practice location, training, personal and professional experiences.

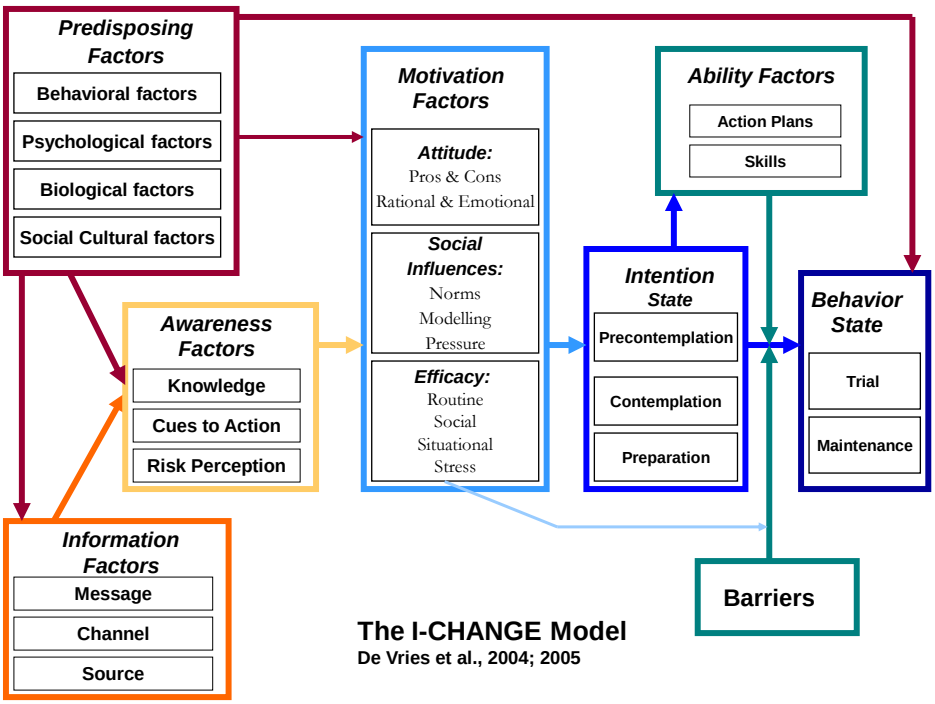



Figure 1: I-Change Model [7]

After this exploratory phase, the question was to know if the influences unveiled during the analysis could be confirmed in a quantitative way, allowing for the measurement of their relative weight, their generalizability and their representativeness. We thus constructed a questionnaire that was sent out to a large sample of Belgian GPs.

# Methods

## Questionnaire

We used De Vries' model again in this phase to ensure consistency between the qualitative and the quantitative phases [7]. The questionnaire was designed to integrate all the components of the model, with the aim to explore all the factors that can possibly influence GPs' behaviour. The qualitative data were used to focus the questions on the relevant topics, i.e. those that were suspected to be the most discriminatory criteria. The questionnaire ended with a question asking for the respondent's personal experience in substance abuse management, with a view to introduce it as a discriminating variable in the statistical processing of the data.

As the qualitative results indicated strong differences between the various substances under study, most of the questions were repeated for the four classes of substances: alcohol, psychotropic drugs, cannabis and other illegal drugs; as a greater tolerance was expressed for cannabis, it was isolated from other illegal drugs.

The final version was made of 54 questions distributed in the categories of the I-Change model. Most of them were five-point Likert scales, and the others were open-ended questions. Among the latter, one explored the respondent's definition of abuse for each substance investigated.

The questionnaire was submitted to a translation/back translation process between French and Dutch; it sent by postal mail to a random sample of 2,567 GPs, selected from the list of about 10,000 Belgian GPs, including French- and Dutch-speaking physicians. Moreover, an announcement made through the scientific societies, the professional networks and specialised medical newspapers, redirected the GPs to the online version of the survey. The questionnaire was administered from September to November 2013.

## Analysis

The Likert scales were limited to three points for the sake of statistical analysis. The open-ended questions were coded according to the responses. The analysis consisted in three parts.

Firstly, a descriptive analysis was performed to describe the sociodemographic characteristics of the sample, and confirm its representativeness, and to have an overall picture of the results. Secondly, cross tabulations were performed to answer the research question and to retrieve the discriminating factors in favour of GPs management, or not, of substance abuse. Seeing people abusing one among the four substance categories was considered as one dependent variable to be explained, while all the variables of the I-Change model were tested as explanatory variables. Thirdly, a logistic regression was run, for each substance separately, with the significant variables (according to the Chi-Square test of the univariate analysis) to measure their relative weight and importance (multivariate analysis). Each logistic regression was modelled to reckon with the GPs who really managed this particular substance abuse.

Data analysis was performed using the SAS software; the significance level was set at 0.05, unless otherwise specified.

# Results

## Respondents' characteristics

A total of 413 GPs answered the survey. Their characteristics are presented in table 1.

**Table 1: Respondents' characteristics**

| Variable | | % | Headcount* |
|---|---|---|---|
| **Sex** | Men | 54,3 | 214 |
| | Women | 45,7 | 180 |
| **Language** | French-speaking | 49,9 | 206 |
| | Dutch-speaking | 50,1 | 207 |
| **Age** | <40 | 28,2 | 112 |
| | 40-55 | 38,8 | 154 |
| | >55 | 33 | 131 |
| **Practice type** | Single-handed | 42 | 165 |
| | GPs associations | 35,6 | 140 |
| | Multidisciplinary associations | 22,4 | 88 |
| **GP are seeing patients with alcohol abuse** | Yes | 88,7 | 336 |
| | No | 11,3 | 42 |
| **GP are seeing patients with hypnotics and** | Yes | 88,8 | 332 |

| | | | |
|---|---|---|---|
| **tranquillisers abuse** | No | 11,2 | 42 |
| **GP are seeing patients with cannabis abuse** | Yes | 54,1 | 191 |
| | No | 45,9 | 162 |
| **GP are seeing patients with other illegal drugs abuse** | Yes | 43,2 | 147 |
| | No | 56,8 | 193 |
| * non-respondents were excluded | | | |

The vast majority of the GPs declared seeing patients who abuse of alcohol and psychotropic drugs, while for cannabis and other illegal drugs, the ratio strongly decreased, lower than 50%.

# Study findings

## Definition of substance abuse, according to the GPs

Tables 2 presents the criteria the GPs are using to define a substance abuse. They reveal some difficulty to define a problematic use, unless it has sanitary (e.g. dependence) or social consequences. However, considering alcohol and psychotropic drugs, a significant number of GPs cited the amount consumed. On the contrary, for illegal drugs (especially if cannabis was isolated), more than half of the GPs considered every consumption as abuse, which is a not strictly health-related position.

**Table 2: Criteria for substance abuse, according to the GPs (in %)**

| Criteria for abuse | Alcohol | Hypnotics and tranquilisers | Cannabis | Other illegal drugs |
|---|---|---|---|---|
| **Evoked Quantity (unspecified)** | 38,4 | 26 | 18 | |
| **Dependence** | 35,9 | 38,4 | 24,2 | 21,9 |
| **Social consequences** | 35 | 17,8 | 35,7 | 25,9 |
| **Changes within the therapeutic relationship** | 22,4 | 19,2 | 18,5 | 11,4 |
| **Health issues** | 18,8 | 12,4 | 20,8 | 14 |
| **Consequences at work** | 12,6 | 7,3 | 14,3 | 8 |
| **Impaired biological test** | 5 | | 0,8 | |
| **Consumption over a long period** | | 23,4 | | |
| **Consumption beyond the prescribed dose** | | 21,8 | | |
| **Every intake is abuse** | | 2,5 | 20,5 | 51,3 |
| **Daily intake** | 11,8 | 12,1 | 16,3 | |
| **Regular intake** | | | 19,1 | 14 |
| **High consumption** | | | | 8,5 |
| **WHO's Recommended maximum intake of alcoholic beverages** | 18,5 | | | |
| **< WHO's Recommended maximum intake of alcoholic beverages** | 7,8 | | | |
| **> WHO's Recommended maximum intake of alcoholic beverages** | 4,2 | | | |
| **Don't know** | | | 0,8 | 1,7 |

## Attitude of GPs towards substance abuse management

Some questions explored the GPs' attitude towards patients with substance abuse. Differences were expressed between the substances: alcohol, hypnotics and tranquilisers abuse were more often considered as part of a GP's job than illegal drug abuse (except for cannabis); more GPs consider it more difficult to address illegal drug abuse in a constructive way, and feel more often powerless in that case, than for alcohol or psychotropic drugs (table 3).

**Table 3: Attitudinal variables of the GPs (in %)**

| Questions | Substance | Disagree | Neutral | Agree |
|---|---|---|---|---|
| **As a GP, I think it is my job to manage abuse of…** | Alcohol | 7,2 | 6,7 | 86,1 |
| | Hypnotics and tranquilisers | 4,7 | 4,9 | 90,4 |
| | Cannabis | 17,8 | 12,3 | 69,9 |
| | Other illegal drugs | 37,9 | 12,1 | 50 |
| **It is difficult for me to address abuse of… in a constructive manner** | Alcohol | 61,8 | 7,2 | 31 |
| | Hypnotics and tranquilisers | 61,1 | 10,3 | 28,6 |
| | Cannabis | 53,6 | 9,6 | 36,8 |
| | Other illegal drugs | 48,8 | 13 | 38,2 |
| **I often feel powerless towards abuse of…** | Alcohol | 29 | 13,8 | 57,2 |
| | Hypnotics and tranquilisers | 29,3 | 17 | 53,7 |
| | Cannabis | 21,6 | 23,6 | 54,8 |
| | Other illegal drugs | 16,8 | 15,3 | 67,9 |

## Place of GPs in a multidisciplinary management of substance abuse

The vast majority of GPs considered that an effective management of substance abuse could only be reached through a multidisciplinary management, *a fortiori* for illegal drugs, but except for psychotropic drugs. GPs often agreed they were at the right place to coordinate this management, especially for psychotropic drugs, but except for illegal drugs (Table 4).

**Table 4: Role of GPs in multidisciplinary management (in %)**

| | Substance | Disagree | Neutral | Agree |
|---|---|---|---|---|
| **Only a multidisciplinary management of … abuse can be efficient** | Alcohol | 15,5 | 14,3 | 70,2 |
| | Hypnotics and tranquilisers | 22,9 | 29,5 | 47,6 |
| | Cannabis | 12,6 | 21,2 | 66,2 |
| | Other illegal drugs | 5,3 | 9,4 | 85,3 |
| **GPs are at the best place to coordinate … abuse management** | Alcohol | 17,7 | 14,2 | 68,1 |
| | Hypnotics and tranquilisers | 12,5 | 12,8 | 74,7 |
| | Cannabis | 26,6 | 21,4 | 52 |
| | Other illegal drugs | 47,7 | 19,3 | 33 |

## Support for GPs

Peer support for substance abuse management was highly desirable for GPs, as increased referral possibilities in specialised facilities (Table 5).

Table 5: Support that GPs wished (in %)

| | Substance | Disagree | Neutral | Agree |
|---|---|---|---|---|
| **I would like specific support in a peer group (e.g. coaching) in case of substance abuse management, to avoid a professional exhaustion** | | 15,2 | 25,3 | 59,5 |
| **Peer groups or intervisions help me in training for substance abuse management** | Alcohol | 8 | 12,5 | 79,5 |
| | Hypnotics and tranquilisers | 8,3 | 15,1 | 76,6 |
| | Cannabis | 8,1 | 16,7 | 75,2 |
| | Other illegal drugs | 11,8 | 17,1 | 71,1 |
| **The availability of referral facilities should be increased** | In ambulatory specialised facilities | 4 | 13 | 83 |
| | In residential specialised facilities | 8,5 | 18,4 | 73,1 |

# Predictors of GPs' engagement in substance abuse management. Multivariate analysis

## Predictors of GPs' engagement in alcohol abuse management

The result of logistic regression are presented in table 6; only the variables containing meaningful modalities are presented (5 variables and 17 modalities were used to build the model). The model is well fitted: (likelihood ratio = .0002; -2LOG L= 225.252).

Table 6: Predictors of GPs' engagement in alcohol abuse management. Threshold ***: p<.001; **: p < .01; *: p < .05

| n = 372; Seeing patients with alcohol abuse: 330; not seeing: 42 | **Seeing patients with alcohol abuse** | | |
|---|---|---|---|
| | | OR [CI] | Threshold |
| **Number of knowledge sources** | 0 or 1 | ref | |
| | > 5 | 3.66 [0.99, 13.51] | * |
| **When I know a patient doesn't want to change, I don't go deeper in the topic at this consultation** | Neutral | ref | |
| | Agree | 0.55 [0.16, 1.87] | * |
| **It is difficult for me to address alcohol abuse in a constructive manner** | Neutral | ref | |
| | Agree | 0.28 [0.06, 1.39] | * |

GPs' engagement in alcohol abuse management is related to a rather large number of knowledge source. Among motivational factors, when GPs think it difficult to address the topic in a constructive manner, or if they don't go deeper in the topic when the patient is not willing to change, the likelihood to see those patients is lower.

## Predictors of GPs' engagement in hypnotics and tranquillisers abuse management

The results of the logistic regression are presented in table 7; only the variables containing meaningful modalities are presented (3 variables and 8 modalities were used to build the model). The model is well fitted: Likelihood ratio < 0.0001; -2LOG L = 229.143.

Table 7: Predictors of GPs' engagement in psychotropic abuse management. Threshold ***: p<.001; **: p < .01; *: p < .05

| n = 364; Seeing patients with psychotropic abuse: 323; not seeing: 41 | **Seeing patients with psychotropic abuse** | | |
|---|---|---|---|
| | | OR [CI] | Threshold |
| **When I know a patient doesn't want to change, I don't go deeper in the topic at this consultation** | Neutral | ref | |
| | Disagree | 1.75 [0.75, 4.05] | * |
| **I find it more difficult to address substance abuse than talking about physical problems** | No | ref | |
| | Yes | 0.44 [0.20, 0.94] | * |

As for alcohol abuse, motivational factors were prominent to predict the likelihood of managing the patients who abuse of psychotropic drugs: willingness to go deep into the problem, and at ease in addressing the topic.

## Predictors of GPs' engagement in cannabis abuse management

The results of the logistic regression are presented in table 8; only the variables containing meaningful modalities are presented; (20 variables and 60 modalities were used to build the model). The model is well fitted: Likelihood ratio < 0.0001; -2LOG L = 324.475.

Table 8: Predictors of GPs' engagement in cannabis abuse management. Threshold ***: p<.001; **: p < .01; *: p < .05

| n = 302; Seeing patients with cannabis abuse: 170; not seeing: 132 | **Seeing patients with cannabis abuse** | | |
|---|---|---|---|
| | | OR [CI] | Threshold |
| **In my professional practice, I address the topic of cannabis** | No | Ref | |
| | Yes | 4.91 [1.81, 13.33] | ** |
| **Number of complementary training needed** | 0 or 1 | Ref | |
| | > 5 | 0.34 [0.13, 0.90] | * |
| **It is difficult for me to address cannabis abuse in a constructive manner** | Neutral | Ref | |
| | Disagree | 2.49 [0.83, 7.48] | * |

Among the predictors, two element were related to the perceived abilities (addressing the topic, and little complementary training needed). One element was related to motivational factors (at ease in addressing the topic).

## Predictors of GPs' engagement in other illegal drugs abuse management

The results of the logistic regression are presented in table 9; only the variables containing meaningful modalities are presented; (30 variables and 86 modalities were used to build the model). The model is well fitted: Likelihood ratio < 0.0001; -2LOG L = 160.818.

Table 9: Predictors of GPs' engagement in illegal drugs abuse management. Threshold ***: p<.001; **: p < .01; *: p < .05

| n = 254; Seeing patients with illegal drugs abuse: 117; not seeing: 137 | **Seeing patients with illegal drugs abuse** | | |
|---|---|---|---|
| | | OR [CI] | Threshold |
| **Patients visit me spontaneously for illegal drugs abuse** | Neutral | Ref | |
| | Agree | 4.56 [0.41, 50.90] | * |

| | | | |
|---|---|---|---|
| | Disagree | 0.15 [0.04, 0.57] | *** |
| **The availability of referral for substance abuse in residential facilities should be increased** | Neutral | Ref | |
| | Agree | 0.49 [0.12, 2.02] | ** |
| | Disagree | 8.12 [1.04, 63.10] | ** |
| **Close or personal experience of illegal drugs abuse** | No | Ref | |
| | Yes | 16.59 [3.07, 89.58] | ** |
| **It is difficult for me to address cannabis abuse in a constructive manner** | Neutral | Ref | |
| | Disagree | 9.54 [1.79, 50.97] | * |
| **GPs are at the best place to coordinate illegal drugs abuse management** | Neutral | Ref | |
| | Agree | 2.91 [0.68, 12.57] | * |
| **Only a multidisciplinary management of illegal drugs abuse can be efficient** | Neutral | Ref | |
| | Agree | 0.01 [0.00, 0.14] | * |
| | Disagree | 0.01 [0.00, 0.17] | * |

Among the variables, a predisposing factor that concern only 11.2% of the respondents, i.e. a close or personal experience with illegal drug abuse, had the strongest predictive influence (OR > 16). Again, some motivational factors were also predictive of abuse management: GPs who declared that these patients consult spontaneously (OR > 4) (or GPs who did not declare the opposite), GPs who obviously did not need more referral facilities (OR > 8). At a smaller threshold (5%), to be at ease with the topic, or to consider to be at the right place for the coordination of care were also positive predictors of illegal drug abuse management.

# Discussion

## Major results

### Different representations of the substances

Strong differences do exist between the different substances under study: GPs are more in favour of alcohol and psychotropic drugs abuse management. Only one on two GPs consider it is his/her job to manage illegal drug abuse, while 80 and 90% agree for alcohol and psychotropic drugs respectively. As a logic consequence, only one on two GPs considers he/she is at the best place to coordinate illegal drugs abuse management. These results echo previous publications, which confirm that substance abuse management is not neutral for a GP, because it fosters the emergence of moral judgement; alcohol and psychotropic drugs are well known and accepted by GPs, while their opinion on patients with illegal drugs abuse are more negative, with possible stereotyping [8-12]. Goffman indicates that this kind of stigmatisation spontaneously lead to associate to the first stigma (i.e. substance abuse in this study) other negative characteristics (i.e. violence, and unreliability in this case) [13]. The various representations and social acceptance of the different substances are probably related partly to their legal status (alcohol and psychotropic drugs are more acceptable at a societal level), and partly to their prevalence (cannabis is socially more acceptable despite it remains illegal in Belgium).

### Motivational factors

The results also underline the importance of motivational factors for understanding GPs' engagement in substance abuse management, for all the substances that were considered. GPs are

not only skilled professionals; some personal elements are also to be considered. This stresses the concept of “doctor-as-person”, the fifth dimension of patient-centeredness, according to Mead & Bower [14]. We already elaborated on this concept in the qualitative phase of the study [6]. The best example is the close or personal illegal drug experience, which increases sharply the likelihood of seeing similar patients, and shows powerfully the weight of the personal experience.

Among the motivational factors, the position of the patient is central. To be visited spontaneously by patients for substance abuse was a significant variable to the four groups of substances (however, the logistic regression found it significant only for illegal drugs). This can favour GP’s engagement in substance abuse management.

## Knowledge

The knowledge of the topic was another important element; except for hypnotics and tranquilisers, the total number of sources of knowledge is a predictor of GP’s engagement in substance abuse management – even if it can be considered as a clue of professional interest concerning this topic. The development of practice-specific guidelines was also requested.

## Support

Besides those factors, the study underlined the needs of the GPs in terms of support. This is all the more important in view of the fact that one on two GPs felt powerless towards this kind of patients. To alleviate this difficulty, the GPs expressed the need of peer groups or intervisions on that particular topic.

Multidisciplinary management appears as a facilitator for engagement, which led the GPs to ask for more referral possibilities, ambulatory and residential. However, it is possible that this particular request hides an unexpressed desire to rid them of these patients, particularly if one considers that not all the GPs consider themselves as relevant for coordination of care in that topic.

## Training

The most popular (73.4%) request among the GPs in terms of training was about the most relevant therapies available for substance abuse.

# Limits

One limit is about the phrasing of a question: we asked the GPs how often they *saw* patients with substance abuse. We wished a neutral phrasing, which was common in both French and Dutch version of the questionnaire, but this can have introduced a bias, since we don’t know if they really manage or treat the patients they declared *being seen*. It is impossible to measure the potential bias; however, this phrasing gave us an indication on the awareness about substance abuse. The statistical results seem to confirm that *see* can be interpreted as *manage,* or *treat*, or *refer* (which is a kind of management).

Substance abuse was voluntarily not defined in the questionnaire. This choice echoes the choice of a phenomenological approach since the preliminary qualitative phase; no consensus, nor uniqueness, on how to define substance abuse was found among the GPs we interviewed. It seemed to us more consistent with the phenomenological framework to start from the field practitioners’ (lack of) definition.

The representativeness of the sample of respondents was consistent with the Belgian social security data in terms of gender, age, and practice type. However, the large percentage of GPs who declared seeing patients with alcohol or psychotropic drugs abuse is questioning. Belgian epidemiological data are lacking to compare this in the age range we studied. One can hypothesise that the respondents were more interested in the topic than the mean; this constitutes an inherent bias for such questionnaires.

# Conclusion

The results confirmed partly the preliminary qualitative study. Strong differences are at work between the GPs about the representations of substance abuse, between moral versus medical standpoints, between patients seen as ill persons versus guilty person. The study didn't look at this, but a semantic link can be observed between the qualitative and the quantitative results.

The criteria used by the GPs for defining substance abuse underline their difficulty to choose a preventive approach, or a health promotion approach. The criteria often refer to harmful consequences or an existing dependence. Little was said about an upstream intervention, except for alcohol, for which GPs often evoked WHO's recommended maximum intake of alcoholic beverages. The opportunities for a preventive approach, and ways to reduce the treatment gap should be studied in depth among GPs.

The need for support is also confirmed in this study. Managing substance abuse, even in the case where GPs have no moral judgment about the topic, seems to be a burden, with risks of professional exhaustion or burn out. Peer support seems to be a relevant improvement, also because it allows to share his doubts with colleagues without judgment. The necessity to support GPs is relevant also because a lot of health professionals could expect GPs to be involved in management of substance abuse.

