A thematic analysis of the roles and experiences of professionals in supporting individuals who require treatment for alcohol dependence.

Andrea McSweeney and Dr Sharon Lambert

School of Applied Psychology, University College Cork

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Abstract

The aim of this study is to provide a thematic analysis of the roles and experiences of professionals who support individuals that require treatment for alcohol dependence. Participants included eight professionals who work in the area of addiction. Semi-structured interviews were carried out to collect data. Data analysis utilised thematic analysis. Five core themes emerged from the analysis: (i) Barriers to Accessing Treatment, (ii) Impact of the Pandemic, (iii) Self-care, (iv) Addressing the Deficits, (v) Motivation for Change. Within the core themes, associated subthemes provided further context to the data. Participants illustrated the inadequate nature of the current system of treatment services in relation to its accessibility, pathways, and provision. Furthermore, the professionals expressed the importance of their self-care whilst working with alcohol dependent individuals. Also, participants expressed the importance of a client's motivation to begin the recovery process and begin treatment. This paper highlights areas of concern which exist among professionals. Overall, this research compiles a wide of experiences from a variety of roles and demonstrates how these professionals navigate despite these unfavourable circumstances.

Literature Review

This study aims to analyse the roles and experiences of professionals in working with those who are alcohol dependent and seeking treatment. Alcohol dependance relates to maladaptive patterns of alcohol consumption which is manifested by several symptoms that can lead to severe distress and impairment (American Psychiatric Association, 1994). In Western societies alcohol use is generally a socially accepted behaviour, however, alcohol dependence is a major public health issue. On a social level, the European Union is the world's heaviest-drinking area, with more than one fifth of Europeans aged 15 and above reporting heavy episodic drinking (WHO, 2019). Alcohol use is the seventh leading risk factor for deaths worldwide, despite the fact that half of the world's population do not consume alcohol (Doyle, 2021). In Europe, reports have shown that less than 10% of those who have been diagnosed with a dependence on alcohol receive any treatment (Luitel et al., 2019). Ireland has been ranked ninth highest per capita alcohol consumption of all members of the Organisation for Economic Co-operation and Development, with alcohol consumption levels and unsafe drinking patterns expected to over increase over the next decade (Manthey et al., 2019). Alcohol remains the most prevalent drug that people seek treatment for in Ireland, with an estimated 250000 people living with alcohol dependency problems in the country. Between the years 2013 and 2019, 53200 cases were recorded by the National Drug Treatment Reporting System or NDTRS, with those attending treatment having alcohol as their main 'problem' drug. In 2019, 7500 cases of treatment alone were reported to the Health Research Board (HRB). Just over half of these 7500 cases were treated in outpatient facilities, and more than one third were treated in a residential setting (Alcohol Action Ireland, 2021). Despite these substantial figures, alcohol dependance often remains

undiagnosed, with many individuals not receiving any treatment. People who are experiencing alcohol dependency often suffer with many adverse effects as a result and a delay in treatment, in many cases, can lead to premature death (Yoon et al., 2020). With such substantial numbers, it is necessary to examine the professionals (GPs, addiction counsellors, community drug workers and key workers) who support these individuals that are dealing with alcohol dependency and require treatment.

Alcohol dependance is associated with neuropsychological impairment (Ioime et al., 2018), fetal alcohol syndrome (Abel, 2022) and domestic violence (Chalfin, Danagoulian & Deza, 2021) among other deleterious outcomes. It has been found that early traumatic experiences can potentially increase the risk of substance use disorders and dependence. This is an attempt to suppress prevalent symptoms as a means of trying to 'self-medicate' (Bartoli, Carretta & Carrà, 2021). The self-medication hypothesis (Chilcoat & Brelau, 1998) is one that is broadly supported as it outlines the comorbidity of substance use disorders and anxiety. Self-medication is an attempt to reduce anxiety through the use of alcohol, or drugs, and relieve the individual's symptoms. It is associated with many adverse outcomes such as increased suicidal behaviour, increased levels of stress, and lower health-related quality of life (Turner et al., 2018). Therefore, those with an anxiety disorder are more likely to become alcohol dependent, rather than those without (Bartoli, Carretta & Carrà, 2021). On the other hand, hazardous alcohol use can also lead to mental health problems. It can create tension in one's life, and particularly in the work and home environment. This can result in stressful scenarios such as job loss or martial disputes and breakdown (Bunga, Bipeta & Molanguri, 2022). Therefore, the individual may experience poor mental health as a consequence of their alcohol use. The current evidence is mixed, with some sources saying the driving force is