# References


1. **Global status report on alcohol and health 2014**. In. Geneva: World Health Organization; 2014.
2. **World Drug Report 2013**. In. Vienna: United Nations Office on Drugs and Crime; 2013.
3. Gisle L, Hesse E, Drieskens S, Demarest S, Van der Heyden J, Tafforeau J: **Health Interview survey, 2008**. In. Brussels: Scientific Institute of Public Health; 2010.
4. **Use of alcohol, illegal drugs, hypnotics and tranquilizers in the Belgian population (UP TO DATE)** [http://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR/60]
5. Guével M-R, Pommier J: **Recherche par les méthodes mixtes en santé publique : enjeux et illustration**. *Sante Publique (Bucur)* 2012, **24**(1):23-38.
6. Ketterer F, Symons L, Lambrechts MC, Mairiaux P, Godderis L, Peremans L, Remmen R, Vanmeerbeek M: **What factors determine Belgian general practitioners' approaches to detecting and managing substance abuse? A qualitative study based on the I-Change Model**. *BMC Fam Pract* 2014, **15**(1):119.
7. **The I-Change Model** [http://www.maastricht-university.eu/hein.devries/interests/i-change-model]

8. Deehan A, Taylor C, Strang J: **The general practitioner, the drug misuser, and the alcohol misuser: major differences in general practitioner activity, therapeutic commitment, and 'shared care' proposals**. *Br J Gen Pract* 1997, **47**(424):705-709.
9. Strang J, McCambridge J, Platts S, Groves P: **Engaging the reluctant GP in care of the opiate misuser: Pilot study of change-orientated reflective listening (CORL)**. *Fam Pract* 2004, **21**(2):150-154.
10. McCambridge J, Platts S, Whooley D, Strang J: **Encouraging GP alcohol intervention: pilot study of change-orientated reflective listening (CORL)**. *Alcohol Alcohol* 2004, **39**(2):146-149.
11. Room R: **Stigma, social inequality and alcohol and drug use**. *Drug and alcohol review* 2005, **24**(2):143-155.
12. Hans SL: **Demographic and psychosocial characteristics of substance-abusing pregnant women**. *Clin Perinatol* 1999, **26**(1):55-74.
13. Goffman E: **Stigmate : les usages sociaux des handicaps**: Les Éditions de Minuit; 1975.
14. Mead N, Bower P: **Patient-centredness: a conceptual framework and review of the empirical literature**. *Soc Sci Med* 2000, **51**(7):1087-1110.

# Part 4/1

# The approach taken to substance abuse by occupational physicians: a qualitative study on influencing factors

Marie-Claire Lambrechts[3]
Frederic Ketterer[1]
Linda Symons[2]
Philippe Mairiaux[4]
Lieve Peremans[2,6]
Roy Remmen[2]
Marc Vanmeerbeek[1]
Lode Godderis[3,5]

1 Department of General Practice/Family Medicine, University of Liege
2 Department of Primary and Interdisciplinary Care, University of Antwerp
3 KU Leuven, University of Leuven, Centre for Environment and Health
4 Department of Occupational Health and Health Promotion, University of Liege
5 IDEWE, External Service for Prevention and Protection at Work
6 Department of Public Health, Vrije Universiteit Brussels

Accepted for publication in Journal of Occupational & Environmental Medicine (2015)

# Abstract

## Objective

Aiming to enhance occupational physicians (OPs) practice when dealing with employee substance abuse, this study analyzes the experiences of OPs to gain insight into the factors influencing their behavior.

## Methods

Semi-structured interviews were conducted and analyzed using Interpretative Phenomenological Analysis.

## Results

OPs act differently depending on the type of drug. Their approach was mainly determined by contextual factors and by their attitudes and skills. Many OPs want to invest in health promotion. Barriers such as lack of time and focus on periodic examinations often hamper both adequate prevention and the management of workers with substance abuse.

## Conclusions

The approach to substance abuse by OPs could be supported by initiatives both at the individual and the collective level. A facilitating work context seems to be particularly important in their commitment to alcohol- and drug-related issues at work.


# Background

The impact of substance abuse in society is considerable, but depends largely on the type of drug used. Alcohol consumption was the third leading risk factor in the Global Burden of Disease Study 2010 of the World Health Organization (WHO) [1]. It plays a role in more than 60 major diseases and injuries [1]. In 2004, 1 in 7 male deaths, and 1 in 13 female deaths in the European Union were caused by alcohol [2]. Alcohol-related health damage can result from occasional or regular heavy drinking [2]. In 2013, 6.4% of Belgian alcohol consumers aged 15 or older were problematic drinkers defined according to the WHO thresholds of more than 14 drinks per week for women and more than 21 drinks per week for men. In 2001-2008 this was 8 to 9% [3]. However both the proportion of daily drinkers (14.2% in 2013 compared with 12% in 2008) and the prevalence of problem drinking (measured with the CAGE questionnaire; 10% in 2013) increased. Finally, 8% of the population exhibited binge drinking behaviour (consuming 6 or more alcoholic drinks on the same occasion) on a regular basis (at least once a week) [3]. Cannabis is by far the most frequently used illegal drug in Europe (lifetime prevalence, 21.7%; last year prevalence, 5.3%) [4]. Although the consumption of cannabis is rather stable in Belgium (lifetime prevalence, 15%; last year prevalence, 5%), the demands for treatment in which cannabis is the primary drug has tripled since 2003 [3, 5]. This could indicate a possible increase in cannabis related problems. 4% of the Belgian population has at least once used another illegal drug (e.g. cocaine, amphetamines, opiats, heroin) [3]. Finally the use of psychotropic medication is one of the highest in Europe. While the use of benzodiazepines has

stagnated over the last few years, the number of users of antidepressants in Belgium has increased from 3.9% to 7.6% in 2013 [3].

The workplace is confronted with the negative consequences of substance abuse. In the European Union the tangible costs of alcohol in 2010 were estimated to be €74.1bn, which is 47% of the total social cost [2]. This is the result of lost productivity through absenteeism, unemployment and lost working years because of premature death. Alcohol-related work performance problems are mainly associated with non-dependent, lower-level drinkers who represent the biggest group of drinkers [6]. Recreational drug use may also reduce performance efficiency and safety at work, but more research is needed in this area [7]. The impact of benzodiazepines has mostly been described in relation to its impact on driving [8].

Following a Collective Labour Agreement (CLA n°100), all private organizations in Belgium must have a policy statement on alcohol and drugs (A&D) in the workplace. This CLA also promotes the development of an appropriate prevention policy [9]. Another important feature for the prevention and management of substance abuse in the working population relates to the role of occupational physicians (OPs). The provision of occupational health services (OHS) in Belgium is compulsory and every enterprise whatever its size must affiliate with an OHS. Some large organizations have developed their own internal OHS (IOHS) but for more than 90% of workers occupational health care is supplied by external (certified) OHS (EOHS). Belgian OHS practice in general includes a broad list of preventive activities: workplace surveys, provision of information, counselling, health examinations, risk assessment, maintenance of first-aid skills, etc. [10]. The provision of regular health surveillance is based on the assessed level of exposure to occupational risks at the workplace. Depending on this risk assessment, it involves periodic medical examinations by the OP on an annual (about 50% of the workers) or tri-annual (about 20% of the workers) basis [10]. In that way OPs are regularly in contact with a significant proportion (≥ 70%) of the working population, and this mostly in a preventive medical setting. Therefore OPs are in a unique position to intervene early when problems occur due to substance abuse [11]. They can detect substance abuse and refer employees for adequate treatment. In addition, they can also take into account the work-related context in which this substance abuse has developed [12].

However, little is known about the factors influencing the OPs' approach to substance abuse of employees. This study aims to describe the experiences regarding OPs' approach in Belgium, and to explore the ways they are collaborating with other professionals in providing appropriate care [13].

# Methods

## Conceptual model

This qualitative study sought to answer the following question: "What are the OPs‟ experiences, attitudes, perspectives and decision-making skills regarding alcohol, illegal drug, hypnotics and tranquilizer abuse of employees from an occupational health perspective?" [13]. As a conceptual framework, we used the Integrated Model of Change (I-Change Model) of de Vries (Figure 1), whose components were used as „sensitising concepts‟ [14]. This psychological behavior theory has already

been used to study various and complex behaviors among health professionals [15, 16]. The broad applicability and the embedded motivational cycle guided our decision to use this model.

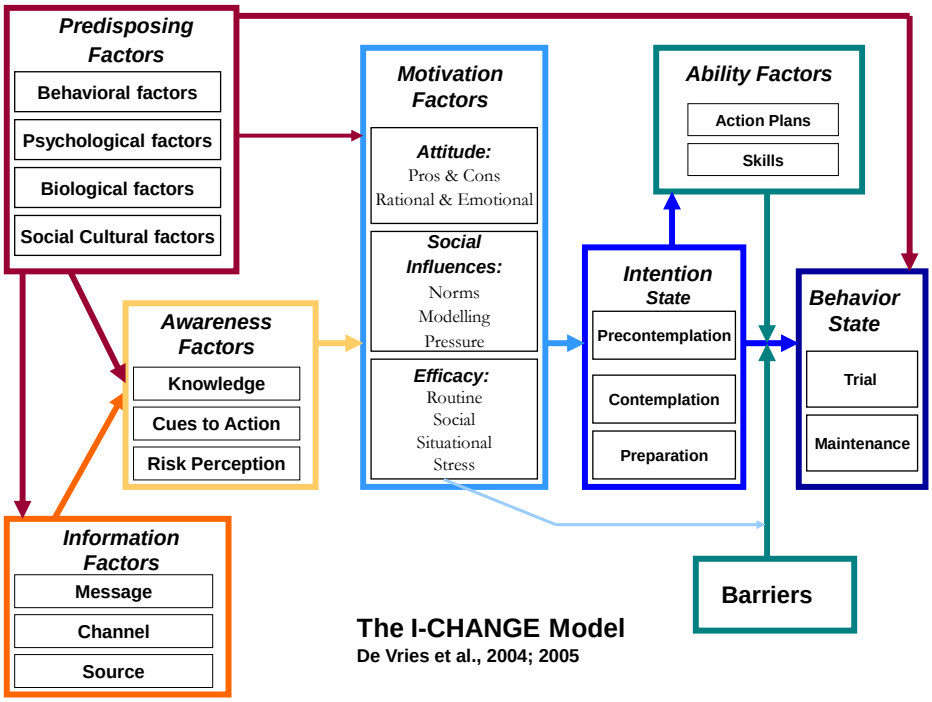



Figure 1: The Integrated Model of Change

Working with this I-Change Model allowed us to distinguish factors underlying the OPs‟ intention in the decision-making process as to whether or not to take care of an employee with substance abuse, or to be involved in prevention initiatives. Subsequently we obtained information concerning factors that come between their intention and actual behavior. The main factors could be identified by deconstructing the process of intention into the separate blocks of the I-Change Model, and searching for the links between them.

## Participants

16 OPs were selected according to the following criteria: age, gender, seniority as an OP, language (Dutch/French), type of occupational health service (IOHS or EOHS), and size and type of company (Table 1).

Despite the qualitative character of this research, we made this selection congruent with the general profile of the occupational physician in Belgium. Currently, there are approximately 1000 occupational physicians. Most of them (90%) are working for one of the 12 external OHS and provide health surveillance in different, rather small, companies. Internal occupational health services are limited, and only present in big companies (> 500 employees [10]. Most OPs are between 40-50 years old and are males. In the younger group of OPs we have more females. The majority is Dutch speaking which corresponds to the situation in Belgium (60% of the inhabitants are living in Flanders, the Dutch speaking part of Belgium). About half of these OPs are member of umbrella organizations, both at the national and the regional level. Consequently, with the collaboration of these organizations, we could include Dutch and French speaking OPs, males and females. The majority of

the interviewees had many years of professional experiences both in small and big companies, and in different types of organizations.

Table 1: Sociodemographic characteristics of participants

| | OP Dutch speaking | OP French speaking | Total |
|---|---|---|---|
| **Language** | 8 | 8 | 16 |
| **Gender** | | | |
| M | 4 | 5 | 9 |
| F | 4 | 3 | 7 |
| **Age** | | | |
| 30-39 | 3 | 0 | 3 |
| 40-49 | 2 | 3 | 5 |
| 50-65 | 3 | 5 | 8 |
| **Occupational health service** | | | |
| Internal OHS | 3 | 3 | 6 |
| External OHS | 5 | 5 | 10 |
| **Professional experience** | | | |
| ≤ 10 years | 2 | 1 | 3 |
| 11-20 years | 3 | 4 | 7 |
| > 21 years | 3 | 3 | 6 |
| **Main topic during interview** | | | |
| Alcohol | 4 | 4 | 8 |
| Cannabis | 1 | 1 | 2 |
| Other Illegal drugs | 1 | 1 | 2 |
| Hypnotics and tranquilizers | 2 | 2 | 4 |

They received an invitation to fill in a short questionnaire asking about their experience in the field of substance abuse. This document allowed the research team to select the specific drug most appropriate for discussion. This was very useful since all interviews started with a concrete case focused on a specific drug (alcohol, cannabis, other illicit drugs or hypnotics and tranquilizers). However all other drugs could be discussed during the rest of the interview. This specification also was introduced in order to find out whether OPs act differently depending on the type of drug. In a parallel study, at the same time and following a similar approach, the research group interviewed general practitioners regarding substance abuse among their patients [17].

## Data collection and analysis

Trained interviewers (ML and FK) conducted the interviews at the working place of the participating OPs in the second half of 2012. A semi-structured interview guide, starting from a recent (< 1 year) case selected by the OPs, was used. The guide was based on the I-Change Model and elaborated through consensus between the researchers (Table 2). The interviews lasted between 1.5 and 2 hours, were audio-taped and transcribed with the informed consent of the respondents.

We carried out Interpretative Phenomenological Analysis (IPA), in which it is possible to combine data collection via in-depth, semi-structured interviewing with existing theoretical constructs. IPA

typically involves an intensive and detailed qualitative analysis of the personal accounts derived from a rather small number of participants. [18, 19]

French- and Dutch-speaking researchers coded first interviews independently using the different main elements of the I-Change Model: predisposing, information, awareness and motivation factors, ability factors, barriers and the intention and the behavior state were used as main codes. The codebooks were then compared, discussed and merged in an iterative consensus process in which the two teams stuck as closely as possible to the wording of the participants when allocating quotes to codes. Both teams included bilingual researchers. Data saturation was not examined because this study was an exploratory first step for designing a survey. The process was facilitated using NVivo software.

# Results

In this qualitative study the approach of the OPs seems to cover a whole range of short- and long-term, although not always successful, initiatives regarding substance abuse. OPs may inform employees, raise their awareness concerning substance abuse, assess problematic use during (periodic) medical screening, and/or refer employees to counseling and treatment. While respecting their professional privacy, they discuss both the health and addiction problems and/or work-related consequences not only with the workers but also with employers and workers‟ representatives. Furthermore, OPs mention they are involved in the reintegration of workers with substance abuse.

The main factors influencing their approach can be described using the structure of the I-Change Model. Quotes from the interviews are presented to illustrate these factors.

## Specific work context of OPs: an important predisposing and facilitating factor

Working for an internal or external occupational service could make a big difference. OPs employed by an EOHS were working for numerous, mostly small-sized companies, and focused on the compulsory medical examinations. In general they had less time and fewer opportunities to work on this issue, either on an individual or collective level.

*I work as a company doctor in an external service and when I was the director of that external service, I also tried to carry over the benefits of an internal service to the external service. But it isn't easy, because things are done in a completely different way. (OP4, F, 59y, Dutch)*

Consequently, they experienced more difficulties in building a trusting relationship with the employee.

The characteristics of the companies OPs work in also played a role. OPs stressed the importance of the company safety and health prevention policy. Both the management vision concerning prevention and the available resources were important. In this context, the importance of the Collective Labour Agreement (CLA n°100) was underlined.

*In that respect, CLA n°100 is of tremendous added value. Alcohol in company restaurants, a beer or two with your meal at lunchtime, never used to be a problem. Now that's no longer allowed in*

*theory. (…) That's definitely an added value. In fact, that legislation has been very positive. (OP1, M, 39y, Dutch)*

In smaller organizations, OPs said, it was usually more difficult to introduce a preventive health approach, including such an alcohol and drug (A&D) policy.

When there was not a well-developed A&D policy in the companies it was difficult to talk about alcohol and drugs. OPs still experienced a lot of resistance from both the employee and the working environment. Due to the absence of comprehensive policies, the role of the OPs and other actors also remained unclear and vague.

*At that time there were rules set out, but not many people respected them because we were very concerned about the company's HR manager who didn't support us in this area. This person was fired a couple of weeks ago and hopefully we can now ask that some of the rules are respected and more especially that there won't be any drinking in the factory; the situation is very clear, and if anyone breaches these rules, there will be sanctions. (OP10, M, 57y, French)*

In addition, the legal duties assigned to OPs were regarded as too limited, especially in Flanders.

*We also have tasks that are prescribed on an entirely legal basis. Often frustrating because we can't do more (OP1, M, 39y, Dutch)*

The company culture was another important factor in whether or not to facilitate the approach to substance abuse. The supporting role of the company management, by giving employees opportunities (e.g. sufficient time, more than one chance to change behavior) to deal with their problem, was an important condition. OPs found collaboration with other actors and clearly defined roles for all actors necessary. The role of supervisors was considered as very important: in the OPs‟ opinion they have to confront the employee with performance problems.

*When the employer is confronted with somebody who drinks, he contacts us to let us know and we try to make that person aware, but it is not binding; it is written in our alcohol/drugs procedure, there is collaboration. The higher management has the task of seeing the person and talking to him, not about his alcohol problem but about him not doing his job properly. And there is a procedure after x-number of reminders to go and meet the company doctor. A few years ago, we told all employees about it, and gave them a leaflet to take home and read. (OP14, F, 48y, French)*

In contrast, some employers and supervisors didn't want to assume their responsibilities, according to OPs, and tried to leave OPs to deal with both work performance and substance abuse problems.

*At the beginning of my career, lots of employers sent me cases and asked me to deal with the alcohol problem. They pass the buck, unwilling to take their responsibility. You're a little desperate when you start out and I'm very glad that the CLA 100 has been passed. (OP12, F, 61y, French)*

Initiatives taken by support services such as Human Resources departments or prevention consultants on the psychosocial aspects of abuse were generally experienced as helpful initiatives by OPs.

## Awareness: knowledge and problems in job performance as cue to action

OPs were actively looking for information, or getting this from others. Their medical education provided the basic knowledge. According to some OPs, the issue of substance abuse was more present in educational training in Flanders. OPs asked for reliable information and effective, evidence-based, guidelines. OPs also got information on substance abuse from their fellow OPs, individually or from umbrella organizations of OPs. Individual data came from the medical records of employees, including the results of medical examinations or questionnaires. But OPs didn't systematically use standard questionnaires, with the exception sometimes of screening for alcohol use by using the AUDIT (Alcohol Use Disorders Identification Test) or the CAGE questionnaire. Guidelines on illicit drugs were not known about in most cases. None of the OPs did use them.

*Alcohol is already being asked about, that seems to be working all right, we're confronted with that every once in a while. Drugs and the like really aren't, not even in standard questionnaires. We realize that we're all doing too little and that we probably also know far too little about these matters. That can be very confronting. We're more likely to talk about medication. (OP1, M, 39y, Dutch)*

The management and supervisors were most likely to inform OPs about employee performance problems. Gathering information from the employee's colleagues was less common, and this was linked to the phenomenon of „co-alcoholism", whereby colleagues were protecting the employee for a long time.

The level of knowledge among OPs differed depending on the product, and was determined by their past experience with employees using alcohol and/or other drugs. Overall they knew more about the effects and the risks of alcohol, hypnotics and tranquilizers, than about illegal drugs. OPs perceived a greater use of benzodiazepines than of alcohol and, to a much greater extent, illegal drugs. According to OPs, substance abuse is a complex problem: there is no adequate definition of substance abuse. Every case is different and employees must give trustworthy information. Substance abuse was a reality in all economic sectors, and was present in all functions. OPs indicated that there was a lot of prejudice and misconception about drugs and drug users in society. OPs mentioned that the use of alcohol and prescribed psychotropic medicines is much more socially accepted than the use of illegal drugs. For some OPs, the use of hypnotics and tranquilizers is an underestimated problem, especially given the possible effects on job performance.

*But when it comes to psychotropic drugs, nobody says anything about those, or does anything about that; yet when you say it, you can hear them thinking, yes that's right. This is still more socially acceptable, more than alcohol… But nobody says anything about it. (OP2, M, 53y, Dutch)*

Nonetheless this use was not always seen by OPs as abuse, but as a necessary means of functioning properly in everyday life as an employee. The fact that these drugs were prescribed by general practitioners (GPs) also played an important role for OPs.

OPs made little distinction between the various terms they were using in practice, such as abuse, problematic use, addiction, and didn't consider such distinctions as being important. Use was considered as problematic when there were consequences at various levels (physical, psychological, social, work) or when it was strictly forbidden in the company. The amount of substance abuse, weighted in reference to job performance, seemed to be crucial for the OPs‟ awareness of problematic use. Another important signal was some loss of control in the employee's behavior.

*To me, abuse is when an employee can no longer control his consumption… When you start seeing clear medical, psychological or social damage, then that's the limit for me. At work, that means somebody who is not functioning properly. (OP1, M, 39y, Dutch)*

However, they said this performance problem was a debatable issue, subject to interpretation. Consumption as such was not always a problem. Depending on the type of work there was less tolerance. As soon as there was a negative impact on work and on safety, OPs found they had to act (i.e. employee is not fit for work or needs more suitable work). They regretted not always being informed in time by the management. In this respect, administrative functions didn't seem to be as problematic as safety functions.

*It's not a problem for me. He doesn't have a safety job, he does his job well, I'm not going to „force‟ him to look after himself and stop drinking because it's not a problem for him, or for his employer. (OP10, M, 57y, French)*

## The importance of motivational factors of OPs, especially attitudes

The aim of OPs‟ action was to help employees who suffer from substance abuse. They also wanted them to return to work. However, OPs stressed they didn't treat alcohol or drug (AOD) problems by themselves, in the way that a GP may do. For OPs neutrality and professional secrecy were very important. They didn't have a standard procedure, and flexibility was appropriate. The responsibility for addressing the substance abuse la with the worker, not with the OP. OPs thought questions about substance abuse should be asked systematically, although in practice this was not the case.

Two main opinions were identified concerning their own role: some OPs stressed the fact that employees should be able to function in the work context; others wanted to invest more in the health of the worker or in health promotion (HP). OPs also had clear ideas about what other actors should do. OPs found that GPs often knew too little about the work context or the job of their patient-employee, yet they prescribed medication that had an impact on work performance. Furthermore, OPs considered they had insufficient opportunities for intervention. The mission of OPs, as formulated by law, was a sensitive item, mainly in Flanders: some OPs wanted to broaden their legal tasks, and wanted to pay more attention to HP in general.

*I'm always strict about that: as an OP you have a relationship with the company on the one hand and the employee on the other. .. And if you take your job as OP seriously, then I think that providing information, explaining and promoting health issues, is one of our most important tasks (OP3, F, 41y, Dutch)*

*I look at things from a work perspective, voluntarily. The public health role is the job of the generalist or specialist doctor; whereas we specialize in work with medical aspects. (OP12, F, 61y, French)*

Previous contacts with the employee, and experiencing sufficient confidence in this relationship, increased the self-efficacy of OPs. Talking about substance abuse was considered harder than talking about physical health problems and the OPs‟ authority was seen as weaker in that case. It was easier to talk about hypnotics and tranquilizers than AOD. Addressing illicit drugs was by far the most difficult task. Self-efficacy was also influenced negatively by the reluctance of the employee involved, and positively affected by success stories with some employees.

*I find it much more difficult to identify or uncover a drugs problem (OP6, F, 38y, Dutch)*

*But I do have a few success stories. That's essential for me (OP4, F, 59y, Dutch)*

At the same time, frustration and negative experiences gave some OPs a feeling of impotence.

*There are people who are already chronic alcoholics and it's well known that these people rarely become abstinent and stay that way! You know they're going to relapse. […] there are quite a few who are in denial and there's no way to help them! It's the results that make us feel bad! It's a major investment in terms of time and energy. (OP14, F, 48y, French)*

Overall older OPs were more experienced and found it easier to talk about substance abuse.

*In the beginning I believed everything that the employees said [....] it was already progress that I could look someone straight in the face and say that they smelled of alcohol. Because in the beginning, I couldn't say a word about it. But after a while, I would say, "No, I don't believe you". […] And I've also made progress in terms of the consequences that has had. (OP5, M, 36y, Dutch)*

OPs said that, in contrast to older colleagues, younger OPs nowadays learn more communication skills in their education, which seemed very useful for talking with the worker about substance abuse. Peer exchanges were also mentioned as a way to share experiences concerning substance abuse management.

*If we had open discussion forums and lateral organizations where we could reflect a little on the aim of our work, on what we could do; something so that OPs can help people (…) (OP15, M, 54y, French).*

## Intention whether to act or not is influenced by barriers and ability factors

Intention was influenced directly and indirectly by the above-mentioned factors. Thereby OPs weighed the advantages and the disadvantages of a possible action. This was a process that was often characterized by doubt and could be facilitated or adversely affected by barriers. The most important barrier appeared to be the lack of time, also due to a shortage of OPs to carry out the job.

*I feel under pressure because there are just far too few OPs. Yesterday 37 people came to see me. That's a lot. Follow-up for accidents, recruitments. I'm completely done in afterwards. It used to be 30 minutes per person, then 20, and now sometimes only 10. (OP2, M, 53y, Dutch)*

This is a particular problem for OPs working for EOHS. Furthermore, they work in many different companies where the culture and context are often very different.

In addition, working in a new company is not always easy when handling AOD problems. OPs want to create a good relationship with the employer and employees, before tackling difficult issues such as AOD problems. In the limited time OPs have, other obligatory tasks need to be performed first.

Having a conversation with a reluctant employee was not effective. OPs generally didn't act in that case. Furthermore, the inadequate communication (no or one-way communication) and the limited collaboration with the curative sector was often an obstacle. The waiting list for specialized centers was a major concern among OPs.

*I think that if there's one thing the government should do, it's invest in psychiatry and acute care. And you shouldn't let these men with alcohol problems keep walking around for another three weeks. That's a major problem for me. (OP7, F, 48y, Dutch)*

# Discussion

In this qualitative study we investigated the factors that influence the approach to employee substance abuse by OPs. Key findings are the impact of contextual factors, such as an integrated alcohol and drug policy, and the importance of personal factors such as attitudes regarding occupational health, and specific skills.

## Importance of a supportive alcohol and drug policy

All OPs in our study stressed the importance of a facilitating context. Many studies show that a positive company culture regarding A&D-related work (e.g. sufficient training, adequate support) influences the OP‟s knowledge and attitude positively [20, 21]. However, working in a small or medium-sized company makes it much more difficult. This is not new either [22]. Although, under CLA n°100, all private organizations in Belgium must have an A&D policy, only a declaration of policy is in fact required. An evaluation study is not yet available on the implementation level, but it seems that a minority of companies has gone beyond the declaration phase and implemented a well-elaborated policy. In Europe (EU=30), 14 countries have national guidelines for the prevention of and counseling for alcohol problems in the workplace. In 12 countries, social partners are involved at the national level [23]. A comprehensive policy on both alcohol and other drugs, facilitated by a national agreement, is however rather unique [24]. Internationally, a tailored and multi-component policy is considered to be an asset when dealing effectively with AOD problems on the work floor [25]. However, there are also very few evaluation studies relating to that internationally [11].

## Health promotion on the work floor

When dealing with substance abuse, Dutch-speaking OPs, more than French-speaking ones, want to go beyond their official assignment. They want to invest in health promotion, as recommended by

the National Institute for Occupational Safety and Health (NIOSH), the "Société Française de Médecine du Travail" (SFMT), the Pompidou Group (Council of Europe) and the International Labor Organization [26-29]. They also see their actions as complimentary to those of GPs. This cultural difference between OPs in Flanders and the French-speaking part of Belgium has been mentioned in other studies dealing with the future of occupational health in Belgium [30]. The shift from the traditional focus of occupational health on high-intensity hazardous exposures to a wider scope (including environment) is an ongoing debate in the international literature [31].

## Attitude: "a little thing that makes a big difference"

In this study the significant effect of OPs‟ attitudes on their approach when treating employee substance abuse is in line with a review by Skinner et al. who concluded that „a wide range of factors influence health professionals‟ responses to AOD issues – one important factor is their attitude towards AOD-related work‟ [20]. According to Archer et al. medical professionalism is rooted in attitudes [32]. Positive attitudes improve the approach of OPs [33]. Ballon & Skinner studied attitudes and stereotyping of medical students regarding addiction problems and concluded with a quote by Winston Churchill: "An attitude is a little thing that makes a big difference" [34].

## Focus on skills and motivational interviewing

Attitudes are strongly influenced by knowledge. Though older OPs in our study were less educated in AOD than their younger colleagues, all OPs acknowledge the importance of knowledge. In Great Britain substance abuse as a theme is a structural part of the physician's education, namely the "Substance Misuse in the Undergraduate Medical Curriculum**"** [35]. Multiple studies have underlined the importance of education and training as a way to facilitate a positive attitude to substance abuse among Ops as well [20, 21]. Investing in education pays off, stipulates the Risk Drinking Project, an ambitious education program for first-aid and OPs in Sweden [36]. In a series of recommendations for OPs about substance abuse, the SFMT mentions the necessity for OPs to evaluate their knowledge of substance abuse, and follow an additional education if needed [27].

OPs in our study also indicated that they tend to engage themselves more in AOD interventions when they have had more specific training, and in particular when they also have the skills to engage in a conversation, i.e. via motivational interviewing. This type of education was specifically mentioned by the Dutch-speaking OPs. The importance of skill-enhancing education, to make OPs feel more comfortable when talking to substance abusers, has been studied and acknowledged internationally [12, 21, 33, 36, 37].

## Need for evidence-based directives and short-term interventions

The interviewed OPs referred to the lack of clear directives and efficient guidelines. This was also one of the conclusions in a review by Van Royen et al. concerning guidelines for collaboration in substance abuse management [38]. The use of standard questionnaires such as AUDIT (Alcohol Use Disorders Identification Test) and ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) should become a structural part of short-term interventions, as is recommended by the SMFT [27]. In a systematic review of work-place interventions for alcohol-related problems, Webb et al. concluded that brief interventions - such as Short Brief Interventions (SBI) and Screening, Brief

Intervention and Referral to Treatment (SBIRT) - are often used in primary care and „have potential to produce beneficial results" [39]. As alternatives to face-to-face SBI, computerized interventions also look promising [40].

The introduction of these tools during periodic health surveillance might be very useful in order to motivate the employee. In addition, clear directives and guidelines, including testing, are appropriate to distinguish screening and testing done by occupational physicians, and the use of tests in alcohol and drug policies. Following CLA 100, it is possible to introduce preventive tests, such as breath tests and reaction tests, to make it easier for employers to decide whether employees perform well. Both types of screening and testing tools do have different purposes, are strictly regulated, and should be done by different actors although this is not always very clear.

## Time as a key obstacle

Lack of time, especially in the case of OPs working for external OHS, and also because there are not enough OPs, was already mentioned in the Belgium study on occupational health [30]. This problem of time can also be linked to the way occupational health is financed in Belgium, whereby EOHS OPs are being paid mainly for health surveillance. Time as a key obstacle to behavioral change of health professionals has been frequently underlined [20].

## Limitations

The strength of this qualitative study is in the use of the I-Change Model, which allowed us to make a detailed and nuanced analysis of the influencing factors of the approach of OPs to alcohol and other drug issues, and this from the OP"s point of view. Although we made a selection based on the characteristics of all OPs in Belgium, due to the small sample and the qualitative character of this research which preliminarily analyzed OPs' behavior, a quantitative survey will be set up to verify the validity of the assumptions made as a result of this qualitative study and to generalize them.

## Conclusions

Our study explored major aspects of the approach to substance abuse among employees by 16 OPs in Belgium. It reveals that not only factors on the individual level (such as knowledge and skills) but also in the environment, and the interaction between them, are influencing OP behavior. The specific work context of OPs seems to be particularly important in their interaction with the employee. The management of substance abuse by OPs could be supported by several initiatives both at the individual and collective level. Finally, we think more research is needed, especially on the possible effects of prevention and early detection interventions.

### Acknowledgement

The authors warmly thank Hein de Vries for his permission to reproduce his model. This work could be realized with the financial support of The Belgian Science Policy Office (Belspo); the Federal Public Service Health, Food Chain Safety and Environment and the Federal Public Service Employment, Labour and Social Dialogue (Contract DR/00/60).

### Conflict of interest

The authors indicated no conflicts of interest.

## Ethical approval

The Ethics committees of the Universities of Liege and Leuven gave their approval (Belgian No respectively B707201214939 and B322201317373).

# References


1. Lim SS, Vos T, Flaxman AD, Danaei G, Shibuya K, Adair-Rohani H et al. A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet* 2012; 380:2224-60.

2. Rehm J, Shield KD, Rehm MX, Maximilien X, Rehm, Gmel G, et al. Alcohol consumption, alcohol dependence and attributable burden of disease in Europe: Potential gains from effective interventions for alcohol dependence. Toronto: Centre for Addiction and Mental Health 2012.

3. Gisle L, Demarest S. (ed.) Gezondheidsenquête 2013. Rapport I en II. Gezondheidsgedrag en leefstijl. Samenvatting van de onderzoeksresultaten. 2014. https://his.wiv-isp.be/SitePages/Reports.aspx. Accessed 29 May 2015.

4. European Monitoring Centre for Drugs and Drug Addiction. *European Drug Report 2014. Trends and developments.* EMCDDA, 2014.

http://www.emcdda.europa.eu/publications/edr/trends-developments/2014. Accessed 25 Jan 2015.

5. Federale overheidsdienst (FOD) Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu (2012a). *Minimale Psychiatrische Gegevens (MPG) 2009-2010.* Brussel: FOD Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu. Accessed 29 May 2015.

6. Mangione TW, Howland J, Amick B, Lee M, Bell N, Levine S. Employee Drinking Practices and Work Performance. *J Stud Alcohol* 1999; 60(2):261–270.

7. Smith A, Wadsworth E, Moss S, Simpson S. *The scale and impact of illegal drug use by workers.* Research Report 193. Centre for Occupational and Health Psychology. Cardiff: Cardiff University 2004.

8. Orriols L, Salmi LR, Philip P, Moore N, Delorme B, Castot A, et al. The impact of medicinal drugs on traffic safety: a systematic review of epidemiological studies. *Pharmacoepidemiol Drug Saf* 2009; 18(8): 647–658.

9. Collectieve arbeidsovereenkomst nr.100 van 1 april 2009 betreffende het voeren van een preventief alcohol- en drugbeleid in de onderneming. http://www.nar.be/cao-COORD/cao-100.pdf. [Dutch]. Accessed 10 Dec 2013.

10. Godderis L, Johannik K, Mylle G, Bulterys S, Moens G. Epidemiological and performance indicators for occupational health services: a feasibility study in Belgium. *BMC Health Serv Res. 2014 Sep 19;14*:410. doi: 10.1186/1472-6963-14-410.

11. Ames GM, Bennett JB. Prevention interventions of alcohol problems in the workplace. *Alcohol Res Health* 2011; 34(2):175-87.

12. Lambert, S. The role of the occupational physician in substance abuse. *Occup Med* 2002; 17(1):1-12.

13. Use of alcohol, illegal drugs, hypnotics and tranquilizers in the Belgian population (UP TO DATE). http://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR/60. Accessed 10 Dec 2013.

14. De Vries H. The I-Change Model. http://www.maastricht-university.eu/hein.devries/interests/i-change-model. Accessed 10 Dec 2013.

15. Cremers HP, Oenema A, Mercken L, Candel M, De Vries H. Which factors play a role in Dutch health promotion professionals' decision to recruit actively primary schools to use a web-based smoking prevention programme? *BMC Res Notes* 2013;6, 504. http://www.biomedcentral.com/1756-0500/6/504 doi:10.1186/1756-0500-6-504

16. Segaar D, Bolman C, Willemsen M, de Vries, H. Identifying determinants of protocol adoption by midwives: a comprehensive approach. *Health Educ Res* 2007;22(1):14-26.

17. Ketterer F, Symons L, Lambrechts M, Mairiaux P, Godderis L, Peremans L, Remmen R, Vanmeerbeek M. What factors determine Belgian general practitioners‟ approaches to detecting and managing substance abuse? A qualitative study based on the I-Change Model**.** *BMC Fam Prac* 2014;15-119, doi:10.1186/1471-2296-15-119

18. Larkin M, Watts S, Clifton E. Giving voice and making sense in interpretative phenomenological analysis. *Qual Res Psychol* 2006;3:102-120.

19. Smith JA. Evaluating the contribution of interpretative phenomenological analysis. *Health Psychol Rev* 2011;5:9-27.

20. Skinner N, Roche AM, Freemann T, McKinnon A. Health professionals' attitudes towards AOD-related work: Moving the traditional focus from education and training to organizational culture. *Drug-Educ Prev Polic* 2009;16(3):232-249.

21. Gross SR, Marshall EJ, Wolff, K. Substance misuse among health care workers: national survey of occupational physicians. *Occup Med* 2012;62(4):254-260, doi: 10.1093/occmed/kqs027

22. Bradshaw LM, Fishwick D. Provision and perception of occupational health in small and medium-sized enterprises in Sheffield, UK*. Occup Med* 2000;51(1):39-44.

23. WHO Regional Office for Europe. Status Report on Alcohol and Health in 35 European Countries 2013. Kopenhagen: WHO. http://www.euro.who.int/__data/assets/pdf_file/0017/190430/Status-Report-on-Alcohol-and-Health-in-35-European-Countries.pdf. Accessed 10 Dec 2013.

24. European Foundation for the Improvement of Living and Working Conditions. Use of alcohol and drugs at the workplace. Dublin: EWCO 2012. http://www.eurofound.europa.eu/docs/ewco/tn1111013s/tn1111013s.pdf. Accessed 10 Dec 2013.

25. Cercarelli R, Allsop S, Evans M & Velander F. 2012. Reducing alcohol-related harm in the workplace (An evidence review: full report), Victorian Health Promotion Foundation, Melbourne, Australia. http://ndri.curtin.edu.au/local/docs/pdf/publications/T214.pdf. Accessed 27 Apr 2014.

26. Research Perspectives on Total Worker Health. Overview of Integration of Health Protection and Health Promotion. http://www.cdc.gov/niosh/twh/perspectives.html – e.g. Guidance from the American College of Occupational and Environmental Medicine. Workplace Health Protection and Promotion. 2011. Accessed 27 Apr 2014]. A New Pathway for a Healthier – and Safer – Workforce. Hymel PA, Loeppke RR, Baase CM, Burton WN, Hartenbaum NP, Hudson TW et al. JOEM 2011.doi: 10.1097/JOM.0b013e31822005d0

27. Société Française de Médecine du Travail et la Société Française d'Alcoologie. Dépistage et gestion du mésusage de substances psychoactives (SPA) susceptibles de générer des troubles du comportement en milieu professionnel 2013.

28. Reference framework. http://www.coe.int/T/DG3/Pompidou/Source/Activities/Workdrug/P-PG-Work (2012)1rev2_framework_reference_en.pdf. Accessed 13 Dec 2013.

29. Available from http://ilo.org/safework/areasofwork/workplace-health-promotion-and-well-being/lang--en/index.htm. Accessed 14 Jun 2014.

30. Belgische Beroepsvereniging van Arbeidsgeneesheren (BBvAG). Eindrapport Enquête bij arbeidsgeneesheren uitgevoerd door de BBvAG in opdracht van FOD WASO HUA.2010. http://www.werk.belgie.be/moduleDefault.aspx?id=29502. Accessed 14 Jun 2014.

31. Schwartz BS, Rischitelli G, Hu H. Editorial: the Future of Environmental Medicine in Environmental Health Perspectives: Where Should We Be Headed? *Environ Healt Perspect* 2005;113(9); A574-A576. PMCID 1280414.

32. Archer R, Elder W, Hustedde C, Milam A, Joyce J. The theory of planned behaviour in medical education: a model for integrating professionalism training. *Med Educ* 2008;42:771-777.

33. Kääriäinen J, Sillanaukee P, Poutanen P, Seppa, K. Opinions on alcohol-related issues among professionals in primary, occupational, and specialized health care. *Alcohol Alcoholism* 2001;36:141-146, doi: 10.1093/alcalc/36.2.1

34. Ballon B, Skinner W. Attitude is a little thing that makes a big difference: reflection techniques for addiction psychiatry training. *Acad Psychiatry* 2008;32:218-224

35. International Centre for Drug Policy (2012). Substance Misuse in the Undergraduate Medical Curriculum. http://www.sgul.ac.uk/research/projects/icdp/pdf/smugprojectreport.pdf. Accessed 15 Dec 2013.

36. Nilsen P, Holmqvist M, Hermansson U. Alcohol prevention in Swedisch occupational health care. *Occup Med* (Lond) 2011;61:472–479, doi: 10.1093/occmed/kqr070 First published online: September 20, 2011

37. Tsutsumi A, Maruyama T, & Nagata M.Psychiatric knowledge and skills required of occupational physicians: priorities in the Japanese setting. *J Occup Health* 2011;53(5):371-6. Epub 2011 Aug 5.

38. Royen K, Remmen R, Vanmeerbeek M, Godderis L, Mairiaux P, Peremans L. A review of guidelines for collaboration in substance misuse management. *Occup Med* 2013;63(6):445-7, doi: 10.1093/occmed/kqt089

39. Webb G, Skakeshaft A, Sanson-Fisher R, Havard A. A systematic review of work-place interventions for alcohol-related problems. *Addiction* 2009;104(3):365-77, doi: 10.1111/j.1360-0443.2008.02472.x.

40. Murray E, Khadjesari Z, Linke S, Hunter R, Freemantle N. Health on the web: randomised trial of work-based online screening and brief intervention for hazardous and harmful drinking. *BMC Public Health* 2013;13:505, doi:10.1186/1471-2458-13-505

41. Godderis L, Johannik K, Mylle G, Bulterys S, Moens G. Epidemiological and performance indicators for occupational health services: a feasibility study in Belgium. BMC Health Serv Res. 2014 Sep 19;14:410. doi: 10.1186/1472-6963-14-410.

Table 2 : Interview guide

| | |
|---|---|
| | ***OP position in sample and in problem definition*** |
| | First, OPs personal definitions concerning substances abuse, differences between consumption and abuse, problematic use and addiction were discussed. Then, the interview further focused on a specific case of the OPs practice. |
| | ***I-Change Model*** |
| **Facilitators and barriers** | Remembering this kind of employees abusing of…, can you tell me some difficult aspects in your approach to them?<br><br>What allows you to overcome obstacles and to manage this case? To the contrary, what are the compromises or concessions you have to do to continue with the management?<br><br>Remembering cases of abuse of… you managed, what would support you to help better? What factors contribute to make it easier? |
| **Skills and abilities** | Do you feel comfortable in this area?<br><br>Where have you learnt the most about this domain? What have you learnt?<br><br>According to you, what competencies does an OP need to manage well this problematic? To what extent do you think you have these competencies? Have they improved with experience?<br><br>What is missing in your curriculum/training? How could it be solved? Do you have any suggestions? |
| **Collaboration** | Are there other people/other professionals concerned by this problematic? Who? How? |
| **Context, Environment** | Is it important for you to know XXXX' status of employment?<br><br>Are these elements addressed in relation with substance abuse? |
| **Attitudes** | According to you, what is the aim of management? What kind of result do you want to obtain?<br><br>Is management of employees with a problematic consumption of substances similar to management of employees with other health problems? |
| **Norms and social influences** | Did some situations or people have an influence on your own management of this problematic?<br><br>How do employees influence this management? What is their role? |
| **Self-Efficacy** | According to you, what makes you decide to take action in the management of this problem? |
| | ***Miscellaneous*** |
| **Physician as a** | To what extent does working on this problematic give you some satisfaction? |

| | |
|---|---|
| **person** | Do you think your personality or your personal story of life has an incidence on your involvement in managing and its success? And in its possible failures?<br><br>Did your behaviour or your feelings concerning substance abuse progress during your carrier? |
| **Professional status** | Is the working context important? To what extent does it influence your management or not? |
| **End of interview** | Let us suppose you have the power and capacity to allow OPs to improve the management of patients with substance abuse; what will be your main points or measures to make this achievable? |

Part 4/2

# What factors determine the approach of substance abuse of employees by occupational physicians? An online-survey based on the I-Change Model

Marie-Claire Lambrechts[3]
Frederic Ketterer[1]
Linda Symons[2]
Philippe Mairiaux[4]
Lode Godderis[3,5]
Lieve Peremans[2,6]
Roy Remmen[2]
Marc Vanmeerbeek[1]

1 Department of General Practice/Family Medicine, University of Liege
2 Department of Primary and Interdisciplinary Care, University of Antwerp
3 KU Leuven, University of Leuven, Centre for Environment and Health
4 Department of Occupational Health and Health Promotion, University of Liege
5 IDEWE, External Service for Prevention and Protection at Work
6 Department of Public Health, Vrije Universiteit Brussels

# Background

Little is known about the motivation and approach of Occupational Physicians (OPs) in the prevention and management of substance abuse among employees. We investigated the factors of influencing their behaviour.

# Methods

An online questionnaire was designed by using the I-Change Model as a theoretical framework, and sent to all Belgian OPs (n=1002). Descriptive analysis, logistic regression and multivariate analysis was done by using SPSS 22.

# Results

Results of 274 OPs were maintained for analysis. The sample was representative for language, age, gender, seniority, and type of occupational health service (OHS). OPs mainly dealt with the use of alcohol (62.5%) and benzodiazepines (39.4%) among employees (frequencies ≤ monthly basis) and less with cannabis (26.3%) and other illicit drugs (6.1%). Their definition of substance abuse primarily was based on work related criteria, followed by health consequences and the quantity of use. Only for illicit drugs other than cannabis, use almost always implicated misuse (82.8%).

For 53% of the OPs talking about substance use was difficult compared to physical health problems. OPs often felt powerless in dealing with substance abuse. They specifically needed training concerning efficient referral possibilities (65%) and skills training on communication and motivational interviewing (42%).

OPs found themselves equally well placed than other health professionals to screen employees about their alcohol and drug consumption. For 45% of the OPs it was frustrating they couldn't do more than their legal tasks with focus on periodic health surveillance, based on an assessment of occupational risks. They wanted to invest in health promotion. Safety problems due to substance abuse were important cues to action. OPs mostly referred to general practitioners and to specialized ambulatory care services.

Most OPs found they had a key role in the development of an alcohol and drug policy (68.6%), and its implementation (73.6%) in enterprises. No significant differences were found for age, sex, seniority and type of OHS. The possibility of being involved in the implementation of such a policy was higher for Dutch speaking OPs (Odds ratio, 2.6; 95 CI, 1.55-4.52) and for those with more knowledge (Odds ratio, 4.7; 95 CI, 1.65 to 13.32). A multivariate model with 3 factors of **social**

**support** explained 26% (Nagelkerke $R^2$) of the involvement of OPs in the implementation of a policy, significant for 2 factors: 'chances given by management' (Odds ratio, 2.1; CI 1.27-3.51) and 'support by trade unions' (Odds ratio, 1.7; CI 1.11-2.69). A model with 3 **contextual** factors explained 37% (Nagelkerke $R^2$), significant for all 3: 'get enough time' (Odds ratio, 2.2; CI 1.49-3.23), 'an elaborated policy' (Odds ratio, 2.9; CI 1.82-4.58), and 'the support of the management' (Odds ratio, 2; CI 1.27-3.18). In both models no significant differences were found for age, sex, seniority, language and type of OHS.