poor mental health (Coakley et al., 2021), whereas others would argue that it is the use of alcohol alone (de Boer et al., 2021). It has also been suggested in the literature that it works as a feedback cycle (Meyer, 1986) which contributes to increased alcohol consumption and deteriorating mental health, for example, people may feel anxious or become depressed and then turn to alcohol as a form of self-medication, which causes further anxiety and depression, fueling alcohol consumption more. Or the reverse of this may occur. Few studies have attempted to test this feedback cycle theory have been limited in methods used to capture the dynamic nature between both variables (Farris et al., 2020). Along with this, a consistent finding in the literature is that the rates of those diagnosed with alcohol dependence are higher among people with a lower socioeconomic status, or SES (Bloomfield, 2020; Grant et al., 2015). Research currently suggest that this is due to the stress that is associated with a low SES (Laghi, 2022; Wallace, 2021). Although findings also suggest that individuals with a higher SES often consume similar amounts of alcohol to those with a lower SES, it is those with a lower SES who appear to face higher negative alcohol-related consequences such as alcohol-related mortality and morbidity (Collins, 2016).

Current national policy in Ireland puts an emphasis on the importance of a health-led response to alcohol use by providing person-centered services that assist in the promotion of rehabilitation and recovery (Ireland Department of Health, 2017). Currently, the policy of 'Reducing Harm, Supporting Recovery' in Ireland is made up of a four-tier system, The Four Tier-Model of Care. It suggests that initially, clients should be given the least intensive intervention, based on their needs. In cases where lower tier treatment is not successful, more intensive, or higher tier, treatment should then be offered (Alcohol Action Ireland, 2021). The first tier involves interventions where the focus is not on treatment, but on other supports

such as social care and educational services. These interventions are usually conducted in a general healthcare setting. Tier two involves specific drug-related interventions for example, outreach and primary care. This tier involves treatment which is usually hospital or community based. Tier three is specialist drug-related interventions and include prison or hospital setting for example and consist of care-planned treatment that may include day care and methadone maintenance, for example. Finally, tier four is specialist dedicated impatient or residential wards and units. This uses an approach that is care planned and extended rehabilitative care (Alcohol Action Ireland, 2021). Residential treatment is often used as a direct intervention for those who are dealing with substance use and require structured care (de Andrade et al., 2019). It involves treatment in a nonhospital, licensed residential facility. Individuals who experience alcohol dependance generally have many different needs depending on the severity of their symptoms, and to allow for these needs to be met, a continuum of support and care is essential in terms of intensive treatment. In Ireland, it is the Minnesota Model which is often used within residential treatment for assisting those with alcohol dependence. Reports which are currently available on the effectiveness of this model generally state that there are benefits for a considerable amount of those who are treated using this model (Gallagher et al., 2018). The Minnesota Model is one which promotes abstinence and equates a good outcome to a decrease of alcohol use following treatment and sustaining the reduction and eventual abstinence beyond the period they received treatment. The Minnesota Model promotes the possibility for change in terms of one's beliefs, attitudes, and behaviors. It follows the 'disease concept' which identifies physical dependence on alcohol as a disease and is made up of the foundational knowledge of recovery, being the 12 steps and main principles of AA. Research often challenges the concept of the disease model, with many believing alcohol dependence is embedded in a social context (Heather et al.,

2018; Lie et al., 2022) The method of motivational interviewing (Miller, 1983) is a therapeutic style that is often used in the case of substance use as it is both client centered and directive in nature. It assists in improving the client's ability to address their ambivalence and find a resolution in attempt to strengthen their desire to alter their behaviour (Doumas, Miller & Esp, 2019). It encompasses four main principles of expressing empathy to the client, support their self-efficacy, rolling with resistance, and the development of discrepancy. Therefore, motivational interviewing aims to assist in helping people decrease their alcohol use by seeing the situation from the client's perspective, holding them responsible for deciding to change and carrying out actions to do so, and using the client's momentum in the moment rather than fighting any resistance. Research suggests that residential treatments for alcohol dependence have mixed effectiveness which are based on a number of factors affecting outcomes, e.g., psychiatric symptom severity (Decker et al., 2017) and therapeutic relationship (Krebs et al., 2018).