# Conclusions

The engagement of Belgian occupational physicians in the prevention and management of substance abuse of employees mainly is influenced by their attitudes concerning job related misuse, their knowledge, and the social support and facilitating contextual factors regarding an alcohol and drug policy.

# Part 5

# Mirrored view

Isabelle Demaret[1,2]
Marc Vanmeerbeek[3]
Marc Ansseau[1]
André Lemaître[2]

1 Department of psychiatry and medical psychology, University of Liege
2 Sociological Research and Intervention Centre (CRIS), University of Liege
3 Department of General Practice/Family Medicine, University of Liege

# Introduction

General practitioners (GPs) and occupational physicians (OPs) are seen as major players in detecting and managing problems related to substance abuse. However, little is known about their collaboration with other professionals in the addiction sector: 1) psychiatrists, psychologists, social workers, and pharmacists (the "health sector"); 2) employer's representatives, trade union representatives, internal prevention advisers and external prevention advisers (the "working sector"); and 3) persons from the judiciary and from youth protection services (the "judicial sector"). Prevention advisers are mandatory in Belgium in companies employing more than 20 workers. Their role is to prevent health and security problems at work. Internal prevention advisers are directly employed by a company in a service of prevention and protection at work (SPP); external prevention advisers are employed by an external company specialised in prevention and protection at work.

Notably, we don't know how the role of, and the collaboration with GPs and OPs is perceived by all these professionals: are GPs and OPs reliable partners, is there a need for more collaborative work and, if yes, what should be their proposals to improve it?

Our research was part of a project investigating the role GPs and OPs in the addiction field in Belgium. It was limited to substance related disorders in the adult population (18 to 65 years old) and to three categories of psychoactive substances: alcohol, hypnotics/tranquilizers and illegal drugs.

# Method

## The nominal group technique

The data collection was based on the nominal group technique (NGT), which is "*a group process for qualitative judgemental problem exploration which is particularly applicable to the subjective and judgemental character of many planning effort*" (Van de Ven & Delbecq, 1972).

The NGT is a structured evaluative method used to rank priorities and to analyse data. This technique makes it possible to collect and rank the opinions of different professionals (even from different languages) in different groups on a specific health question. NGT has been widely used in health planning research from cancer needs (Corner et al., 2007) to planning for a new service (Ng, 2000). It has been used to enhance participation of users or care givers in palliative care (Aspinal, Hughes, Dunckley, & Addington-Hall, 2006) or in the very narrow domain of end of life care for users with dementia (Dening, Jones, & Sampson, 2013). This technique was used also in the field of criminology with delinquent (Vander Laenen, 1997). Each group must count between 5 and 10 participants, some authors recommend 5 to a maximum of 8 participants (Van de Ven & Delbecq, 1972). The NGT allow interviews of different professional in a short space of time (Carney, McIntosh, & Worth, 1996). For our research, it had more advantages than survey or focus group. "*For example, an evaluation survey can capture numeric data on learners' opinions about aspects of a course (e.g., on a 5-point Likert scale with anchors from "poor" to "excellent"), but the survey items are generated by the course organizers, not the learners. Therefore, learners may lack the opportunity to comment on issues not covered by the survey items. Focus groups encourage learners to generate evaluation issues about a course, but they involve only small numbers of learners rather than the whole cohort,*

*and they do not generate numeric data. Also, in a focus group, one or two vocal members who hold strong opinions can influence the group discussion to the exclusion of quiet members' ideas*." (Dobbie, Rhodes, Tysinger, & Freeman, 2004). This method is recommended in new domain. "*It is a form of qualitative research that is employed when no definitive empirical data is available to answer an important question. By achieving informed consensus as a group, the methodology diminishes individual bias. In health care, this technique has been successfully used to develop clinical practice guidelines and establish research priorities*." (Shortt, Guillemette, Duncan, & Kirby, 2010).

Nominal groups are based on "a participatory approach". Participatory research sees research as a democratic process where participants are active citizens rather than passive subjects (Corner et al., 2007).

## Selection and invitation of participants

Eighteen group meetings were planned: one French speaking and one Dutch speaking group for each of the nine professions. Each group was limited to 10 participants. Participants had to be directly involved with the subject of substance-related disorders (Van de Ven & Delbecq, 1972). The researchers first built a list of names that was assessed and completed by a panel of experts of the field (academics and professionals). Other personal contacts and Internet were used to complete the recruitment.

## Organisation of a NGT meeting

### *Homework*

Before coming to the meeting, each participant was asked to think about the role of GPs and OPs in the field of substance related problems, related to their daily practice.

### *Introduction of the nominal group*

Two researchers were involved in managing each groups. One, called the leader, led the meeting. The other helped the leader by distributing and collecting the forms, writing the arguments on the flip chart and writing the main point of the discussion.

After the presentation of each participant, the leader explained them the objectives of the study and their role. They were invited as experts on their collaboration with GPs and OPs and were asked to characterise this collaboration, if it exists, and to give their opinion on the best way to improve it, separately for GPs and OPs.

### *Silent generation of ideas*

In the first round, the participants began by answering the question: "*In your profession, when you were confronted with someone who showed a problem with substance abuse, what did you expected from a GP / what did you expect from an OP?*" The question was in the past tense in order to encourage participants to remember concrete problems they encountered. Participants had to fill in as many expectations they could on an A4 form, in a maximum of 15 minutes (Figure 1). The leader's assistant then collected the forms. Most of the groups finished this task in 10 minutes.

| **Up-To-Date: a mirrored view of the GP and OP role in the field of substance-related disorder**<br>***Drug concerned** : alcohol, benzodiazepines (tranquillisers and sleeping pills) or illicit drugs* | |
|---|---|
| **In your profession, when you were confronted with someone who showed a problem with substance use,** | |
| **what did you expect from a general physician?** | **what did you expect from an occupational practitioner?** |
| | |

**Figure 1: Form example**

## *Sharing ideas and clarification*

In the second round, each participant was asked to give his first expectation for GPs. On a flip chart, the leader's assistant wrote each proposition. When a robin-round was completed, the first participant was asked to give his second proposition, and so on. The flip chart's sheets were stuck on the wall so that each participant could see the expectations given by the group. The leader tried to limit each proposition to one idea. When all expectations were expressed, the ideas were discussed and the participants with the help of the leader tried to merge the propositions containing similar ideas.

## *Voting and ranking*

In the third round, when the discussion was over, the participants were asked to choose 5 propositions over the role of GPs and to rank them with a number from 5 (most important) to 1 (less important). They received a second form to perform this task (Figure 2).

## *Fourth and fifth rounds*

The fourth and fifth rounds were the same as the second and third rounds but for OPs. For participants of the working sector (who had more proximity with OPs), the second and third rounds were done for OPs and the fourth and fifth for GPs.

**Up-To-Date: a mirrored view of general physicians and occupational practitioners in the field of substance-related disorder**

***Drug concerned** : alcohol, benzodiazepines (tranquillisers and sleeping pills) or illicit drugs*

**Please write the 5 propositions that you find the most important** (write their number)
**and rank them from 5** (most important) **to 1** (less important)

**In your profession, when you were confronted with someone who showed a problem with drug use** (alcohol, psychotrop medicine or illicit drugs)**,**

| what did you expect from **a general physician?** | what did you expect from **an occupational practitioner?** |
|---|---|
| | |

**Figure 2 : Form example**

## *Nominal groups by e-mail*

For some professions difficult to gather in a single meeting (psychiatrists, judicial sector, internal prevention advisers), we asked participants to do the same exercise by e-mail. The method was as close as possible to the method described for the NGT. Consent to participate was asked by e-mail and/or by phone. In case of agreement, the operating instructions and the question were sent by e-mail to fulfil the first form (Fig. 1). The responses were gathered in a table and two researchers merged the propositions which had a same meaning in a consensual manner. The final list was sent back to each participant for ranking in a similar way than for classical nominal group meetings. The scores were sent back to each participant as a feedback.

## *Categorisation*

As the analysis was performed by the French-speaking team, the Dutch results were translated into French, and back translated into Dutch for checking by the Dutch-speaking team.

After translation, the propositions were copied in two Microsoft Excel tables (one for GPs and one for OPs). During the categorisation process, we created at first a subcategory for each proposition. Then we built categories and themes. We revised the result a few times in order to have a coherent categorisation, as close as possible to the meaning of each proposition. The analysis was done separately with the same method for both professions. When this was done, the other researcher reviewed the analysis and made some comments. The first researcher reviewed these comments and, during a meeting, the last discrepancies in their analysis were solved.

### *Calculation*

In order to find the most important subcategories for our participants, we evaluated the relative weight of each subcategory. We calculated first the sum of the points given for GPs propositions (GPs denominator) and for OPs propositions (OPs denominator). Then we divided the sum of the points of the propositions in a subcategory by the denominator. We did the same for the votes. After calculating the relative score of each subcategory, we sorted all the subcategories by decreasing order of these scores and analysed the first 10 subcategories.

# Results

## Recruitment process

For the recruitment of French speaking participants, more than 200 persons were contacted at least once by e-mail or by phone. We gathered 49 participants in 6 nominal groups and 2 groups per e-mail (Table 1). Participants for the psychologists group and the social workers group could be quickly found almost only with one e-mail. Internal prevention advisers also gave quickly their consent when contacted by phone, thanks to the names and phone numbers given by a professional association of internal prevention advisers. For these three professions, one third of the persons contacted once agreed to participate. As trade union delegates were difficult to contact, we asked to each internal prevention adviser to give us names of persons in their company. The delegates were then contacted and agreed to participate quite easily by phone. Some were also invited after finding their names and e-mail on Internet. For employer's representatives, we also asked a name to the internal prevention advisers and used Internet but it was much more difficult to find enough participants. For external prevention advisers, participants or key persons often did not answer to e-mails or negatively, so we searched names on the Internet site of the different companies specialised in prevention and protection at work and try to contact them. Numerous phone calls and e-mails were necessary.

In the French speaking groups, we used a NGT by e-mail to gather propositions from psychiatrists and from the judicial sector. People from the judicial sector were interested to participate (one on three persons contacted), but they sometimes needed phone calls and e-mails to remember to send their propositions or their ranking of the propositions we sent. Psychiatrists were very difficult to recruit even if we had a name and a referee. We tried to do a NGT by e-mail with pharmacists, however they were difficult to contact (as psychiatrists, they did not answered to e-mail and were not easily motivated when contacted by phone). 6 pharmacists agreed to participate but only 3 sent propositions. As we ran out of time in our research, we stopped the inclusion of pharmacists. Another reason was that the propositions sent by the 3 pharmacists were not different from the propositions already gathered in the other groups.

Psychiatrists, psychologists and social workers who accepted to participate worked in health care institutions (hospital or specialised addiction centres). Internal prevention advisers, employer's representatives and trade union delegates worked in different type of companies: banking and insurance, hospital, chemistry, manufacturing, steel company, public utility, public transportation and municipality.

Due to the method of the nominal group, each participant actively participated to the expression and ranking of propositions. The process was designed for a meeting of 90 min. However, since the

questions were asked two times (GPs and OPs), 90 min was a minimum and our meetings lasted up to 180 min.

The Dutch speaking researchers had great difficulties to find participants. They gathered 2 nominal groups (for social workers and psychologists) and 2 groups per e-mail (for psychiatrists and internal prevention advisers).

**Table 1 : Results of the recruitment process**

| | | French speaking groups | | | | | | Dutch speaking groups | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| N | **Professions** | **Type of group** | **N partic.** | **N partic. GP** | **N partic. OP** | **N propos. GP** | **N propos. OP** | **Type of group** | **N partic.** | **N partic. GP** | **N partic. OP** | **N propos. GP** | **N propos. OP** |
| **1** | Social workers | Meeting | 6 | 6 | 6 | 20 | 9 | Meeting | 6 | 6 | 0 | 16 | - |
| **2** | Psychologists | Meeting | 6 | 6 | 5 | 21 | 10 | Meeting | 4 | 4 | 3 | 20 | 8 |
| **3** | Employers | Meeting | 4 | 4 | 4 | 9 | 12 | - | - | - | - | - | - |
| **4** | Internal prevention advisers | Meeting | 8 | 8 | 8 | 10 | 19 | E-mail | 3 | 3 | 3 | 9 | 12 |
| **5** | Trade union delegates | Meeting | 8 | 8 | 8 | 10 | 15 | - | - | - | - | - | - |
| **6** | External prevention advisers | Meeting | 5 | 5 | 5 | 9 | 13 | - | - | - | - | - | - |
| **7** | Psychiatrists | E-mail | 5 | 5 | 5 | 18 | 15 | E-mail | 6 | 6 | 6 | 24 | 25 |
| **8** | Judicial field | E-mail | 7 | 7 | 4 | 18 | 10 | - | - | - | - | - | - |
| **9** | Pharmacists | E-mail | 6 | - | - | - | - | - | - | - | - | - | - |
| | | | **Sum:** | **49** | **45** | **115** | **103** | | **Sum:** | **19** | **12** | **69** | **45** |

## Participant's expectations about GPs

The 68 participants made 184 propositions on the role of GPs in substance abuse problems. The propositions were categorised in 43 subcategories (see Appendix 1), grouped in 13 categories and 4 themes (see Table 2). Among the 184 propositions, 88 (48%) were related to the health care relationship between GPs and their patients; 57 (31%) to the contact between GPs and other professions; 33 (18%) to the training of GPs and their attitude about addiction; 6 (3%) to the organisational level of GPs' work.

In Appendix 1 and in Table 3, the subcategories are sorted with a centrifugal logic starting from the person of the GPs (training and attitude in general) to the organisational level of health care. In the theme "Action of GPs towards patients", we sorted subcategories and categories by chronological order.

Table 2: Themes and categories on the role of GPs

| Propos. (n=184) | Themes and categories |
|---|---|
| **33** | **Training and attitude of GPs related to addiction** |
| 16 | - Specific training for GPs |
| 17 | - Attitude of GPs about addiction |
| **88** | **Action of GPs towards patients** |
| 6 | - Addiction prevention |
| 20 | - Diagnose |
| 30 | - Taking care of the alcohol/drug use problem |
| 1 | - Harm reduction |
| 26 | - Taking the context into account |
| 5 | - Controlling the patient |
| **57** | **Contact of the GPs with other professions** |
| 39 | - Contact with the health field |
| 11 | - Contact with services of prevention and protection |
| 7 | - Contact with the judicial sector |
| **6** | **Organisational level** |
| 2 | - GPs referee |
| 4 | - Recording substitution treatment and controlling patients |

## Most important themes selected by the participants for GPs

To find which the most important subcategories were for the participants, we calculated the relative weight of each subcategory. Table 3 shows the 10 most important subcategories by decreasing order. These subcategories contained half of the propositions (n=91; 49%) made for GPs.

4 subcategories belonged to the theme "Contact of the GPs with other professions" and asked for more collaboration. In the first subcategory, the 9 propositions were given and supported only by the working sector (8 propositions from internal and external prevention advisers and 1 from an employer's representative). These propositions asked for collaboration between the OPs and the SPP. More precisely, participants asked GPs to give information about their patient to OPs (n=3) or SPP (n=1); to take contact with OPs (n=2) or SPP (n=2) and to follow the recommendations of OPs (n=1). The third subcategory contained 19 propositions made by the 3 professions of the health sector. The participants asked for more collaboration with other professions (n=10); GPs must exchange information about the patients (n=3); they should be more available for dialog with the health sector (n=3); they must work with the network (n=2); they must take contact with specialised services (n=1). In the fourth subcategory, 5 professions (health and working sectors) expected GPs to

be the referee for patients with alcohol/drug problem (n=5), the active coordinator of the care of their patients (n=2) or a confidential counsellor (n=1). In the tenth subcategory, participants asked GPs to direct, to refer or to support their patients towards specialised care services. 3 propositions added a precision: "according to the demand of the patient", "GPs must refer to the psychologist before an emergency situation" and "GPs must first assess if they are competent".

4 other subcategories were in the theme "Action of GPs towards patients". The second subcategory was made of propositions expressed by the health sector (3 professions) and by the working sector (2 professions), by French and Dutch speaking participants. In this subcategory, participants wanted GPs to be more active and quicker in addressing alcohol/drug use problems (n=4), they must do screening (n=3) and must question their patients about alcohol/drug (n=1). The fifth subcategory gathered 8 propositions from the working sector. Participants wanted GPs to be conscious of the professional risks taken when a worker with substance abuse problem is at work (n=3), to put their patient on a sick leave to prevent professional hazards (n=3), to assess the risks due to substance abuse problem of the patient (n=1), to inform the worker about these risks (n=1). The sixth subcategory was also about prevention but in the health field. 5 different professions wanted GPs to do general prevention (n=2), prevention about the health risks (n=2), about the risk of addiction (n=1) and about the social and familial risks (n=1). In the ninth subcategory, participants of the health sector wanted GPs to support their patients during the care process: following patients on the long term (n=5), taking care of the relapses (n=1), giving specific consultations for addiction (n=1), taking care globally of the patient (n=1), making a treatment plan (n=1).

2 subcategories were related to the theme "Training and attitude of the GPs". In the seventh subcategory, participants of 4 professions wished that GPs knew better the possibilities of care for their patients with alcohol/drug problem. In the eighth subcategories, participants hoped that GPs were available to take care of patients with alcohol/drug problem (n=3), paid attention to this problem (n=2), did not ignore the alcohol/drug problems of a patient (n=2) and dared to take care of these patients (n=2).

In the subcategories not listed in Table 5, participants asked for a better training of GPs concerning substance abuse problems and the different possibilities of treatment. Participants also wanted GPs to have a more positive attitude towards addiction and its complex evolution. GPs must listen and understand the situation of the patient, with tolerance and without judging. They must take care of the addiction problem and activate their patients: make patients aware of this problem and encourage them to treat it. GPs must also take care of the comorbidities (on the physic, mental and social level) and must pay attention to the context of the patient (including his/her family). They must be careful when prescribing benzodiazepines. Participants from the domain of youth protection wanted GPs to communicate information about their patients if children were at risk. Participants form the judicial sector wanted GPs to treat patients in mandatory treatment and to communicate information about the follow-up of this mandatory care. Some psychiatrists and social workers wanted to create GPs specialists of addiction problems.

**Table 3: The 10 most important subcategories by decreasing order on GPs role**

**Table 3**

| N | Themes | Categories | Sub-categories | Relative weight | Sum of points | Sum of votes | Nb of prop. | Nb of prop. from health field | Nb of prop. from work field | Nb of prop. from judiciary field | Nb of prop. (French) | Nb of prop. (Dutch) | Nb of profes-sions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Contact of the GPs with other professions | Contact with SPP* | Collaboration with SPP | 10% | 105 | 33 | 9 | 0 | 9 | 0 | 6 | 3 | 3 |
| 2 | Action of GPs towards patients | Diagnose | Addressing the alcohol/drug use problem quickly and clearly | 8% | 80 | 21 | 8 | 6 | 2 | 0 | 3 | 5 | 5 |
| 3 | contact of the GPs with other professions | Contact with other health and social workers | Collaboration with other health or social workers | 7% | 73 | 25 | 19 | 19 | 0 | 0 | 7 | 12 | 3 |
| 4 | Contact of the GPs with other professions | Contact with other health or social workers | Coordination of care around the patient | 6% | 63 | 20 | 9 | 7 | 2 | 0 | 7 | 2 | 5 |
| 5 | Action of GPs towards patients | Taking the context in account | Taking in account the professional risks | 6% | 59 | 20 | 8 | 0 | 8 | 0 | 7 | 1 | 3 |
| 6 | Action of GPs towards patients | Addiction prevention | Doing prevention of drug/alcohol use problems | 5% | 56 | 20 | 6 | 3 | 2 | 1 | 5 | 1 | 5 |
| 7 | Training and attitude of GPs related to addiction | Specific training for GPs | Knowing the care network | 4% | 41 | 12 | 6 | 5 | 1 | 0 | 4 | 2 | 4 |
| 8 | Training and attitude of GPs related to addiction | Attitude of GPs about addiction | Accepting to take care of addiction problems | 4% | 39 | 12 | 9 | 7 | 2 | 0 | 4 | 5 | 5 |
| 9 | Action of GPs towards patients | Taking care of the alcohol/drug use problem | Following the patient during and after special care | 4% | 37 | 12 | 9 | 8 | 1 | 0 | 4 | 5 | 4 |
| 10 | Contact of the GPs with other professions | Contact with other health or social workers | Referring to specialised care services | 4% | 37 | 12 | 8 | 6 | 1 | 1 | 7 | 1 | 5 |

** Services of prevention and protection at work*

## Expectations about OPs

The 147 propositions for OPs were categorised in 4 themes, 9 categories (Table 4). A table with the 37 subcategories is in Appendix 2.

Table 4: Themes and categories on the role of OPs

| N propos. | Themes and categories |
|---|---|
| **18** | **Training and attitude of OPs related to addiction** |
| 10 | - Specific training for OPs |
| 8 | - Attitude of OPs about addiction |
| **57** | **Action of OPs towards worker** |
| 11 | - Risks prevention |
| 6 | - Screening |
| 22 | - Follow-up of the worker |
| 18 | - Adapting the work of the worker |
| **63** | **Contact of the OPs with other professions** |
| 39 | - Contact in the company |
| 24 | - Contact outside the company |
| **9** | **Organisational level** |
| 9 | - Organisation of the prevention and protection at work |

We listed the 10 most important propositions for our participants in Table 5. These subcategories contained half of the propositions made for OPs (79; 54%).

4 subcategories belonged to the theme "Action of the OP towards the worker". In the first subcategory, participants asked OPs to take action to prevent professional risk: like stopping the worker from working (in 4 propositions) or adapting the work station (n=3). In the fifth subcategory, participants wished OPs to pay attention to the worker and his situation. OPs, in the seventh subcategory, must inform the worker on the risks taken by his/her substance use: in general (n=2), about professional risks (n=2), about health risks (n=1) and about risk of dismissal (n=1). In the eighth subcategory, participants (mainly from the health sector) wanted OPs to find solutions to help the worker: helping the worker to get back to work gradually (n=3), giving sick leave to protect the worker from the employer (n=1), supporting the worker in sick leave from pressure from the employer (n=1), finding other solution than sick leave (n=1).

5 other subcategories concerned the theme "Contact of the OPs with other professions". In the second subcategories, propositions, mainly from the working sector (n=9), asked for more collaboration between OPs inside the company: with SPP (n=5), with other social help (n=5) or with

the confidence person asked by the worker (n=1). In the third subcategory, participants wanted OPs to collaborate with the employer: to discuss with the employer to find a solution about the substance abuse problem of a worker (n=5), to give information about substance abuse problem (n=4), to help the employer by preventive actions (n=1) or by training (n=1), to attest the incapacity of a worker in an emergency situation (n=1), to inform the worker of the expectancies of the employer (n=1). In the fourth subcategory, 6 propositions on the 7 came from the working sector who wanted OPs to collaborate with GPs about the alcohol/drug problem of the worker: collaboration must concern the treatment (n=3), the sick leave (n=2), the screening by the GP (n=1) and the reasons of alcohol/drug problem (n=1). In the ninth subcategory, OPs must do active alcohol and drug use prevention inside the company to prevent problems: they must give a sense of responsibility to the employer (n=2), make prevention campaign or help the company to do it (n=3), do screenings in the company (n=2) and change the internal work rules (n=1) or prohibit alcohol use in the company (n=1). In the tenth subcategory, participants asked OPs to direct or refer the worker to external health and social service (n=7).

The sixth subcategory belonged to the theme "Training and attitude of the OPs". 5 on the 6 propositions came from the health sector. Participants wanted OPs to see the worker without judging and stigmatising (n=4) and as a patient (n=2).

In subcategories not shown in Table 4, participants wished that OPs had more specific training in alcohol and drug problems, OPs must also know the health and social care network. They must understand and accept the difficult process of addiction (a long process different for each patient, with relapses).

In their relationship with workers, OPs must give information on treatment and other possibilities. They must do active screening to reveal alcohol and drug users. They must address quickly and clearly the problem before a crisis. They must make the worker aware of his/her problem, speaking of addiction if necessary. They must take care of the substance abuse problem and put pressure on the worker to find help. If the worker was on sick leave, they must help him/her to reintegrate his/her work (like seeing him/her before the return to work and trying to adapt their work).

OPs must also dialog with other professions: inside the company, with trade union delegates and with the team of the worker (respecting the professional secrecy); outside the company, with other health and social professions.

On an organisational level, some participants of public institutions would like the collective agreement 100 on prevention of alcohol and drug in the working sector to be mandatory in their field. Others wished OPs would be more available (by phone, after work hours) and would be identifiable.

**Table 5: The 10 most important subcategories by decreasing order on OPs role**

| | Themes | Categories | Sub-categories | Relative weight | Nb of prop. | Nb of prop. from health field | Nb of prop. from work field | Nb of prop. from judiciary field | Nb of prop. (French) | Nb of prop. (Dutch) | Nb of profes-sions | Sum of points | Sum of votes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Action from the OP towards the worker | Adapting the work to the worker | Adapting the work to prevent risks | 8,4% | 8 | 3 | 2 | 3 | 7 | 1 | 4 | 72 | 19 |
| 2 | Contact of the OP with other professionals | Contacts in the company | Collaborating with SPP | 6,9% | 11 | 2 | 9 | 0 | 9 | 2 | 5 | 59 | 19 |
| 3 | Contact of the OP with other professionals | Contacts in the company | Collaborating with the employers | 6,7% | 13 | 3 | 9 | 1 | 8 | 5 | 6 | 57 | 20 |
| 4 | Contact of the OP with other professionals | Contacts outside the company | Collaborating with GP | 6,5% | 7 | 1 | 6 | 0 | 6 | 1 | 5 | 56 | 19 |
| 5 | Action from the OP towards the worker | Follow-up of the worker | Listening to the worker and understanding his situation | 6,3% | 5 | 1 | 4 | 0 | 3 | 2 | 3 | 54 | 17 |
| 6 | Training and attitude of the OP towards addiction | Attitude of the OP towards addiction | Showing tolerance and no judging | 5,7% | 6 | 5 | 1 | 0 | 4 | 2 | 4 | 49 | 15 |
| 7 | Action from the OP towards the worker | Prevention of the risks | Informing on risk related to alcohol/drug use | 5,4% | 6 | 2 | 4 | 0 | 5 | 1 | 4 | 46 | 14 |
| 8 | Action from the OP towards the worker | Adapting work to the worker | Adapting work to help the worker | 5,4% | 6 | 5 | 1 | 0 | 5 | 1 | 4 | 46 | 15 |
| 9 | Contact of the OP with other professionals | Contacts in the company | Doing active prevention in the company | 4,6% | 10 | 2 | 8 | 0 | 7 | 3 | 6 | 39,5 | 14 |
| 10 | Contact of the OP with other professionals | Contacts outside the company | Referring to health and social professionals | 4,3% | 7 | 4 | 2 | 1 | 6 | 1 | 4 | 37 | 14 |

** Services of prevention and protection at work*

# Discussion

## Process

When participants were gathered in a meeting, the nominal group was very easy to manage. However, finding participants ready to participate was difficult for some professions (psychiatrists, pharmacists, external prevention advisers and employer's representatives). It was a time consuming procedure. The French speaking researchers managed 8 groups but were out of delay to gather the pharmacists. The Dutch speaking researchers managed to gather 4 groups. However, the number of propositions was sufficient to have the expectations of the participants on the different aspects of the role of GPs and OPs.

Sixty-eight professionals, representing 8 different professional fields, participated. Little is known about the representativeness of participants in consensus development groups. Our sample is to be considered as a qualitative sample rather than a representative one designed for statistical purpose. We chose homogeneous groups to isolate particular opinions that could arise during the meetings, and to avoid conflicts between participants (e.g. between employers and trade unions delegates); however, it is known that heterogeneous groups can have better performance (Murphy et al, 2008).

## Main findings for GPs

For GPs, the theme containing the higher number of propositions was related to their main role: the health care relationship with their patients. Participants wanted GPs to clearly address the substance abuse problem to the patient and without delay (at the first signs of use). GPs must not ignore the problem or judge it. They must tackle the substance abuse problem, while taking care globally of the patient: taking in account comorbidities and contexts (familial, social and professional). However, participants did not expect GPs of the substance abuse problem to take care from A to Z. On the contrary, after addressing the problem, GPs were expected to refer their patient if necessary to specialised health care professionals. GPs must collaborate with these other professions (communicating, being available and listening to their advices). After refereeing a patient, GPs must keep a central role: following the patient and coordinating the care actions around him/her.

To help the GPs in this role, participants wished that GPs had a better training on addiction and on the possibilities of care.

For professions of the working sector, the main concern was the work hazards represented by a patient using substances. To avoid these risks, they expected GPs to take in account the professional risks and to put the patient in sick leave if necessary. They especially expected GPs to collaborate with OPs and SPP in case of alcohol/drug problem.

Many propositions revealed suspiciousness from the health sector towards GPs. Participants were afraid that GPs confronted with substance abuse problem would shut their eyes, minimise the problem or refuse to take care of these patients. Participants also suspected GPs to be unaware of the chronic side of addiction and of its uncertain evolution with relapses.

## Main findings for OPs

In the propositions about the role of OPs, participants asked OPs to have more knowledge about addiction. They wished OPs to be more active in screening and in detecting substance abuse problems. They wanted OPs to help actively the company in doing preventive action, in general screening, in giving information to employers if alcohol/drug problem were detected, in helping employers to find a solution for a specific worker or a general solution at the level of the company. With a worker on sick leave, participants asked OPs to find solution to reintegrate the worker in his/her work.

The majority of propositions about OPs were in relation with the professional risks represented by a worker with substance abuse problem. However, 3 participants (from the health and judicial sectors) seemed to misunderstand the role of OPs and wished OPs could take care of the substance abuse problem themselves.

## Strengths and weaknesses

We based the discussion on what participants said. This reflected the way the participants saw GPs and not how GPs are really working. The advantage of this method was that the propositions were not changed or resumed: they still appear in the table used for our analysis. Our analysis was very close to what participants said and we did not deduce their thoughts. As we interviewed different professions and as the method aimed at collecting different arguments, we should have an overview of the different expectations possible for the role of GPs and OPs. The categorisation of each proposition was made by two researchers, and the discrepancies were solved in a consensual way. A limit of the NGT was that we could only ask one question to the participants. So we have information about their expectations but not about their actual collaboration with GPs and OPs.

Some proposals that were expressed could seem unrealistic: some professionals desired to know elements that are under professional secrecy of the physicians. This is a fact that underlines the need for correct information on this topic, particularly for OPs' professional secrecy.

# Conclusion

The participants expected GPs to play a major role in the care of substance abuse problems. An important part of this role is to detect the substance abuse problems, to make the patient aware of it, to motivate the patient to treatment and to follow the patient during the long process of the treatment of addiction. However, in their majority, our participants did not expected GPs to stay alone in the treatment of these patients or to solve themselves the alcohol/drug problem of their patients. On the contrary, they wished GPs to send patients to specialised care when needed and to collaborate with other professions, while keeping a central position in the follow-up of their patients.

From OPs, participants expected an active role in detecting substance abuse problem and in protecting the company from the risks represented by workers using alcohol or drugs, while finding a solution for these workers.

**Contributors**

Isabelle Demaret, Linda Symons and Marc Vanmeerbeek contributed to the collection of the data. Isabelle Demaret and Marc Vanmeerbeek analysed the data. Isabelle Demaret wrote most of the manuscript. All authors contributed to this research.

**Acknowledgement**

We thank all the participants who kindly agreed to help us in our research.

**Declaration of interest**

The authors report no conflict of interest.

# References

Aspinal, F., Hughes, R., Dunckley, M., & Addington-Hall, J. (2006). What is important to measure in the last months and weeks of life?: A modified nominal group study. *Int J Nurs Stud, 43*(4), 393-403. doi: 10.1016/j.ijnurstu.2005.06.005

Carney, O., McIntosh, J., & Worth, A. (1996). The use of the Nominal Group Technique in research with community nurses. *J Adv Nurs, 23*(5), 1024-1029.

Corner, J., Wright, D., Hopkinson, J., Gunaratnam, Y., McDonald, J. W., & Foster, C. (2007). The research priorities of patients attending UK cancer treatment centres: findings from a modified nominal group study. *Br J Cancer, 96*(6), 875-881. doi: 10.1038/sj.bjc.6603662

Dening, K. H., Jones, L., & Sampson, E. L. (2013). Preferences for end-of-life care: a nominal group study of people with dementia and their family carers. *Palliat Med, 27*(5), 409-417. doi: 10.1177/0269216312464094

Dobbie, A., Rhodes, M., Tysinger, J. W., & Freeman, J. (2004). Using a modified nominal group technique as a curriculum evaluation tool. *Fam Med, 36*(6), 402-406.

Murphy, M., Black, N., Lamping, D., McKee, C., Sanderson, C., Askham, J., & Marteau, T. (1998). Consensus development methods, and their use in clinical guideline development. Health Technology Assessment, 2(3), 100. Retrieved from: http://www.hta.ac.uk/fullmono/mon203.pdf

Ng, P. (2000). Applying nominal group method to needs identification in Hong Kong mental health services. *Adm Policy Ment Health, 27*(4), 247-252.

Shortt, S. E., Guillemette, J. M., Duncan, A. M., & Kirby, F. (2010). Defining quality criteria for online continuing medical education modules using modified nominal group technique. *J Contin Educ Health Prof, 30*(4), 246-250. doi: 10.1002/chp.20089

Van de Ven, A. H., & Delbecq, A. L. (1972). The nominal group as a research instrument for exploratory health studies. *Am J Public Health, 62*(3), 337-342.

Vander Laenen, F. (1997). The nominal group technique, a participative research technique holding great potential for criminology. In M. Cools, De Kimpe, S., De Ruyver, B., Easton, M., Pauwels, L., Ponsaers, P., Vander Laenen, F., Vande Walle, G., Vermeulen, G. (Ed.), *Contemporary issues in the empirical study of crime* (pp. 262). Antwerpen: Maklu.

## More references on the nominal group technique

Castiglioni, A., Shewchuk, R. M., Willett, L. L., Heudebert, G. R., & Centor, R. M. (2008). A pilot study using nominal group technique to assess residents' perceptions of successful attending rounds. J Gen Intern Med, 23(7), 1060-1065. doi: 10.1007/s11606-008-0668-z

Drennan, V., Walters, K., Lenihan, P., Cohen, S., Myerson, S., & Iliffe, S. (2007). Priorities in identifying unmet need in older people attending general practice: a nominal group technique study. Fam Pract, 24(5), 454-460. doi: 10.1093/fampra/cmm034

Harvey, N., & Holmes, C. A. (2012). Nominal group technique: An effective method for obtaining group consensus. International Journal of Nursing Practice, 18(2), 188-194. doi: 10.1111/j.1440-172X.2012.02017.x

Hawkins, P. R. (1969). Social class, the nominal group and reference. Lang Speech, 12(2), 125-135.

Miller, D., Shewchuk, R., Elliot, T. R., & Richards, S. (2000). Nominal group technique: a process for identifying diabetes self-care issues among patients and caregivers. *Diabetes Educ, 26*(2), 305-310, 312, 314.

Ng, P. (2000). Applying nominal group method to needs identification in Hong Kong mental health services. Adm Policy Ment Health, 27(4), 247-252.

van Teijlingen, E., Pitchforth, E., Bishop, C., & Russell, E. (2006). Delphi method and nominal group technique in family planning and reproductive health research. J Fam Plann Reprod Health Care, 32(4), 249-252. doi: 10.1783/147118906778586598

Wainwright, D., Boichat, C., & McCracken, L. M. (2013). Using the nominal group technique to engage people with chronic pain in health service development. Int J Health Plann Manage. doi: 10.1002/hpm.2163

# Appendix 1: Code structure for GPs

| Theme | N | Category | N | Sub-category | N |
|---|---|---|---|---|---|
| **Training and attitudes about substance abuse** | **33** | Specific training | 16 | Knowledge about addiction and substances | 6 |
| | | | | Knowledge of specific management techniques | 3 |
| | | | | Knowledge of the help and care network | 6 |
| | | | | Common training with psychologists | 1 |
| | | Attitudes | 17 | Be tolerant and avoid judgement | 3 |
| | | | | Accept addiction management | 9 |
| | | | | Accept addiction as a complex process | 5 |
| **GP's action with the patient** | **88** | Addiction prevention | 6 | Prevent abuse-related problems | 6 |
| | | Diagnosis | 20 | Avoid trivialising substance abuse | 4 |
| | | | | Quick and clear approach of substance abuse | 8 |
| | | | | Be sensitive to patients and understand the situation | 6 |
| | | | | Assess motivation for change | 2 |
| | | Substance abuse management | 30 | Actively manage substance abuse | 4 |
| | | | | Home visits | 1 |
| | | | | Activate the patient | 6 |
| | | | | Substance withdrawal | 2 |
| | | | | Prescribe adequate drugs | 2 |
| | | | | Prescribe carefully | 5 |
| | | | | Support the patient during and after treatment | 9 |
| | | | | Accept patients placed under judicial control | 1 |
| | | Risk reduction | 1 | Treat substance abuse-related problems, without requiring | 1 |

| | | | | | |
|---|---|---|---|---|---|
| | | | | withdrawal | |
| | | Consideration to context | 26 | Manage co-morbidities | 7 |
| | | | | Take context into account | 4 |
| | | | | Involve relatives, and take them into account | 4 |
| | | | | Family referral | 2 |
| | | | | Take professional risks into account (sick leave if necessary) | 8 |
| | | | | No convenience sick leave | 1 |
| | | Patient control | 5 | Avoid prescriptions theft | 2 |
| | | | | Supervise treatment adherence | 3 |
| **Relationship with other professionals** | **57** | Relationship with specialised professionals | 39 | Refer to specialised care facilities | 8 |
| | | | | Collaborate with other help professionals | 19 |
| | | | | Ensure respect of professional secrecy | 2 |
| | | | | Use a data sharing system | 1 |
| | | | | Coordination of care | 9 |
| | | Relationship with occupational health services | 11 | Refer the patient to an occupational health service (including occupational physician) | 2 |
| | | | | Collaborate with occupational health service (including occupational physician) | 9 |
| | | Relationship with judicial staff and youth protection | 7 | Share information about treatment adherence | 2 |
| | | | | Share information about the medical treatment (drugs) | 1 |
| | | | | Be available for a tripartite meeting | 1 |
| | | | | Share information to protect children | 3 |
| **Organisation of GP's work** | **6** | GP adviser | 2 | Create a new role of GP adviser for addictions | 2 |
| | | Patient control | 4 | Register the patients to avoid simultaneous management by different GPs | 2 |
| | | | | Collaborate with pharmacist to avoid double-doctoring | 2 |

| | | | | | |
|---|---|---|---|---|---|
| | **184** | | **184** | | **184** |

# Appendix 2: code structure for OPs

| Theme | N | Category | N | Sub-category | N |
|---|---|---|---|---|---|
| **Training and attitudes about substance abuse** | **18** | Specific training | 10 | Knowledge about addiction and substances | 4 |
| | | | | Knowledge of the legal framework | 1 |
| | | | | Knowledge of the help and care network | 2 |
| | | | | Training and follow-up by peers | 3 |
| | | Attitudes | 8 | Accept addiction as a complex process | 2 |
| | | | | Be tolerant and avoid judgement | 6 |
| **OP's action with the worker** | **57** | Risk reduction | 11 | Give information about substance abuse-related risks (on health and/or work) | 6 |
| | | | | Give information about available treatments and solutions | 5 |
| | | Screening | 6 | Screen actively substance abusers | 6 |
| | | Follow-up | 22 | Quick and clear approach of substance abuse | 7 |
| | | | | Be sensitive to workers and understand the situation | 5 |
| | | | | Activate the worker | 2 |
| | | | | Manage substance abuse | 3 |
| | | | | Support and follow-up of the worker | 5 |
| | | Job accommodation | 18 | Adapt workstation to help the worker | 6 |
| | | | | Adapt workstation to avoid risks | 8 |
| | | | | Support and follow-up for people back to work | 4 |
| **Relationship with other professionals** | **63** | Relationship within the company | 39 | Collaborate with occupational health service | 11 |
| | | | | Collaborate with employers | 13 |

| | | | | | |
|---|---|---|---|---|---|
| | | | | Collaborate with trade unions | 1 |
| | | | | Ensure respect of professional secrecy | 2 |
| | | | | Make prevention in the company | 10 |
| | | | | Support the worker's team | 2 |
| | | Relationship outside the company | 24 | Refer to help professionals | 7 |
| | | | | Ensure respect of professional secrecy | 2 |
| | | | | Collaborate with GPs | 7 |
| | | | | Collaborate with other help professionals | 5 |
| | | | | Collaborate with judicial staff and youth protection organisations | 3 |
| **Organisation of OP's work** | **9** | Organisation of occupational health services | 9 | Propose a personalised follow-up | 3 |
| | | | | Be easily available | 4 |
| | | | | Put a psychiatrist or a specialised professional into occupational health services | 1 |
| | | | | Apply CLA 100 in the public sector | 1 |
| | ***147*** | | ***147*** | | ***147*** |

# Part 6

# International comparison

Marie-Astrid Berrewaerts
Frederic Ketterer
Marc Vanmeerbeek

Department of General Practice/Family Medicine, University of Liege

# Objective

The aim of this work package was to identify relevant experiences or programs which aim to improve the implication of general practitioner (GP) and/or occupational physician (OP) in management of addictions. The substances considered were alcohol, illegal drugs (including cannabis), psychotropic drugs like hypnotics and tranquilizers and opiate painkillers.

# Methods

## Literature research

The literature was searched for the last ten years.

The search strings in Pubmed were:

- for GPs:

  ((("Therapeutics"[Mesh] OR "therapy"[Subheading] OR "Opiate Substitution Treatment"[Mesh]) AND ("General Practice"[Mesh] OR "General Practitioners"[Mesh])) AND ("Substance-Related Disorders"[Mesh] OR "Substance Abuse Detection"[Mesh]) AND (hasabstract[text] AND "2003/10/20"[PDat] : "2014/10/16"[PDat] AND "adult"[MeSH Terms])).

- for OPs:

  ((("Therapeutics"[Mesh] OR "therapy"[Subheading] OR "Opiate Substitution Treatment"[Mesh]) AND ("Occupational Health"[Mesh] OR "Occupational Health Physicians"[Mesh])) AND ("Substance-Related Disorders"[Mesh] OR "Substance Abuse Detection"[Mesh]) AND (hasabstract[text] AND "2003/10/20"[PDat] : "2014/10/16"[PDat] AND "adult"[MeSH Terms])).

## Grey literature research through expert networks

At the same time, a mail was sent to international experts (annex 1), asking for references of programs involving GPs and/or OPs in substances abuse management. The mail was sent to:

- National representatives of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)[1] (22 experts);
- Academic colleagues involved in a COST project on alcohol reduction harm (13 experts from Denmark, France, Germany, Greece, Ireland, Italy, Luxemburg, The Netherlands, Poland, Portugal, Spain, the United-Kingdom, and Belgium);
- The experts involved in the EQUS consensus on Minimum Quality Standards in Drug Demand Reduction (56 experts)[2]
- National representatives of the T3E network (Drug Addiction Europe Exchange Training)[3] (16 experts).

[1] EMCDDA http://www.emcdda.europa.eu/countries
[2] Minimum Quality Standards in Drug Demand Reduction EQUS http://ec.europa.eu/justice/anti-drugs/files/equs_main_report_en.pdf
[3] T3E http://www.t3e-eu.org/

Experts that were proposed by colleagues of the first round were contacted the same way in the next round.

The list of all the experts that were contacted is in annex.

The inclusion criteria were the following:

- The substances to be considered are alcohol, illegal drugs, including cannabis, psychotropic drugs (hypnotics and tranquilizers) and opiate painkillers;
- The program aims at improving or increasing GPs or OPs' involvement in the management of substance abuse(working process and/or collaboration);
- A formal assessment process is described; partial or informal assessment process can be considered;
- Reports in following languages: French, English, Dutch;
- Western or occidental way of life and working context.

The exclusion criteria were:

- No evaluation or monitoring available;
- Program concerning tobacco.

# Results

The selection process is described in figure 5. At the end, only six references were kept and discussed. Four of them concern alcohol, one concerns cannabis, and the last one concerns opioids. None concerned psychotropic drugs abuse.

It is noticeable that we didn't found any relevant publication concerning OPs (but one concerning both GPs and OPs); documents concerning OPs were mainly guidelines rather than evaluated programs or projects.