The most recent development in Ireland's alcohol policy is the enactment of the Public Health Act 2018 which introduce minimum unit pricing. This set a compulsory minimum price of any alcohol product at ten cent per gram of alcohol. This act also introduced the separation of alcohol products, physically, from other grocery items. The introduction of minimum unit pricing (MUP) has been quite controversial (Lesch & McCambridge, 2021). The rationale for MUP is based on systemic review evidence on the consumption, price, and related harm (Public Health England, 2016). Although findings suggest that the policy of MUP is effective in reducing off-trade purchases (Anderson et al., 2021), there is a concern about how it will affect those who are alcohol dependent with lower incomes. This is because those who are alcohol dependent with lower incomes buy most of their alcohol for less than

the minimal unit price, therefore it is suggested that they could be significantly affected (Holmes et al., 2014). In Scotland, similarly where MUP was implemented in 2018, findings show a decrease in the purchase of alcohol. These reductions were seen in households that previously bought the most alcohol, therefore suggesting that MUP has a progressive effect in relation to health outcomes (Burton et al., 2017; Robinson et al., 2020).

It has been suggested that at one given time, 10% of such a cohort can be seeking out treatment for alcoholism, based on data that has been collected internationally (Irish Medical Organisation, 2015). Therefore, a significant number of people who are experiencing alcohol dependency are not receiving the necessary support. There are many known benefits from treatment of alcohol dependence, treatment seeking is a low occurrence (May & Nielsen, 2019). Although some individuals may recover from alcohol dependence without treatment, many people have shown to benefit from different treatment services, such as residential treatment (de Andrade et al, 2019), one-to-one counselling (Guenzel & McChargue, 2021), and group counselling (Yusop et al., 2020). This low treatment occurrence is a result of the existence a multitude of blockages and barriers to treatment of alcohol dependence, and therefore, it may be difficult for those seeking out treatment to get the correct professional help quickly. The waiting time (including being placed on a program-generated waiting list) is frequently cited as one of the most significant hurdles to treatment. The longer substance users have to wait to be accepted to treatment, the more likely they are to abandon their treatment plans (Stanojlović & Davidson, 2021). Another blockage is the prevalent gender differences which exist in relation to the way men and women experience treatment in terms of access and outcomes (Meyers et al., 2021). Research has found that women who find themselves dependent on alcohol do not receive the same level of support socially as their

male counterparts (Fonseca et al., 2021). In Ireland, for example, only three in ten people accessing services which help those with substance dependence are female. Research has suggested that the reasoning for this is related to sociocultural factors which prevent women from access to treatment, such as stigma, maternal responsibilities, and economic issues (Ivers, Giulini & Paul, 2021). Stigmatisation is often experienced by those with alcohol dependence and involves people labelling the differences of one's characteristics and then linking it to negative stereotypes (Houghton & Taylor, 2021). The stigma which surrounds alcohol dependence has the capability to aggravate the already existing negative effects which exist, such as its influence on one's social behaviour and endless physical effects. The existing stigma is so prominent, not only in Ireland, but worldwide, that it may cause a hinderance in one seeking out professional help, or even asking for help from a family member or friend, due to the fear of being perceived as 'choosing' to use alcohol (Nair, 2021). The prevalence of substance dependence in urban and rural areas is a public health issue. Rural areas have continuously been disadvantaged in terms of the availability of treatment services, therefore this acts as another barrier to accessing treatment for individuals in this position. Currently, less is known about those who are living in rural areas and dealing with alcohol dependence. The findings of existing studies are often based entirely on urban samples, with little to no rural representation Browne et al., 2016; Small, Curran & Booth, 2010). This can put not only those with alcohol dependence, but also those key workers in the area at a disadvantage as it may be difficult to discuss the needs of clientele when they are not within the ideal proximity to do so.