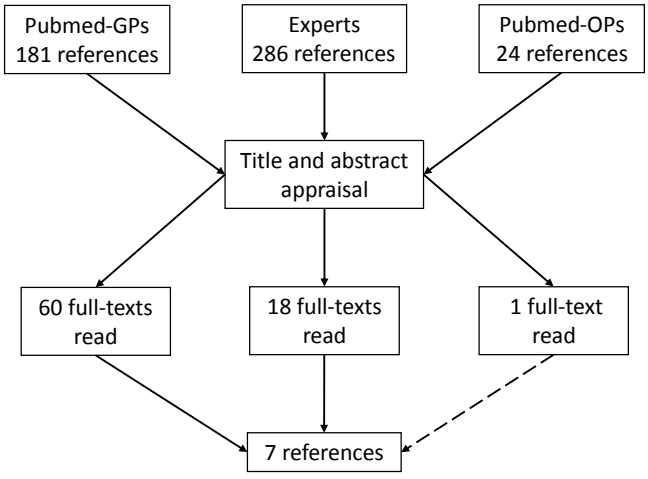



**Figure 2: Sources selection process**

The following results are presented using a systematic analysis framework including the following criteria:

- Publication date;

- Country;
- Substance(s);
- Target group(s);
- Promoter(s);
- Particular background;
- Objective(s) of the program;
- Methods;
- Recruitment process;
- Incentives;
- Results: change, pitfalls, added value, resistances, suggestions for improvement; results will be considered for patients, caregivers, promoters; the motivation factors will be of particular attention;

## Feasibility of routine alcohol screening in a primary care environment (1)

| | |
|---|---|
| **Publication date** | 2012 |
| **Country** | New Zealand |
| **Substances** | Alcohol |
| **Target group(s)** | 14 General practice centres WRPHO, and Whanganui Accident and Medical Clinic |
| **Promoter(s)** | Whanganui Regional Primary Health Organisation (WRPHO), the umbrella for participating Whanganui general practices, in partnership with Te Kaunihera Whakatupato Waipiro o Aotearoa / ALAC. |
| **Particular background** | New-Zealand – Maori population |
| **Objective(s) of the program** | The demonstration project aimed to facilitate a change in the way that alcohol was being addressed at primary health care level. Components of the intervention included systematising the recording of alcohol consumption, increasing patient knowledge of low risk drinking, and creating simple pathways by which to address potentially harmful alcohol consumption: a systemised ABC alcohol screening and brief intervention (SBI) (A: interrogation; B: Brief advice; C: Counselling). |
| **Methods** | Clinicians were provided with specific training to equip them to screen patients for alcohol consumption and provide brief advice.<br>Training included the purpose of screening, administration of ABC screening, completion of the advanced clinical form, communication skills /motivational interviewing and the use of brief intervention skills. Three training options were available; professional development workshops delivered by outside consultants, locally facilitated inter-professional education meeting sessions and small group/peer learning support in the practice setting.<br>The Patient Dashboard clinical reminder system which WRPHO practices use to monitor and record key individual patient health data, provided the technical platform support for implementation of the ABC alcohol SBI approach. The demonstration project |

| | |
|---|---|
| | involved the development of a clinical alcohol recording template accessed through the Patient Dashboard, allowing the recording of the data.<br>A qualitative process evaluation was conducted to assess effectiveness of the training component, factors influencing provider participation, and factors influencing implementation of the project in particular relevance, ownership, impact on work and linkages with other providers with respect to referrals. |
| **Recruitment process** | |
| **Incentives** | A subsidy payment was available for assessment of patients whose reported alcohol use necessitated completion of the 10-question AUDIT tool. A further subsidy payment was available for providing subsequent alcohol counselling within the practice. |
| **Results: change, pitfalls, added value, resistances, suggestions for improvement…** | Key motivators for participation ranged from responding to the perceived expectation that all practices would take part as members of the PHO, through to the much more commonly cited interest in influencing positive change around acknowledging and dealing with patient alcohol issues. Financial incentives, while considered by some to be a necessary component of the intervention, were not cited as being the critical motivator for participating clinicians. These incentives were however, considered necessary to secure additional clinical time to carry out the intervention.<br>In relation to this, practice configuration appeared to play a role in ease of implementation; those practices that had a wellness focus and protected nurse time for health screening were able to implement all components of the intervention with ease. While this type of practice configuration was considered ideal for implementation, key informants generally took the view that the A, and even the B, phases of the ABC alcohol SBI intervention were able to be implemented without significant impact on existing workload.<br>Practice infrastructure such as integrated IT support and familiarity with IT programmes allowed for quick uptake and reporting.<br>Patient participation in the intervention was also a key factor in uptake.<br>Clinical leadership was a critical feature contributing to project success.<br>A further positive development influenced by project implementation was improved referral processes to specialist alcohol and other drug (A&OD) services.<br>The most significant challenge to project implementation identified was the non-alignment of the formal component of the training to the needs of the project; the externally contracted professional development workshops were considered least useful and face to face training in the practice setting the most useful. Key issues identified were the importance of ensuring availability of skills based as opposed to theory based training. This included an emphasis on individual coaching as well as the opportunity for 'hands on' exposure to the use of both tools and methods in a |

| | |
|---|---|
| | supervised setting.<br>Implementing the interpersonal component of the intervention, in tandem with the IT component, was challenging for some primary care practitioners. Alcohol use patterns are influenced by social and cultural factors and can be an emotive issue for both practitioner and patient. Repositioning alcohol use patterns as a health consideration, which the intervention attempted to do, requires a shift in consciousness, for both practitioner and patient which may be fraught with difficulties.<br>In 10 months, WRPHO practices '**a**sked' and recorded the alcohol consumption of 43% of patients aged over 15.<br>The success of the project is primarily attributed to the use of the Dashboard reminder software and linked alcohol recording form. Other factors impacting on the successful implementation of the ABC alcohol SBI approach included the use of a clinical champion, the role of a project leader, the availability of education and training, funding for extra GP and nurse assessment time and the linking of the approach to other existing services. |

## Effectiveness of skills-based training using the Drink-less package to increase family practitioner confidence in intervening for alcohol use disorders (2)

| | |
|---|---|
| **Publication date** | 2006 |
| **Country** | Australia |
| **Substances** | Alcohol |
| **Target group(s)** | GPs |
| **Promoter(s)** | Road & Traffic Authority of New South Wales |
| **Particular background** | Urban and rural New South Wales |
| **Objective(s) of the program** | To determine whether the interactive training session using the 'Drink-less' package led to improvement in GPs' self-reported level of confidence in detecting and providing interventions for risky alcohol consumption |
| **Methods** | Introductory one-hour session 'Alcohol use disorders: update on assessment and management' (detection, diagnosis, management, pharmacotherapy).<br>Interactive skills-based training session centred on the use of the Drink-less package. Participants were trained in scoring the AUDIT, in advising the patient on drinking, arranging for ongoing treatment including pharmacotherapy for dependent cases, indications for referral, and planning follow-up. Interactive discussions of case studies illustrated the use of the package. Further informal discussions took place after the activity. The presentations were led by a local drug and alcohol specialist, by one of the authors (KC or PH) or by another Fellow from the Chapter of Addiction Medicine, Royal Australian College of Physicians.<br>Participants completed before and after evaluation forms. |
| **Recruitment process** | GPs were invited to evening training sessions though their local Divisions of General Practice. In rural areas, other guests such as |

| | |
|---|---|
| | practice nurses, emergency department staff, ambulance officers and pharmacists were also invited as part of a community project that was taking place in some of the smaller towns in 2005. |
| **Incentives** | To increase the appeal of training sessions, we applied to The Royal Australian College of General Practitioners and to the Australian College of Rural & Remote Medicine for continuing education (CME) points for participants. In addition, training activities were conducted after a complimentary restaurant dinner, with a guest expert speaker. |
| **Results: change, pitfalls, added value, resistances, suggestions for improvement …** | 24 training sessions were conducted over 2003, 2004 and 2005 with a total of 424 people attending, of whom 419 completed evaluation forms. Responders were 300 (73%) GPs. 56% GPs were from urban areas and 44% from rural areas.<br>The learning expectations the doctors described covered three general areas: information; identification and assessment skills; and intervention and management skills.<br>While 49% (CI 43-55) of the attending GPs indicated at baseline that they felt confident in identifying at-risk drinkers, this proportion rose to 90% (95% CI: 87-93) post-session, and they also reported increases in confidence from 36% (95% CI: 31-41) to 90% in their ability to advise patients. Urban FPs reported lower levels of confidence than rural FPs, both pre- and post-session.<br>Further research is needed to determine the duration of this effect and its influence on practice behaviour. It is likely that reinforcement of learned skills in follow-up sessions will be required. In other countries, practice nurses take on screening and brief intervention and this would be especially useful in rural and remote areas where there are shortages of doctors. In addition, time saving techniques such as waiting room screening including using handheld computers are being investigated. |

## ["Drinking less is better". Combining early identification and brief intervention for patients at risk] (3)

| | | |
|---|---|---|
| **Publication date** | 2006 | |
| **Country** | France | |
| **Substances** | Alcohol | |
| **Target group(s)** | GPs and OPs | |
| **Promoter(s)** | BMCM programme | |
| **Particular background** | | |
| **Objective(s) of the program** | To shift the social (and medical) representations of alcohol-related problems from “alcoholism” to “hazardous drinking”. | |
| **Methods** | 1. Adapting intervention tools: development of 2 new booklets for patient’s information explaining the alcohol-related risks and the “standard drink” concept, and designed to reduce alcohol consumption. Training for brief intervention was provided to voluntary GPs.<br>2. Adapting screening strategies. Translation of the AUDIT questionnaire, and development of the FACE questionnaire (Fast Alcohol Consumption Evaluation – *Formule pour Approcher la Consommation par entretien*).<br>3. Adapting training methods. Training session’s duration: 2h to 2 days (OPs). A typical session about screening and brief intervention contained:<br>• How to carry out a brief intervention | |

| | | |
|---|---|---|
| | • Role play of professional situations<br>• Illustrative situations with excessive drinking<br>• Advantages of a more systematic approach to detection<br>• Public's confidence in GP's role concerning alcohol related problems<br>Scientific publications (5 articles in the GP press), media campaign, article in the mainstream media.<br>Long term project. Strong involvement of governmental agencies and professional organisations. | |
| **Recruitment process** | Adapting medical mobilization strategies: Telephone marketing, mail | |
| **Incentives** | Financial incentive (2€ for a screening questionnaire, 10€ for a brief intervention) | |
| **Results: change, pitfalls, added value, resistances, suggestions for improvement …** | 400 GPs and 140 OPs were trained (2004)<br>The presence of a full-time assistant raises the level of screening.<br>The FACE questionnaire seems more acceptable than AUDIT.<br>Strong evidence for the efficiency of telephone marketing; poor efficacy of mail. Economic stimulation had a rather positive effect on implication post-information (x6) than on participation in training.<br>No statistically significant difference in doctors' perception and practice on alcohol-related risk.<br>Integration of EIBI activity in medical practice is realistic for trained GPs, and changes their overall relationships with patients.<br>Community-based approach increased significantly the proportion of the screened population. | |

## Engaging the reluctant GP in care of the opiate misuser: Pilot study of change-orientated reflective listening (CORL).(4)

| | |
|---|---|
| **Publication date** | 2004 |
| **Country** | United Kingdom |
| **Substances** | Opioid |
| **Target group(s)** | GPs |
| **Promoter(s)** | London Region of the NHS Executive as part of a London-wide General Practitioner Training Initiative in the Management of Drug Misuse and Dependence. |
| **Particular background** | GPs who had neither attended training events nor were involved in the treatment of drug dependence. The target sample was deliberately constructed to identify those who were either uninterested or inactive in this area of work. |
| **Objective(s) of the program** | To test the feasibility of delivery and potential value of a brief motivational enhancement intervention targeting the quality of primary care given to opiate misusers by GPs. To explore the fixed or movable status of GPs who were not currently providing care to opiate misusers. |
| **Methods** | Observational study (« before and after ») with follow-up assessment after 2–3 months.<br>After receiving invitations to participate, telephone-administered change-orientated reflective listening intervention, based on principles of motivational interviewing, with informational adjunct. |
| **Recruitment process** | All GPs of 2 primary care group |
| **Incentives** | Participants were paid £40 for their involvement with the study. |
| **Results: change, pitfalls,** | The extent of change, both in overall therapeutic commitment and |

| | |
|---|---|
| **added value, resistances, suggestions for improvement …** | among individual practitioners according to either criterion, is very encouraging.<br>Therapeutic engagement has been improved over time but not motivation. For categorical variables (provision of general medical services, provide HIV or hepatitis C testing, vaccinate injecting drug users for hepatitis B, refer opiate addicts to local specialist services, provide care for opiate addicts in formal shared care arrangement with specialist drug), individual-level change refers to commencement of actual provision of clinical care or willingness to be involved in the event of local demand. Attitudinal or behavioural change was detected in 19 of the 27 GPs.<br>Positive and negative changes, in relation to intervention, were observed among doctors. Positive changes were more than twice as frequent as negative changes. |

## Cannabis use and the GP: brief motivational intervention increases clinical enquiry by GPs in a pilot study (5)

| | |
|---|---|
| **Publication date** | 2003 |
| **Country** | United Kingdom |
| **Substances** | Cannabis |
| **Target group(s)** | GPs |
| **Promoter(s)** | |
| **Particular background** | GPs who neither provided care to drug misusers, nor attended training events |
| **Objective(s) of the program** | |
| **Methods** | The discussion component of the intervention was based on the principles of motivational interviewing, an approach which specifically addresses ambivalence about change. Additionally, an information pack was provided addressing general drug misuse management issues with material specifically on cannabis. |
| **Recruitment process** | All GPs in a single inner-London borough who were believed not to be involved in methadone prescribing and had not attended the organised training events were sent a letter inviting their participation. One week later telephone contacts sought to arrange a time for interview. |
| **Incentives** | Participants were paid £40 for study involvement. |
| **Results: change, pitfalls, added value, resistances, suggestions for improvement …** | There was a significant increase in the overall number of patients identified with problems associated with the use of cannabis.<br>Overall therapeutic commitment improved over time.<br>Improvement on the motivational measure was not statistically significant.<br>The most consistent evidence of practitioner behavioural change was with respect to interventions with dependent users.<br>The observed benefit probably derives from some combination of attention effect (simply having the issue raised), motivational enhancement, and improved role legitimacy and information provision. It is intriguing that clinical interventions, such as motivational interviewing, may also facilitate behavioural change among practitioners. |

## Encouraging GP alcohol intervention: Pilot study of change-orientated reflective listening (CORL). (6)

| | |
|---|---|
| **Publication date** | 2004 |
| **Country** | United Kingdom |
| **Substances** | Alcohol |
| **Target group(s)** | GPs |
| **Promoter(s)** | London Region of the NHS Executive as part of a London-wide General Practitioner Training Initiative in the management of Drug Misuse and Dependence. |
| **Particular background** | |
| **Objective(s) of the program** | To test the feasibility of delivery and potential value of a brief motivational enhancement intervention targeting GPs in relation to alcohol as a public health issue, and to compare data obtained with similar attempts to influence GP intervention with drug users. |
| **Methods** | A brief adaptation of the principles of motivational interviewing was constructed as 'change-orientated reflective listening' (CORL). |
| **Recruitment process** | Only GPs who had not attended local training events in the management of drug misuse and dependence and were not known to be involved in methadone prescribing.<br>After receiving invitations to participate, targeted GPs were contacted 1 week later by telephone to arrange a time for telephone interview. |
| **Incentives** | £40.00 (€60.00) |
| Results: **change, pitfalls, added value, resistances, suggestions for improvement …** | There was a greater level of detection of patients drinking more than the previously specified levels, though this was not a statistically significant increase. Overall therapeutic commitment and motivation did not change following intervention. There was thus no evidence of change over time in the study population as a whole. Comparisons with cannabis and drug misuse intervention targets suggest that it may be more difficult to alter views on intervening with drinkers. |

# Discussion

## Methods used

### Personal involvement of the GPs

One important objective of these programmes was to increase the involvement of GPs in substance abuse management, mainly through the preliminary steps: screening and brief intervention. Specific training was therefore often organized at the beginning of the programme (1, 2). Several ways of training were used, either consecutively scheduled, or at the participants' preference: professional development workshops delivered by outside consultants, local meetings and small group/peer learning support in the practice setting (1), interactive skills-based training sessions or discussions of case studies (2, 3), general considerations (on a more systematic approach to detection, public's confidence in GPs' role), or training in the use of specific screening tools (3). Training session varied from 2 hours to 2 days (this case for OPs).

A particular technique was used in the UK to motivate GPs known as reluctant in drug abuse management (no attendance to specific training, no methadone prescription). The target sample were deliberately constructed to identify those who were either uninterested or inactive in this area of work (4, 5, 6). A brief adaptation of the principles of motivational interviewing was constructed as "change-orientated reflective listening" (CORL); this approach specifically addresses ambivalence about change. After receiving invitations to participate, the GPs received a telephone-administered CORL intervention, with an information pack addressing general drug misuse management issues with material specifically on the particular substance under study (alcohol, cannabis or opiates).

## Specific tools

Specific computerized recording tools for clinical data were sometimes developed and used within the programmes (1).

A vast French programme (BMCM) developed new intervention tools designed for patients' information. Within this programme, the AUDIT questionnaire was first translated into French and validated; a new questionnaire (FACE – Fast Alcohol Consumption Evaluation) was developed to facilitate GPs' practice of screening (4).

## Public health involvement

The French BMCM programme cited above was a nationwide and long term project (3). It involved public health authorities at national, regional and local levels, including community actions, as well as professional organizations. Information was provided to both health professionals, through five scientific publications, and to the general population through media campaigns. Such a coordinated action demonstrated a search for efficiency and legitimacy.

## Incentives

Most of the programmes provided financial incentives to the participating GPs (1, 3-6). It was either linked to the amount of patients included, and larger for brief intervention than for screening (1, 3), either made by lump-sum for study involvement (4-6). Financial incentives were considered necessary to secure additional clinical time to carry out the intervention (1). They were described having a more positive effect on intervention than on participation in training (3).

In one programme, the incentive was made of continuing medical education (CME) points for participants, with a complimentary restaurant dinner! (2)

More interesting were some mobilization and follow-up strategies. Telephone recruitment was proved more efficient than postal mail (3). Targeting GPs that were known as reluctant in managing substance abuse was rather efficient at recruitment step and in some outcome measures (4, 5), provided that the first contact was designed at the expression of the physicians' ambivalence (CORL).

# Outcomes

The various programmes showed interesting outcomes, although measures are difficult, and improvement over time is not guaranteed.

## Motivation of the GPs

Key motivators for participation ranged from responding to the perceived expectation that peers would take part at the programme, through to the much more common interest in influencing

positive change around acknowledging and dealing with patient alcohol issues (1). The influence of peers was also expressed through the importance of clinical leadership (1).

GPs were less interested in theory than in clinical skills (1, 2). This may include an emphasis on individual coaching and face to face training (1). The Australian study reported good results in improving the feeling of self-efficacy among participating GPs, for identifying abuser patients as for their ability to advise them (2).

An individual approach to motivate the GPs was particularly illustrated by the CORL technique, which associated practical information to personal expression of ambivalence towards substance abuse management (4-6). This technique demonstrated a significant increase in the overall number of patients identified with substance-related problems for cannabis and opioids. Overall therapeutic commitment improved over time. The observed benefit probably derives from some combination of attention effect (simply having the issue raised), motivational enhancement, and improved role legitimacy and information provision. The improvement on the motivational measure was not statistically significant (4, 5). However, it is noticeable that no significant effect could be measured with alcohol, nor for therapeutic commitment, nor for motivation (6). It may be more difficult to alter GPs' views on intervening with drinkers since alcohol use patterns are influenced by social and cultural factors and can be an emotive issue for both GP and patient (1).

### Organizational factors

Some interesting considerations on organizational factors were raised.

In the New Zealand programme, one noticed that practice infrastructure such as integrated IT support and familiarity with IT programmes allowed for quick uptake and reporting. The success of this project was primarily attributed to the use of the Dashboard reminder software and linked alcohol recording form (1).

Both in the New Zealand and the French programmes, the practices that had protected time for health screening (nurse, assistant) were more able to implement the proposed activities and their recording (1, 3). Moreover, better screening rates can also be achieved in case of community-based approach (3).

## Conclusions

The improvement of the management of substance abuse by GPs requires action on training, motivation and organization.

Training methods have to be tailored on GPs' preferences. Building clinical skills and competencies is probably their greatest desire, and this can be achieved in small peer groups or individual training.

Working on motivation is the most original way of improvement. It is remarkable that a well-known method for patient's motivation to change such motivational interviewing is so little used for clinicians. The group of three British articles that report this experience is more than ten years old, and it seems they fell into neglect, at least on this side of the Channel.

As a response to the recurrent complaint of GPs about the lack of time, two studies stressed the importance of allied health professionals to share the workload. Practice assistants do not yet exist in Belgium, but this could be an illustration of their future job.

Incentives can be useful; some financial arrangements can be perceived by the GPs as a fair compensation for extra work; peer support can be useful to avoid quick demotivation.

# References


1. Gifford H, Paton S, Cvitanovic L, McMenamin J, Newton C. **Is routine alcohol screening and brief intervention feasible in a New Zealand primary care environment?** *N Z Med J*. 2012; 125(1354):17–25.
2. Proude EM, Conigrave KM, Haber PS. **Effectiveness of skills-based training using the Drinkless package to increase family practitioner confidence in intervening for alcohol use disorders**. *BMC Med Educ*. 2006; 6(1):8.
3. Michaud P, Dewost AV, Fouilland P, Arfaoui S, Fauvel G. **Phase IV Study in France. In: HEATHER Nick. WHO collaborative project on identification and management of alcohol-related problems in primary health care: Report on phase IV collaborative: Development of country-wide strategies for implementating early identification and brief intervention in primary health care**. World Health Organization, Geneva, 2006, pp. 131-144.
4. Strang J. ***Engaging the reluctant GP in care of the opiate misuser: Pilot study of change-orientated reflective listening (CORL).*** *Fam Pract*. 2004 Apr 1; 21(2):150–4.
5. McCambridge J, Strang J, Platts S, Witton J. **Cannabis use and the GP: brief motivational intervention increases clinical enquiry by GPs in a pilot study**. *Br J Gen Pract*. 2003 Aug; 53(493):637-9.
6. McCambridge J. **Encouraging GP alcohol intervention: pilot study of change-orientated reflective listening (CORL).** *Alcohol Alcohol*. 2004 Mar 1; 39(2):146–9.

# Part 7

# Valorisatiefase. Beschrijving en resultaten

Marie-Claire Lambrechts

Vereniging voor Alcohol- en andere Drugproblemen, VAD
Maart 2015

# A. Inleiding

De specifieke opdracht voor VAD in het Belspo-onderzoek UP-TO-DATE betrof het valoriseren van de onderzoeksresultaten in de laatste projectfase (WP7). Deze opdracht situeert zich in de natuurlijke habitat van VAD die het merendeel van de Vlaamse organisaties die werken rond de thematiek van alcohol, illegale drugs, psychoactieve medicatie en gokken overkoepelt. Kernfuncties van VAD zijn het ondersteunen van een kwaliteitsvolle en wetenschappelijk onderbouwde aanpak van de alcohol- en drugthematiek, en het faciliteren van praktijkgerichte initiatieven. VAD is tevens de partnerorganisatie van de Vlaamse overheid in het kader van het preventiebeleid omtrent alcohol- en andere drugproblemen.
In dit document wordt vooreerst het belang (B) en de methode (C) van deze valorisatiefase besproken. Nadien beschrijven we de drie valorisatie-initiatieven (D), achtereenvolgens bij huisartsen, arbeidsgeneesheren en bij stakeholders tijdens de slotconferentie. Tot slot wordt een aantal aanbevelingen geformuleerd.

# B. Belang van valorisatie

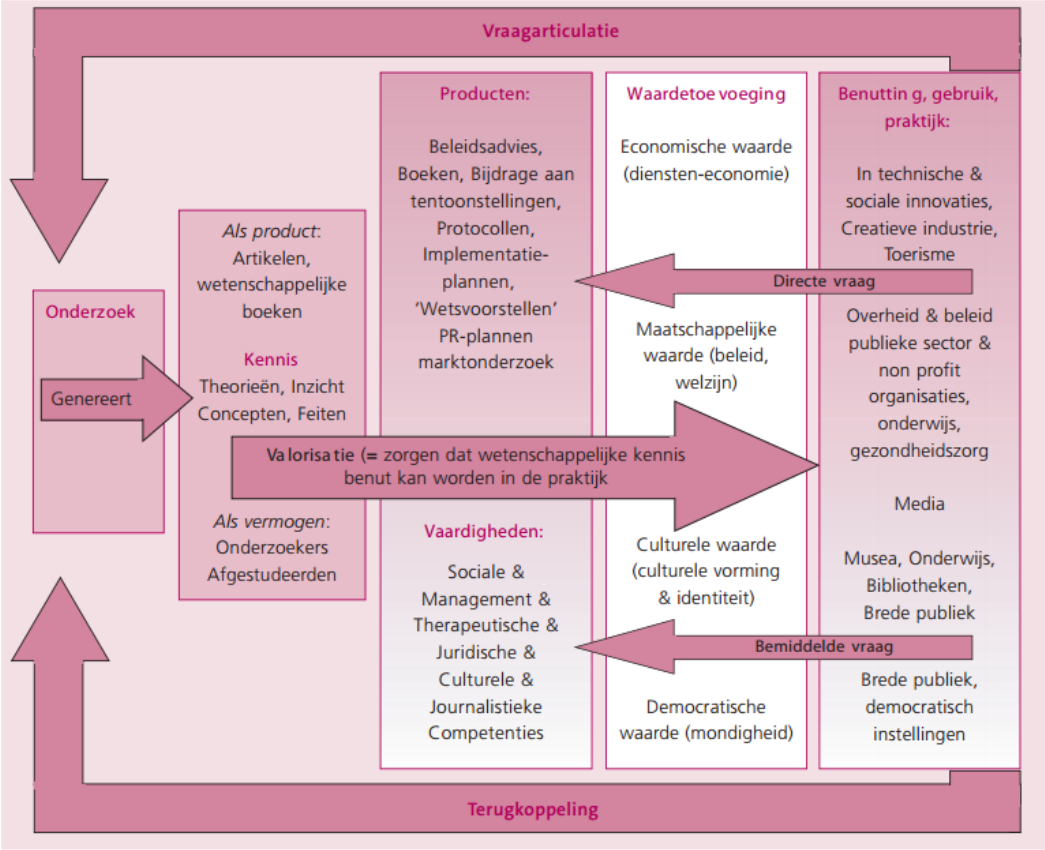
De onderzoeksprogramma's van Belspo hebben tot doel de opdrachtgevers 'betrouwbare en valabele gegevens aan te reiken waarmee onderbouwde beslissingen kunnen genomen worden' op diverse terreinen.[1] Samengevat werd in het UP-TO-DATE-project onderzocht welke factoren de aanpak van huisartsen en arbeidsgeneesheren omtrent problematisch middelengebruik van patiënten en werknemers beïnvloeden. Om het gedrag van deze eerstelijnsgezondheidswerkers te onderzoeken, werd het Integrated Model of Change (of I-Change model), een gedragsverklaringsmodel, als theoretisch kader gehanteerd.[2]

Vanuit bovenvermelde kernfuncties vond VAD het aangewezen om een uitgebreide valorisatiefase te organiseren, deel uitmakend van het project zelf, en voorafgaand aan de formele rapportage van de onderzoeksresultaten. In deze fase werden de onderzoeksbevindingen getoetst bij de deelnemende artsengroepen. Bijkomend werd een slotconferentie georganiseerd om de resultaten kenbaar te maken aan de betrokken stakeholders, meer bepaald preventieadviseurs, preventiewerkers en hulpverleners uit de alcohol- en drugsector, beroepsverenigingen, leden van wetenschappelijke organisaties en academici *(zie bijlage 1, voorstelling tijdens Belspo-begeleidingscommissie 17/9/14).*
Doorheen deze valorisatiefase konden belanghebbenden de onderzoeksresultaten bespreken en input geven in functie van mogelijke aanbevelingen. Bijkomend zijn deze stakeholders uitermate belangrijk om de resultaten te helpen implementeren in de dagelijkse praktijk.

Vooraleer de output van deze valorisatiefase te bespreken omschrijven we de term 'valorisatie'. Geïnspireerd door het beleidsadvies van de Nederlandse Adviesraad voor Wetenschap, Technologie en Innovatie (AWTI) [3], formuleerden Steenssens en Gijselinckx in hun eindrapport van het onderzoek 'Valorisatie van onderzoek in de Humane en de Sociale Wetenschappen', valorisatie als volgt:

*"Een proces dat ervoor zorgt dat wetenschappelijke kennis kan gebruikt worden in de praktijk. Valorisatie is het **geschikt en bruikbaar maken** van onderzoeksresultaten opdat de **kans groter** wordt dat **derden** ze zouden kunnen benutten."* [4]

De valorisatie van onderzoeksbevindingen is dus geen statisch gegeven. Het is een proces waarbij diverse activiteiten worden georganiseerd en waarde wordt toegevoegd die in relatie staan tot het onderzoeksproces. Interactie tussen onderzoeker en praktijkwerker is hierbij aangewezen. Het AWTI benadrukt dat valorisatie niet enkel commercieel, maar ook cultureel, democratisch en maatschappelijk moet ingevuld worden. Maatschappelijke waardetoevoeging is essentieel bij onderzoek op vlak van gezondheidszorg *(zie figuur 1)*.[3]




Figuur 1: schema proces van valoriseren. Adviesraad (NL) voor Wetenschap, Technologie en Innovatie (2007)

De overdracht van kennis uit onderzoek kan volgens Steenssens en Gijselinckx op drie manieren gebeuren [4]:

1/ de **'kennistransfer'** (of 'disseminatie' of 'kennisverspreiding') waarbij de overdracht van de onderzoeksresultaten naar de gebruikers in een eenrichtingsproces naar de gebruikers of het werkveld gaat. Die kunnen ervoor kiezen om de kennis al dan niet te benutten.

2/ de **'kennisuitwisseling'** waarbij de nadruk ligt op interacties en uitwisselingen tussen onderzoekers en gebruikers. Wetenschappelijke en praktische kennis zijn gelijkwaardig.

In deze benadering onderzoekt men de effectiviteit en efficiëntie van de interactie tussen wetenschap en praktijk.

3/ de '**kennismobilisatie'** (of 'kennisintegratie', 'kennistranslatie') is een benadering waarbij de interactie met de (groep van) gebruikers nog verder gaat. Vaak is er sprake van co-producenten.

Kennis kan rechtstreeks of onrechtstreeks in de professionele praktijk gevaloriseerd worden. Rechtstreeks valoriseren is mogelijk bij georganiseerde professionals die een goede toegang hebben tot onderzoek [5] of via het verwerken van de onderzoekskennis in het onderwijs. Soms worden ook intermediaire organisaties betrokken om deze valorisaties te realiseren (bv. omtrent evidence based behandelingen, protocollen of evaluatie- en effectiviteitstudies in therapeutische beroepen).
In andere gevallen moet er een vertaalslag naar de praktijk georganiseerd worden om de wetenschappelijke kennis te kunnen toepassen. Omdat deze vertaalslag vaak een veranderingsproces inhoudt, is een wisselwerking tussen terreinorganisaties, onderzoekers en beleid aangewezen. Die interactie is belangrijk doorheen het ganse proces vanaf het formuleren van de doelstellingen tot het integreren van de resultaten in de dagelijkse praktijk. Nochtans is deze doelstelling niet altijd realiteit: praktijkmensen vinden niet altijd hun weg naar wetenschappelijke data, en gaan er vaak pas laattijdig mee aan de slag, mede als gevolg van het gebrek aan specifieke onderzoeksexpertise. Andersom hebben onderzoekers de neiging om hun resultaten vaak nogal abstract voor te stellen, terwijl de professionelen op het terrein om concrete en scherp geformuleerde resultaten vragen. [5]

# C. Methode

De mate van participatie is een belangrijk gegeven tijdens het valorisatieproces. Hiervoor lieten we ons inspireren door de methodes van 'Large Scale Interventions' (LSI). Volgens LSI worden stakeholders in alle fases van een veranderingsproces betrokken.

## Kenmerken LSI

Large Scale Interventions (LSI) vormen een aanpak voor het organiseren van duurzame veranderingen met actieve deelname van belanghebbenden uit het hele systeem (organisatie of gemeenschap en zijn omgeving). LSI bestaat uit een traject met een mix van werken in kleine groepen en grote groepen. Het aantal betrokken personen in dit traject kan sterk variëren, gaande van enkele tientallen tot duizenden.[6] In onderstaand schema wordt een aantal aspecten opgelijst waarbij het onderscheid tussen LSI of Top down benaderingen duidelijk wordt *(zie tabel 1).*[6]

| **Aspecten van veranderen** | **Large Scale Interventions** | **Top down benaderingen** |
|---|---|---|
| **Visie** | Gevormd met betrokkenheid van het | Gevormd door een speciale groep van |

| | | |
|---|---|---|
| | hele systeem, met ontwikkeling van verandervermogen. | experts en senior management. |
| **Beschikbaarheid informatie** | De betrokkenheid van een grote en diverse groep van stakeholders zorgt voor een brede blik op de werkelijkheid, als basis voor informatie en strategische beslissingen. | De beperkte blik op de werkelijkheid van een kleine groep vormt de basis voor informatie en strategische beslissingen. Weinig betrokkenheid van interne stakeholders. Externe belanghebbenden, klanten en de locale gemeenschap worden vaak genegeerd. Sommige cruciale punten komen nooit aan de orde. |
| **Commitment en verantwoordelijkheid** | Mensen voelen zich mede verantwoordelijk voor het resultaat van de organisatie als geheel. Ze sturen mede het veranderproces. | Mensen voelen zich alleen verantwoordelijk voor hun eigen taken. |
| **Perspectief op veranderen** | Verandering wordt gezien als een integraal onderdeel van het werk. | Verandering wordt gezien als een tijdelijke verstoring van het "echte" werk van mensen. |
| **Planning en implementatie** | Planning en implementatie verlopen simultaan, in de hele organisatie tegelijk geïnitieerd. | Implementatie komt na de planningsfase. De wereld wordt geacht stil te staan terwijl de planners aan het werk zijn. |

Tabel 1: Aspecten van veranderen
Tonnie van der Zouwen, 2011, adaptatie R.W. Jacobs (1997) en M. Leith (2004).

# D. Valorisatieproces

Het valorisatieproces omvat **drie initiatieven**, waarbij de resultaten van het UP-TO-DATE-onderzoek achtereenvolgens getoetst werden bij huisartsen, arbeidsgeneesheren en bij stakeholders tijdens een slotconferentie.

## Huisartsen

### Organisatie

In de periode maart-mei 2014 werden in samenwerking met de huisartsenkoepels Domus Medica en SSMG (Société Scientifique de Médecine Générale) de verantwoordelijken van de LOKs (Lokale Kwaliteitskringen[4]) en GLEMs (Groupe Local d'Evaluation Médicale[5])

[4] Een LOK is een groep van collega's, artsen of apothekers-biologen, die hun medische praktijkervaring delen en kritisch beoordelen (peer review) om de zorgkwaliteit te verbeteren (Rijksinstituut voor Ziekte- en Invaliditeitsverzekering; http://www.inami.fgov.be/nl)

gecontacteerd *(zie bijlage 2,* Recrutering - uitnodiging deelname LOK - GLEM*).* De opzet van de valorisatie, alsook de praktische organisatie ervan, werden hierbij toegelicht.
Voor het toetsen van de resultaten werden in beide landsdelen 3 tot 4 groepen beoogd. We ontvingen 32 positieve antwoorden (29 LOKs en 3 GLEMs).

## Deelnemende LOKs – GLEMs

Er werd een selectie van 5 LOKs en 2 GLEMs gemaakt op basis van locatie (stedelijk, landelijk) en praktische mogelijkheden (data, tijdstippen).
De duur van de bijeenkomsten varieerde van 1,5 tot 2 uur op locatie van de LOKs/GLEMs *(zie tabel 2).*

| | **Locatie** | **Datum** | **Aantal deelnemers** | **Type praktijk** | | | **Duur sessie** |
|---|---|---|---|---|---|---|---|
| LOK 1 | Stedelijk | 8/10/14 | 11 | Solo 6 | Duo 3 | Groepspraktijk 2 | 2u |
| LOK 2 | Stedelijk | 9/10/14 | 7 | Solo 4 | Duo 2 | Groepspraktijk 2 | 1u25 |
| LOK 3 | Landelijk | 29/10/14 | 9 | Solo 8 | Duo | Groepspraktijk 1 | 1u31 |
| LOK 4 | Landelijk | 4/11/14 | 11 | Solo 5 | Duo 3 | Groepspraktijk 3 | 1u31 |
| LOK 5 | Stedelijk | 13/11/14 | 12 | Solo 5 | Duo 3 | Groepspraktijk 4 | 1u30 |
| GLEM 1 | Stedelijk | 6/11/14 | 12 | Solo 11 | Duo 1 | Groepspraktijk | 1u35 |
| GLEM 2 | Landelijk | 26/11/14 | 15 | Solo N/A | Duo N/A | Groepspraktijk N/A | 1u23 |

Tabel 2: Profiel deelnemende LOKs - GLEMs

## Toelichting resultaten en toetsing

Naast een korte introductie omtrent het UP-TO-DATE-project, werden de resultaten van de bevraging bij huisartsen in drie afzonderlijke blokken toegelicht:
1/ Alcohol- en druggebruik in de huisartsenpraktijk; 2/ Factoren in relatie tot het gedrag van huisartsen en 3/ communicatie en samenwerking met huisartsen. Gezien de omvang

[5] Un GLEM est un groupe de pairs, médecins, ou pharmaciens biologistes, qui partagent et évaluent de manière critique leurs pratiques médicales (peer review) pour promouvoir la qualité des soins (http://www.inami.fgov.be/fr)

van de bevraging bij huisartsen (54 vragen) werd hierbij een selectie gemaakt op basis van significante resultaten en relevantie voor de praktijk.
De toelichting bij de Nederlandstalige huisartsen werd gegeven door VAD (MC Lambrechts), bij de Franstalige huisartsen door de onderzoekers van de universiteit van Luik (F. Ketterer en M. Vanmeerbeek). Niemand van de deelnemende huisartsen had de UP-TO-DATE-vragenlijst ingevuld (*gebruikte powerpoint zie bijlage 4, Toetsing resultaten LOK - GLEM).*

## *Alcohol- en druggebruik in de huisartsenpraktijk*

Aan de hand van prevalentiegegevens uit de peilpraktijken (WP2) en uit de frequentievraag in de bevraging zelf (WP3) werd een profiel geschetst van de patiënt waarmee de huisarts (HA) in contact kwam. Beide initiatieven bevatten andere, maar complementaire vragen *(zie tabel 3).* Daarnaast werden ook de diverse types van aanpak door de huisarts, zoals bevraagd in de peilpraktijken, toegelicht. Deze huisartsen voeren vooral een kortdurende interventie uit (69%), een farmaceutische behandeling (61%) en een niet-farmaceutische/psychologische ondersteuning (53%). Van de patiënten wordt 52% enkel door de huisarts behandeld, bij een eerste behandeling is dat 14%.

| **Peilpraktijken (WP2) (mei-oktober 2013)(*)** | | **Bevraging huisartsen (WP3) (najaar 2013) (**)** | |
|---|---|---|---|
| **HA registreren patiënten met middelenmisbruik** | | **HA zien patiënten met misbruik van** | |
| Enkel alcohol | 37% | Alcohol | 88,7% |
| Alcohol met ander middel | 23% | Slaap- en kalmeermiddelen | 88,8% |
| Geen alcohol | 30% | Cannabis | 54,1% |
| | | Andere illegale drugs | 43,2% |
| **Leeftijd problematisch gebruik** | | | |
| 55-64 | 23% | | |
| 45-54 | 35% | | |
| 35-44 | 20% | | |
| 25-34 | 17% | | |
| < 25 jaar | 5% | | |
| **Jaren van gebruik** | | | |
| + 20 jaar | 21% | | |
| 10-19 jaar | 35% | | |
| 5-9 jaar | 21% | | |
| 2-4 jaar | 18% | | |
| < 1 jaar | 5% | | |
| **Tewerkstelling** | 40% | | |
| **Meerderheid mannen** | 66% | | |
| **Problemen gerelateerd aan middelenmisbruik** | | | |
| Fysieke problemen | 49% | | |
| Mentale problemen | 79% | | |
| Problemen op werk (binnen de groep die werkt) | 51% | | |
| Sociale problemen | 73% | | |

| | | | |
|---|---|---|---|
| (*) op basis van voorstelling resultaten WP2 tijdens begeleidingscomité 17/09/2014 | | (**) na dichotomisering 5punt-Likertschaal (dagelijks > nooit naar ja (dagelijks, wekelijks, maandelijks) / nee (enkele keren p/jaar, nooit) | |

Tabel 3: Profiel patiënt met middelenmisbruik op basis van resultaten peilpraktijken (WP2) en enquête bij huisartsen (WP3)

Tot slot werd dit profiel besproken en getoetst bij de deelnemers van de LOKs. Vaak voorkomende opmerkingen vormden de basis voor een bijsturing van de onderzoeks-resultaten, weliswaar op basis van de praktijkervaring van de deelnemende LOKs/GLEMs.

1/ Voorstelling Profiel patiënt middelenmisbruik gebaseerd op data enquête huisartsen en peilpraktijken

Chronische gebruiker (langdurig gebruik > 10 jaar)
Meestal man
Vooral gebruik van alcohol / slaap- en kalmeermiddelen
Beperkt gebruik van illegale drugs
Vaak nog aan het werk

Zie PPT in bijlage 4

Samenvatting van herhaalde opmerkingen tijdens de toetsing bij LOKS/GLEMs

- Alcoholgebruik
  Bevestiging (chronische) gebruiker
  Meer en meer problematisch gebruik bij vrouwen
  Jongeren: minder naar huisarts en praten niet over middelengebruik
  Bingedrinken: 35-40 jarigen
- Cannabis: gebruik wordt niet als een probleem gezien in tegenstelling tot roken en tot andere illegale drugs; geen hulpvraag, zeker niet bij jongeren
- Illegale drugs: wél hulpvraag; huisartsen voelen zich er niet bekwaam voor
- Slaap- en kalmeermiddelen: 'ze slapen al jaren met een pilleke dat niet meer helpt'
  Gebruik ligt hoog, wat is problematisch? <> waarom zoveel benzodiazepines nodig?
  Huisartsen krijgen door voorschrijfgedrag schuld van hoge consumptie
- Geen systematische bevraging/screening van alcoholgebruik (ook verschillen tussen huisartsen) versus beschikbare cijfers
- Geen systematische bevraging van illegaal druggebruik
- Shopgedrag van patiënten; als wij niet voorschrijven, gaan ze naar een ander
- Stijgend gebruik van Rilatine.

**1/ Profiel patiënt middelenmisbruik na toetsing: BIJSTURING (*)**

Chronische gebruiker (langdurig gebruik > 10 jaar) **enigszins gerelativeerd, afhankelijk van het type drugs**
Mannen – (**stijgend aantal) vrouwen**
Vooral alcohol / slaap- en kalmeermiddelen **(vraag: is dit problematisch gebruik en wanneer?)**
**Cannabisgebruik: gebruik ligt hoger dan verondersteld en vaak gebanaliseerd door gebruiker: geen probleem voor gebruiker, geen hulpvraag (itt andere, minder vaak gebruikte, illegale drugs)**

Vaak nog aan het werk
**Kanttekening bij cijfers: in de praktijk geen systematische bevraging en/of screening)**

**(*) in vetjes wat aangepast werd na toetsing**

## *Factoren in relatie tot het gedrag van huisartsen*

Uit de bevraging werden enkele factoren toegelicht die het gedrag van huisartsen met betrekking tot hun aanpak van problematisch gebruik bij patiënten beïnvloeden, respectievelijk de rol van kennis en attitudes.

2a/ Voorstelling Kennis gebaseerd op data enquête huisartsen

Waar haalt de huisarts zijn kennis?
Initiële artsenopleiding (62,3%)
Colloquia/seminaries (58,6%)
Internet (41,1%)

Nood aan bijkomende vormingen:
De meest geschikte therapieën om deze patiënten naar te verwijzen (73,4%)
Symptomen/signalen misbruik illegale drugs (47%)
Minimale/kortdurende interventies (42,1%)

Zie PPT in bijlage 4

Samenvatting van herhaalde opmerkingen tijdens de toetsing bij LOKS/GLEMs

- Kennis initiële opleiding blijft niet veel van over; relatief beperkt maar meer aanwezig in Nederlandstalige universiteiten
- Kennis over illegale drugs? Ja, maar kunnen niet in alles specialist zijn; moeten geen kennis hebben van illegale drugs; ook drempel om dit te doen
- Kennis omtrent beweegredenen/motieven van de patiënten
- Bijscholing is vooral gericht op kennis; bijscholing vaardigheden nodig (bv. afbouwen, ander middel overstappen)
- Communicatie - motiverende gespreksvoering: opleiding is nodig maar niet voldoende; dit moet ook onderhouden worden
- Minimale/kortdurende interventies: interessant voor alcohol en benzodiazepines, maar niet voor illegale drugs.

**2a/ Kennis NA toetsing: <u>BEVESTIGING – AANVULLING (*)</u>**

Waar haalt de huisarts zijn kennis?
Initiële artsenopleiding (62,3%): **is relatief (beperkt en vaak lang geleden)**
Colloquia/seminaries (58,6%)
Internet (41,1%)

Nood aan bijkomende vormingen:
De meest geschikte therapieën om deze patiënten naar te verwijzen (73,4%)
Synoniemen/signalen misbruik illegale drugs (47%)
Minimale/kortdurende interventies (42,1%)
**Verschillen tussen soorten drugs**

**Vaardigheidstrainingen (communicatie, motiverende gespreksvoering): aanbieden en onderhouden.**

**(*) in vetjes wat aangepast werd na toetsing**

2b/ Voorstelling Attitudes gebaseerd op data enquête huisartsen

- HA vinden dat het tot hun job behoort om de zorg op te nemen van patiënten met misbruik van alcohol (86%), slaap- en kalmeermiddelen (90%), cannabis (70%) en andere illegale drugs (50%).
- HA (57%) vinden het moeilijker om middelenmisbruik bespreekbaar te maken in vergelijking met lichamelijke problemen.
- HA gaan niet akkoord met de uitspraak dat het moeilijk is om misbruik om een constructieve manier bespreekbaar te maken (alcohol en benzo's: 60%); cannabis (50%) en andere illegale drugs (44%).
- HA (60% voor alle type drugs) gaan niet akkoord met de uitspraak dat het bespreekbaar maken van middelenmisbruik risico's inhoudt mbt het verbreken van de therapeutische relatie met de patiënt.
- HA voelen zich dikwijls machteloos ten overstaan van patiënten met middelenmisbruik (iets meer voor illegale drugs dan alcohol, benzo's en cannabis)
- Faciliterende factoren: persoonlijke ondersteuning, opleiding en de uitbreiding van ambulante en residentiële gespecialiseerde hulpverlening.

Zie PPT in bijlage 4

Samenvatting van herhaalde opmerkingen tijdens de toetsing bij LOKS/GLEMs

- Resultaten werden grotendeels herkend en erkend
- Geen systematische bevraging/screening van middelengebruik (ook verschillen tussen huisartsen) versus beschikbare cijfers
- Huisartsen: vooral confronteren en doorververwijzen, niet teveel verwachten
- Richtlijnen? voor alle drugs?
- Doorverwijzen naar weinig toegankelijke gespecialiseerde 2$^{de}$ lijn is een probleem (geen plaats, lange wachttijden, geen zin in therapie in groep); misschien daarom belang van zelfhulpgroepen
- Familie betrekken
- Demotivatie: slaagpercentages zijn zo goed als nul; geen verband met hoeveelheid tijd dat je eraan spendeert. Motivatie van patiënt is doorslaggevend, hij heeft de keuzevrijheid
- Bespreken is geen taboe maar in de praktijk lukt het niet vaak; frustrerend
- Huisartsen komen soms heel moeilijke situaties tegen.
- Als je ze zelf niet wilt of kunt helpen dan begin je er niet over
- Onderscheid patiënten: bv. aanspreken bij goed uitziende mensen: breken van vertrouwen

**2b/ Attitudes mbt rol huisartsen NA toetsing: <u>BEVESTIGING – AANVULLING (*)</u>**

- HA vinden dat het tot hun job behoort om de zorg op te nemen van patiënten met misbruik van alcohol (86%), slaap- en kalmeermiddelen (90%), cannabis (70%) en andere illegale drugs (50%).