Professionals play a significant role in both the identification of symptoms and aid in the accessibility to treatment (Nyblade et al., 2019). There are many studies available which

focus on the experiences of those who have dealt with alcohol dependency, however there are fewer available insights into the experiences and roles of the professionals who support these individuals. The attitudes of health professionals towards those who are suffering with substance dependence have a significant impact on the effectiveness of treatment (de Vargas et al., 2020). It is common for healthcare providers to be of the belief that they are lacking in sufficient competence to implement treatment methods for alcohol dependence. Along with this, many people who are experiencing alcohol dependence initially deny their addiction. Therefore, communication difficulties between the patient and professional may act as another hindrance which can negatively impact the process of providing care for these individuals (Hanpatchaiyakul et al., 2016). It is essential that these professionals have the adequate skills, such as therapeutic alliance, and specific attitudes to allow for effective communication and assist those dealing with alcohol dependence in their recovery and journey to sobriety. Furthermore, self-care is an important preventative approach to ensure that burnout risk factors do not affect professionals' experiences, as this can lead to difficulty in forming successful care relationships with clients (Reyre et al., 2017).

As a result of the COVID-19 pandemic, the issue of alcohol dependence has progressively become more prevalent with alcohol consumption in Ireland becoming a health emergency (Carbia et al., 2022; Reynolds et al., 2021). Due to isolation and prevalent feelings of loneliness, the pandemic has led to the creation of new cases of alcohol use disorders (da Silva & Testino, 2020). To cope with the drastic lifestyle change that the pandemic has caused, many individuals have turned to alcohol as a method of addressing their anxieties and stress in relation to COVID-19. As a result of the restrictive conditions many of those who are alcohol dependant are at risk due to a decrease in the usual available supports. For

example, physical distancing has caused a delay in contact with services for many people due to the fear of contracting COVID-19. Also, another challenge which exists is the limited access to other treatment services and aftercare services. In some instances, individuals have not attended emergency medical treatment because of this fear (Kelleher, 2020). It was not possible for face-to-face group-based interventions to occur, with many of these services having to be provided through video conferencing online. This led to a digital divide amongst those attempting to access online services in cases where were unable to use online resources effectively, due to not having a phone or lack of a private space for example (Satre et al., 2020). Moreover, this stress and anxiety has been prevalent among healthcare workers also (O'Callaghan & Lambert, 2022). There is not only an increased workload for the staff, but resources are also stretched to the limit. Therefore, there is a major pressure on all aspects of healthcare services and healthcare professionals as a result (Walton, Murray & Christian, 2020).

This study aims to collect data in relation to the roles and experiences of professionals who support individuals who require treatment for alcohol dependence. This will be carried out through a series of interviews that will work to collect relevant data and information in relation to the research question. Qualitative research allows for coverage of a wide variety of concepts and provides an in-dept analysis of data. The data will be analysed using the qualitative method of thematic analysis (TA). This mechanism of thematic analysis is highly flexible and works to identify and analyse patterns and themes of meaning within a particular dataset (Braun & Clark, 2019). It is seen as flexible as it is not tied to a specific theoretical perspective, unlike other qualitative methods. Through a process of coding, themes which work to explain the phenomenon are created. Themes are used as a mechanism to interpret

data in a way that describes it and says something about a relevant issue (Maguire & Delahunt, 2017). Moreover, there are both inductive and deductive methods of thematic analysis which adds to its flexibility. The deductive method of thematic analysis will be used for this study. This method is used in cases where there is a predetermined framework and preconceived themes based on the relevant theories and knowledge. It is necessary to gain an insight to these experiences and roles of professionals as it may assist in improving current policy and redefining the structures that are currently in place to help those alcohol dependent individuals in accessing treatment and in their recovery.

Method

The current study aims to explore the roles and experiences of a range of professionals (e.g., key workers, counsellors, GPs) who work with those that are alcohol dependent. For example, their experiences with outpatient and residential treatment, and their opinion on the barriers to accessing treatment. The author conducted eight individual semi-structured interviews with each participant using a pre-prepared interview schedule consisting of 8 questions (see Appendix 1). The qualitative method of deductive thematic analysis (Braun & Clark, 2019) was the framework utilised to analyse the transcripts and generate themes and sub-themes in relation to the data and research question.

Participants and sampling

The study includes eight participants, consisting of three men and five women. All participants are professionals working in the area of addiction. Participants are involved in a range of different areas such as public health services, homelessness, and the criminal justice system. The process of recruitment involved purposive sampling. This involved emailing individuals who have experience working with those with alcohol dependence. The email contained an information sheet (see Appendix 2) which outlined relevant information about the research study and interview process. It informed participants that their participation was completely voluntary and offered details for support services. The information sheet also outlined the confidentiality and anonymity of the study and stated where data would be stored. A consent form (see Appendix 3) was attached to the email. This was to be signed by participants, electronically, and emailed back to the researcher. This research was carried out in collaboration with Alcohol Action Ireland. Alcohol Action Ireland assisted in both

reviewing the interview topic guide and the recruitment process by emailing potential participants who are currently working in addiction services and have experience with alcohol dependent individuals. The study had no restrictions on sex and gender. This study is widely spread geographically with participants working throughout the Republic of Ireland based in the south, south-east, mid-west, and east of the country. However, specific locations and workplaces of participants are kept anonymous for confidentiality.

Table 1.

Participant and Participant Roles

Participant number	**Gender**	**Participant role**
Participant 1	Female	Polydrug and alcohol community detox worker
Participant 2	Male	General practitioner
Participant 3	Female	Community response & project worker
Participant 4	Male	Psychologist and clinical governance
Participant 5	Male	General practitioner
Participant 6	Female	Counsellor & clinical director of drug and alcohol services
Participant 7	Female	Treatment centre worker
Participant 8	Female	Community project worker

Design

Eight semi-structure interviews were carried out and based on an interview schedule that was pre-prepared. This allowed for pre-determined topics to be discussed but also spontaneous concepts and issues to be raised while maintaining a loose and flexible structure. Examples of interview questions asked, and their rationale are stated below:

1. "Are they any challenges involved in supporting someone with alcohol dependence?" This question was chosen as it allows for the participant to share their own experience with personal challenges and issues that may occur whilst assisting a client who is experiencing alcohol dependency. It gives the participant an opportunity to discuss their own struggles that can be an effect of working in this area.

2. "Are there any barriers you find are affecting accessibility to treatment currently?" This question offers the participant a chance to discuss the blockages that they personally have experienced which may be affecting an individual's capability to access treatment services in Ireland. For example, the stigma surrounding alcohol dependence, or the lack of services available to those in rural areas.

3. "Are there any changes you would like to make to the system in place to improve both your experience and the client's?" This allows the participant to share their opinion on necessary changes that they would like to see and consider necessary to improve the treatment of alcohol dependence for the client, but also changes that would assist the professional in relation to providing treatment.

Data collection

The author collected interview data through eight semi-structured interviews. All these interviews took place online via Microsoft Teams and were recorded using the recording feature available on the Microsoft Teams application. All interviews were then transcribed verbatim on Microsoft Word. The interviews ranged from 13 minutes to 37 minutes, with the average interview being 27 minutes. This process of data collection took place for the duration of February 2022 to March 2022. Prior to carrying out the interviews an interview schedule was formed. This would assist in guiding the interviewing process. The interview schedule contained introductory comments, a list of key topics and questions, a set of associated prompts, and closing comments to end the interview. Questions were open-ended in nature as this would allow for the exploration of topics throughout each interview. These questions were created following the review of relevant literature. Using an interview schedule ensured for smooth conduct of the interview and allowed for accurate data to be collected due to well thought out questions which provided crucial details of the topic at hand. It also increases the likelihood of collecting data that is relevant and accurate, ensuring data is consistent across all cases while allowing for flexibility if necessary. Participants spoke about their role in working with those who are alcohol dependent along with the experiences they have had whilst working in this role. They spoke about several topics, with some of the most persistent being related to the COVID-19 pandemic and the existing barriers to accessing treatment. Interviewer prompts and appropriate questions fostered further dialogue, as per general interview methodology for qualitative research.