- HA (57%) vinden het moeilijker om middelenmisbruik bespreekbaar te maken in vergelijking met lichamelijke problemen.
- HA gaan niet akkoord met de uitspraak dat het moeilijk is om misbruik om een constructieve manier bespreekbaar te maken (alcohol en benzo's: 60%); cannabis (50%) en andere illegale drugs (44%).
- HA (60% voor alle type drugs) gaan niet akkoord met de uitspraak dat het bespreekbaar maken van middelenmisbruik risico's inhoudt mbt het verbreken van de therapeutische relatie met de patiënt.
- HA voelen zich dikwijls machteloos ten overstaan van patiënten met middelenmisbruik (iets meer voor illegale drugs dan alcohol, benzo's en cannabis)
- Faciliterende factoren: persoonlijke ondersteuning, opleiding en de uitbreiding van ambulante en residentiële gespecialiseerde hulpverlening.
- **Discussie of alle patiënten moeten bevraagd worden of gerichte screening? Richtlijnen zijn nodig.**
- **HA moeten veeleer herkennen en doorverwijzen.**
- **Maar opvallend herbevestigd knelpunt: weinig toegankelijke 2$^{de}$ lijns hulpverlening.**

**(*) in vetjes wat aangepast werd na toetsing**

## *Communicatie/samenwerking met arbeidsgeneesheren*

Tot slot werden de meest belangrijke knelpunten voorgesteld omtrent de communicatie en samenwerking met arbeidsgeneesheren, en dit zowel vanuit het oogpunt van de huisarts, als van de arbeidsgeneesheer.

3/ Voorstelling knelpunten in Communicatie/samenwerking met ARBEIDSGENEESHEREN gebaseerd op data enquête huisartsen en arbeidsgeneesheren.

| Voor huisartsen (HA) | % | Aantal |
|---|---|---|
| Ik ken de naam en de coördinaten van de AG niet. | 72,2 | 285 |
| Ik zou beter willen samenwerken, er is vooral een praktisch probleem om elkaar te contacteren. | 44,8 | 177 |
| Ik krijg geen enkele feedback van de AG. | 42,8 | 169 |
| Ik heb geen toestemming van de patiënt om de AG te contacteren. | 37,5 | 148 |
| Het komt gewoon niet bij me op. | 34,7 | 137 |

| Voor arbeidsgeneesheren (AG) | % | Aantal |
|---|---|---|
| HA weten niet precies wat mijn werk inhoudt. | 52,6 | 132 |
| Ik krijg geen enkele feedback van de HA. | 44,6 | 112 |
| HA zien me als een controle-arts. | 37,5 | 94 |
| HA proberen hun patiënt aan het werk te houden zonder rekening te houden met mogelijke functioneringsproblemen. | 33,1 | 83 |
| Ik zou beter willen samenwerken, er is vooral een praktisch probleem om elkaar te contacteren. | 31,1 | 78 |

Bron: Belspo 2014, WP3 & WP4

Samenvatting van herhaalde opmerkingen tijdens de toetsing bij LOKS/GLEMs

- Alle elementen uit het onderzoek worden bevestigd.
- Huisartsen hebben omtrent hun vraag aan arbeidsgeneesheren voor aangepast werk voor patiënten weinig goede ervaringen. Ze geloven niet dat dit bij middelenmisbruik wel zou kunnen.
- De meeste huisartsen hebben géén ervaringen omtrent samenwerking met arbeidsgeneesheren.
- Verschil interne en externe diensten preventie en bescherming op het werk (IDPB/EDPB): positieve ervaringen met interne bedrijfsartsen die doorgaans wel tijd hebben, en werken in grotere bedrijven met meer mogelijkheden en middelen versus KMO's die met artsen van EDPB werken die geen tijd hebben.
- Patiënten willen niet dat huisartsen informatie aan de arbeidsgeneesheer geven. Ze hebben schrik dat de werkgever geïnformeerd zal worden. Groot wantrouwen.
- Wat kan een arbeidsgeneesheer aan hulpverlening doen?

**3/ Knelpunten mbt Communicatie/samenwerking met arbeidsgeneesheren NA toetsing: <u>BEVESTIGING en VERSTERKING van de voorgestelde knelpunten (*)</u>**

| Voor huisartsen (HA) | % | Aantal |
|---|---|---|
| Ik ken de naam en de coördinaten van de AG niet. | 72,2 | 285 |
| Ik zou beter willen samenwerken, er is vooral een praktisch probleem om elkaar te contacteren. | 44,8 | 177 |
| Ik krijg geen enkele feedback van de AG. | 42,8 | 169 |
| Ik heb geen toestemming van de patiënt om de AG te contacteren. | 37,5 | 148 |
| Het komt gewoon niet bij me op. | 34,7 | 137 |


| Voor huisartsen (HA) | % | Aantal |
|---|---|---|
| Ik ken de naam en de coördinaten van de AG niet. | 72,2 | 285 |
| Ik zou beter willen samenwerken, er is vooral een praktisch probleem om elkaar te contacteren. | 44,8 | 177 |
| Ik krijg geen enkele feedback van de AG. | 42,8 | 169 |
| Ik heb geen toestemming van de patiënt om de AG te contacteren. | 37,5 | 148 |
| Het komt gewoon niet bij me op. | 34,7 | 137 |


**Huisartsen én patiënten wantrouwen de arbeidsgeneesheer omwille van mogelijke communicatie naar werkgever.**
**(*) in vetjes wat aangepast werd na toetsing**

## Samenvatting toetsing bij huisartsen

De toetsing van een select aantal onderzoeksresultaten van UP-TO-DATE leverde volgend resultaten op:

- attitudes van huisartsen omtrent hun rol bij middelenmisbruik van patiënten werden bevestigd.
- de ervaringen met de verschillende type drugs werden enigszins aangepast op basis van de praktijkervaring van de deelnemende huisartsen.
- De knelpunten in de communicatie en samenwerking met arbeidsgeneesheren werden niet alleen gedeeld, maar nog versterkt.

**Pluspunt:** deze toetsing van onderzoeksresultaten werd in alle LOKs en GLEMs interessant bevonden en voor herhaling vatbaar. Vooral het feit dat men over dergelijk thema met collega-huisartsen in discussie kon gaan, gekoppeld aan onderzoeksgegevens, werd als waardevol ervaren.

# Arbeidsgeneesheren

## Organisatie

Anders dan bij de huisartsen, werd voor de valorisatie bij arbeidsgeneesheren geopteerd om dit op één centraal moment te organiseren. Eind februari 2014 werd bij de

koepelorganisaties van de arbeidsgeneesheren gepeild naar de haalbaarheid van dergelijk initiatief, met positieve reacties. De precieze datum werd vastgelegd op 15 december 2014. De bespreking werd gepland in twee delen: een gedeelte per taalgroep, en nadien een plenaire bespreking *(zie bijlage 3,* Recrutering - uitnodiging deelname arbeidsgeneesheren*).* Op deze uitnodiging kwam om onduidelijke redenen (te) weinig respons, waardoor we genoodzaakt werken om dit initiatief te annuleren. Een toelichting van het kwalitatieve gedeelte van het onderzoek op de Nationale Dagen van de Arbeidsgeneeskunde eind 2013 zou een verklaring kunnen zijn van de lage respons. De arbeidsgeneesheren werden in deze communicatie wel al geïnformeerd over de slotconferentie van 23 januari 2015. Valorisatie-initiatieven worden voorzien na afloop van het project.

# Slotconferentie

## Organisatie

De slotconferentie werd georganiseerd in samenwerking met de FOD WASO (beschikbaarheid zaal Storck en vertaalfaciliteiten). Het initiatief werd bekendgemaakt aan alle deelnemende LOKs en GLEMs, via de koepelorganisaties van huisartsen (Domus Medica) en arbeidsgeneesheren (VWVA, BBvAg, en SSSTr), de betrokken FOD Volksgezondheid en FOD WASO, de website van VAD en de elektronische QADO-Nieuwsflash[6] van VAD *(zie bijlage 5, Uitnodiging – slotconferentie 23/1/15).*

## Programma

Rekening houdend met het, vooraf beoogde, heterogeen publiek werd een programma samengesteld waarin een mix van onderzoeksresultaten (presentatie M. Lambrechts) en het integreren/bespreken ervan in de uiteenzettingen van gastsprekers-eerstelijnsgezondheidswerkers (presentaties dr. R. Verrando en dr. E. Verwerft). Bijkomend stelde het WIV de meest recente prevalentiegegevens omtrent alcohol- en druggebruik voor als referentiekader. Tot slot werd er ruimte voorzien voor het toetsen van stellingen bij de deelnemers *(zie bijlage 6, Programma – slotconferentie 23/1/15).*

## Resultaten

### *Deelnemers*

Het **aantal** inschrijvingen bedroeg 129. Dit was ver boven het verwachte aantal. Een honderdtal personen nam uiteindelijk deel aan de conferentie.
De deelnemersgroep was **zeer** heterogeen, maar weerspiegelde evenwel de relevante stakeholders in dit domein, zoals preventiewerkers en hulpverleners uit de alcohol- en drugsector, onderzoekers, beleidsverantwoordelijken, politie/justitie, welzijn en gezondheid. Arbeidsgeneesheren waren in verhouding het meest vertegenwoordigd, wellicht door de eerdere aankondiging bij de geplande valorisatie van arbeidsgeneesheren in december 2014. Daarenboven kunnen arbeidsgeneesheren zich

[6] www.qado.be, VAD-website mbt preventief alcohol- en drugbeleid op het werk. Oplage Nieuwsbrief en Nieuwsflash ongeveer 1100.

wellicht, anders dan huisartsen, makkelijker organiseren om deel te nemen aan een seminarie op een doordeweekse dag.

## *Evaluatie programma en organisatie*

Globaal scoorde de slotconferentie **8,3/10**. De deelnemers waren in hoge mate tevreden over de uiteenzettingen (eerder tevreden tot helemaal tevreden op een 5-punt Likertschaal), en dit zowel voor de presentaties als voor de inhoud. Vooral de twee praktijkpresentaties werden gesmaakt. Ook over de organisatie van de studiedag (infrastructuur, catering, locatie) waren de deelnemers tevreden *(zie bijlage 13, Evaluatie - slotconferentie 23/1/15).*

## *Discussieronde*

In de discussieronde werd eerst een aantal voorstellen toegelicht en in zijn context geplaatst *(zie bijlage 11, Discussieronde - slotconferentie 23/1/15).* Nadien konden de deelnemers elk voorstel – met diverse subvoorstellen – afzonderlijk scoren (5-punt Likertschaal) *(zie tabel 4).* Daarnaast was er ruimte voorzien voor bijkomende schriftelijke suggesties Van deze mogelijkheid werd opvallend veel gebruik gemaakt *(zie bijlage 12, Verwerking Discussieronde - slotconferentie 23/1/15).*
De discussieronde werd beëindigd met enkele mondelinge vragen.

Onderstaand worden de verschillende voorstellen beschreven op basis van conclusies uit de Likertschaal, gevolgd door te onthouden aandachtspunten uit de suggesties van de deelnemers.

| | **Helemaal niet akkoord** | **Niet akkoord** | **Neutraal** | **Akkoord** | **Helemaal akkoord** |
|---|---|---|---|---|---|
| **1. Meer sensibilisering van de volwassen bevolking omtrent A&D-gebruik (n=58)** | | 2x | 1x | 21x | 34x |
| Alcohol (n=66) | | 1x | 2x | 27x | 36x |
| Cannabis (n=57) | | 1x | 7x | 38x | 21x |
| Andere illegale drugs (excl. cannabis) (n=67) | 1x | 1x | 6x | 34x | 21x |
| Slaap- en kalmeermiddelen (n=63) | 1x | 1x | 1x | 24x | 36x |
| 1a. Huisartsen (HA) zouden meer aan preventie moeten doen (n=72) | | | 5x | 33x | 34x |
| 1b. Arbeidsgeneesheren (AG) zouden meer aan preventie moeten doen (n=66) | | 3x | 4x | 34x | 25x |
| 1c. Artsen dienen een vergoeding te vragen voor screening (n=64) | 2x | 14x | 21x | 15x | 12x |
| 1d. Preventie-actoren moeten de aanvaardbare drinknormen | | 2x | 8x | 29x | 23x |

| | | | | | |
|---|---|---|---|---|---|
| beter onder de aandacht brengen (n=62) | | | | | |
| **Aantal suggesties deelnemers: 23** | | | | | |

Tabel 4: scores van deelnemers slotconferentie mbt voorstel 1

**Beoordeling voorstel 1 op basis van Likertschaal**

Ruime consensus omtrent de oproep voor meer sensibilisering voor alle soorten drugs (iets meer voor alcohol en slaap- en kalmeermiddelen).

Enkel voor de vraag omtrent screening zijn de meningen verdeeld. Het is niet duidelijk wat de beweegredenen daarvoor zijn (heterogeniteit van het publiek?, screening vaak verdeelde opinies?).

**Te onthouden? (op basis van suggesties deelnemers, uitgebreid overzicht zie bijlage 12)**

Sensibilisering alleen is niet voldoende.

Voor illegale drugs is een opsplitsing tussen cannabis en de andere illegale drugs aangewezen.

Opvallend: arbeidsgeneesheren geven aan dat hun wettelijke opdracht weinig geen of weinig ruimte biedt voor gezondheidspromotie.

| | **Helemaal niet akkoord** | **Niet akkoord** | **Neutraal** | **Akkoord** | **Helemaal akkoord** |
|---|---|---|---|---|---|
| **2. Maak werk van een concreet alcohol- en drugbeleid op het werk (n=30)** | | | 3x | 1x | 26x |
| Uitbreiding wettelijke regeling naar publieke sector (n=66) | | 1x | 11x | 17x | 37x |
| Uitbreiding wettelijke regeling naar onderwijs (n=64) | | 1x | 11x | 21x | 31x |
| Concrete uitwerking alcohol- en drugbeleid (fase 2) n=62) | | | 4x | 21x | 37x |
| **Aantal suggesties deelnemers: 36** | | | | | |

Tabel 5: scores van deelnemers slotconferentie mbt voorstel 2

**Beoordeling voorstel 2 op basis van Likertschaal**

Consensus omtrent het voorstel om werk te maken van een concreet alcohol- en drugbeleid op het werk, en de uitbreiding van het wettelijk kader (cao 100, private organisaties) naar de publieke sector en het onderwijs. In verhouding het meest aantal bijkomende suggesties.

**Te onthouden? (op basis van suggesties deelnemers, uitgebreid overzicht zie bijlage 12)**

Onderscheid wettelijke verplichting en concrete toepassing (cf. uitgewerkt alcohol- en drugbeleid op basis van kwaliteitscriteria).

Situeren binnen welzijnsbeleid (psychosociale risico's op het werk).

Draagvlak en op maat.

Multidisciplinariteit.

| **3. Screening** | **Helemaal** | **Niet** | **Neutraal** | **Akkoord** | **Helemaal** |
|---|---|---|---|---|---|

| | niet akkoord | akkoord | | | akkoord |
|---|---|---|---|---|---|
| 3a. Huisartsen kunnen beter inzetten op screening doorsnee patiënt (n=64) | | 5x | 18x | 29x | 12x |
| 3b. Arbeidsgeneesheren screenen best élke werknemer op alcoholgebruik (n=64) | 3x | 20x | 14x | 14x | 12x |
| 3c. Elektronische screening kan de werklast van HA en AG verminderen (n=63) | 3x | 8x | 23x | 19x | 10x |
| **Aantal suggesties deelnemers: 19** | | | | | |

Tabel 6: scores van deelnemers slotconferentie mbt voorstel 3

**Beoordeling voorstel 3 op basis van Likertschaal**

Over deze voorstellen zijn de meningen meer verdeeld, wellicht als gevolg van heterogeniteit van het publiek.

**Te onthouden? (op basis van suggesties deelnemers, uitgebreid overzicht zie bijlage 12)**

Systematisch bevragen van alle patiënten/werknemers of gerichte screening, en hoe?
Screening is niet voldoende, moet georganiseerd worden in een groter kader.
Mogelijkheden elektronische screening.

| | Helemaal niet akkoord | Niet akkoord | Neutraal | Akkoord | Helemaal akkoord |
|---|---|---|---|---|---|
| **4. HA en AG creëren mogelijkheden om te overleggen (n=41)** | | | 3x | 18x | 20x |
| 4a. Huisartsen organiseren formeel overleg met arbeidsgeneesheren (n=60) | 1x | 4x | 10x | 30x | 15x |
| 4b. Huisartsen organiseren formeel overleg met de alcohol- en drugsector (n=59) | 1x | 1x | 11x | 26x | 20x |
| 4c. Arbeidsgeneesheren organiseren formeel overleg met huisartsen (n=60) | | 2x | 7x | 32x | 19x |
| 4d. Arbeidsgeneesheren organiseren formeel overleg met A&D-sector (n=60) | | 3x | 15x | 21x | 21x |
| **Aantal suggesties deelnemers: 29** | | | | | |

Tabel 7: scores van deelnemers slotconferentie mbt voorstel 4

**Beoordeling voorstel 4 op basis van Likertschaal**

Consensus omtrent de oproep voor meer samenwerking tussen huisartsen en arbeidsgeneesheren, maar modaliteiten moeten bekeken worden.

**Te onthouden? (op basis van suggesties deelnemers, uitgebreid overzicht zie bijlage 12)**

Aansporen tot of formeel organiseren/verplichten?

Huisartsen en arbeidsgeneesheren moeten elkaar leren kennen en vertrouwen.
Andere actoren, zoals preventieadviseurs psychosociale aspecten, moeten betrokken worden.
Inspraak patiënt/werknemer.
Belang van vertrouwelijk kader, beroepsgeheim.

| | **Helemaal niet akkoord** | **Niet akkoord** | **Neutraal** | **Akkoord** | **Helemaal akkoord** |
|---|---|---|---|---|---|
| **5. HA & AG hebben meer ondersteuning nodig in preventie en aanpak van A&D (n=37)** | | | | **14x** | **23x** |
| 5a. Organisatie van ervarings-uitwisseling kan HA & AG helpen bij preventie A&D (n=64) | | | 6x | 27x | 31x |
| 5b. Meer aandacht voor middelenproblematiek binnen het curriculum (n=63) | | 1x | 1x | 34x | 29x |
| 5c. Meer aandacht niet alleen in het curriculum, maar ook in navorming (n=64) | | | 2x | 28x | 34x |
| 5d. Praktijkgerichte guidelines zijn nuttig in de onder-steuning dagelijkse werking (n=64) | | | 5x | 24x | 35x |
| **Aantal suggesties deelnemers: 17** | | | | | |

Tabel 8: scores van deelnemers slotconferentie mbt voorstel 5

**Beoordeling voorstel 5 op basis van Likertschaal**
Ruime consensus omtrent voorstel voor meer ondersteuning in preventie en aanpak van alcohol- en andere drugproblemen.

**Te onthouden? (op basis van suggesties deelnemers, uitgebreid overzicht zie bijlage 12)**
Ondersteuning is nodig via basisopleiding als arts, maar ook in bijscholing.
Onvoldoende tijd is een belangrijke handicap.
Attitudes van huisartsen en arbeidsgeneesheren spelen ook een rol.

## *Procesevaluatie*

De uitgebreidheid en beoordeling van deze valorisatiefase was een succes, en is zeker voor herhaling vatbaar bij gelijksoortige projecten. De methode van Large Scale Interventions was hierbij een interessant gegeven. Deze aanpak veronderstelt een actieve betrokkenheid van stakeholders in de diverse fases van te realiseren veranderingen, ook op vlak van de alcohol- en drugproblematiek. In het UP-TO-DATE-project werd dit gerealiseerd door de terugkoppeling van resultaten in de begeleidingscommissie, en vooral door de actieve valorisatie in de eindfase. Het is een

interessante oefening om te kijken of en in welke mate we deze betrokkenheid van stakeholders kunnen verbeteren in toekomstige projecten.

# Aanbevelingen

Tot slot willen we een aantal aanbevelingen suggereren, en dit op basis van de toetsing bij de huisartsen en bij stakeholders tijdens de slotconferentie.

- Meer sensibilisering omtrent alcohol- en ander druggebruik is aangewezen, vooral bij volwassenen maar ook bij jongeren.
- Cannabis wordt anders gepercipieerd dan de overige illegale drugs, ook door gezondheidswerkers. Dit is belangrijk bij preventie en aanpak.
- Debat aangaan omtrent het systematisch bevragen en/of gericht screenen van alcohol- en ander druggebruik door huisartsen en arbeidsgeneesheren.
- Maak werk van een concreet alcohol- en drugbeleid op het werk.
- Huisartsen en arbeidsgeneesheren moeten meer ondersteund worden bij de preventie en aanpak van alcohol- en andere drugproblemen, bv. door organisatie van ervaringsuitwisseling tussen HA en AG, door meer aandacht voor middelenproblematiek in het curriculum,….
- Huisartsen en arbeidsgeneesheren moeten elkaar beter leren kennen en met elkaar communiceren.
- Multidisciplinariteit is nodig.
- (meer) Overleg tussen alle actoren inzake preventie en aanpak van middelenmisbruik is aangewezen.

# Referenties


1. http://www.belspo.be/belspo/organisation/intro_nl.stm
2. The I-Change Model [http://www.maastricht-university.eu/hein.devries/interests/i-change-model]. Accessed 23/02/15.
3. AWTI (2007). *Alfa en Gamma stralen. Valorisatiebeleid voor de Alfa- en Gammawetenschappen*. Den Haag: Adviesraad voor Wetenschap, Technologie en Innovatie.
4. Steenssens, S. & Gijselinckx, C. Valorisatie van onderzoek in de humane en sociale wetenschappen: bepaling van het onderzoeksobject In Gijselinckx, Caroline en Steenssens, Katrien (eds.) (2011). *Naar waarde geschat. Valorisatie van onderzoek in de humane en sociale wetenschappen.* Eindrapport van het onderzoek 'Valorisatie van onderzoek in de Humane en de Sociale Wetenschappen', gefinancierd door de Vlaamse Raad voor Wetenschap en Innovatie.
5. Cultuurforum 2020 (2013). Geïntegreerd verslag van de gesprekstafels 'Kennisgebaseerd beleid en praktijk'. Kortrijk, 27/5/2013. https://cjsm.be/cultuur/sites/cjsm.cultuur/files/public/cf2013-verslag-sessie007.pdf. Accessed 23/02/15.
6. Zouwen, van der T. (2011). *Building an evidence based practical guide to Large Scale Interventions. Towards sustainable organizational change with the whole system*. Delft: Eburon Academic Publishers.

**Bijlagen**

| | |
|---|---|
| Bijlage 1 | Voorstelling organisatie valorisatiefase - Begeleidingscomité 17/9/2014 |
| Bijlage 2 | Recrutering – uitnodiging deelname huisartsen LOK (NL)- GLEM (FR) |
| Bijlage 3 | Recrutering – uitnodiging deelname arbeidsgeneesheren NL - FR |
| Bijlage 4 | Toetsing resultaten LOK - GLEM |
| Bijlage 5 | Slotconferentie - uitnodiging NL - FR |
| Bijlage 6 | Slotconferentie – programma NL - FR |
| Bijlage 7 | Slotconferentie – presentatie Lydia Gisle FR - NL |
| Bijlage 8 | Slotconferentie – presentatie Marie-Claire Lambrechts NL - FR |
| Bijlage 9 | Slotconferentie – presentatie Rita Verrando NL - FR |
| Bijlage 10 | Slotconferentie – presentatie Elke Verwerft NL - FR |
| Bijlage 11 | Slotconferentie – voorstelling discussieronde NL - FR |
| Bijlage 12 | Slotconferentie – resultaten discussieronde NL - FR |
| Bijlage 13 | Slotconferentie – evaluatie deelnemers NL - FR |