Data analysis

The qualitative method of thematic analysis was used to analyse the data. Thematic analysis allows for the exploration and development of understand of a patterned meaning across a particular data set. The reflexive thematic analysis process (Braun et al., 2019) follows six steps. First the author gained a familiarisation with the data. This process was done through the transcription of the interviews and listening to the audio of the interview whilst doing so. During this process potential interest points were noted. Following transcription, codes were generated. Each interview was systemically coded through the identification of snippets of the interview that had meaning that was relevant to the research topic. This was done using a three-column table constructed on Microsoft Word (see Appendix 4 for sample transcript and coding). This approach was used at it would make it easier to export the coded transcripts and excerpts when constructing themes. Coding can be carried out using an inductive or deductive approach which depends on the extent which the analysis is driven by the data content, and the influence of theoretical perspective. In this case, a deductive or 'top down' approach was utilised as the topic of alcohol dependence has a thorough theoretical foundation. The focus of the coding was on participant's specific experiences of working with those with alcohol dependence, relevant points about their main roles, and treatment accessibility. The codes generated were semantic in nature as they generally had an explicit meaning in relation to the language of the participant. Themes were constructed using the coding process. The codes were used as building blocks when forming themes and were sorted into different areas based on the topic. A candidate of themes was then produced through thorough engagement with the data. The themes were then revised and defined before the production of the final report of the analysis.

Ethical considerations

The author completed the necessary ethics application form which outlined the basis of the study in terms of its aims, justification, recruitment methods and methods to be used. It also contained an ethical approval self-evaluation and GDPR compliance. This ethics application form was submitted for approval. The author was given ethical approval to conduct this research by the departmental ethics committee at the authors' university. Furthermore, the research carried out followed the Psychology Society of Ireland's Code of Ethics. The participants recruitment emails all had an attached information sheet and a consent form. The information sheet encompassed all necessary information that participants needed to know prior to the study, for example, who their data would be available to and where it would be stored. Participants signed the consent form (electronically), and they sent them back by email. The consent forms outlined that the study was voluntary and assured that the participant's identities would be anonymized. It also laid out the confidentiality of participants information. Participants were informed that the interviews would be recorded. The audio-recordings were deleted following transcription and only the anonymized transcript remained. These transcripts will be stored on the University College Cork OneDrive system and subsequently on the UCC server. This study will promote awareness and emphasise the importance of the role of professionals supporting those who are alcohol dependent. It will also give pertinent information about treatment services accessibility in Ireland.

Results

Five core themes were developed from the analysis (1) barriers to accessing treatment, (2) impact of the pandemic, (3) self-care, (4) addressing the deficits, (5) motivation for change. Subthemes were also generated which support the core themes. Subthemes provide further context to the core themes and in-dept information in relation to the research topic.

Table 2.

Themes and Sub-themes

Theme	Sub-theme(s)
1.1 Barriers to accessing treatment	1.1.1 Inadequate pathways
	1.1.2 The wait for treatment
	1.1.3 Stigma & shame
1.2 Impact of the pandemic	1.2.1 Overwhelmed resources
	1.2.2 Moving to an online medium
	1.2.3 Isolation & loneliness
1.3 Self-care	
1.4 Addressing the deficits	1.4.1 Education & awareness
	1.4.2 Client individualism
1.5 Motivation for change	

1.1 Barriers to accessing treatment

The focus of this research was the barriers to treatment so as expected this theme was highly prevalent throughout interviews. Participants spoke of blockages which are preventing and delaying individuals who are alcohol dependent from seeking out and efficiently receiving the appropriate treatment. These barriers may have effects on one's recovery process and can cause negative effects for not only the client but also causing frustration among the professionals who are doing what they can to help these individuals. Participant 5 illustrates the effect these barriers have on professionals as it can cause feelings of aggravation due to their effect: *"If I am delaying seeing someone from the GP, the GP's getting more aggravated and if I see someone, I want to get them into residential and I'm getting a delay, you know it's not helping me or the client."* Therefore, highlighting the prevalence of barriers to accessing treatment, which can lead to a negative experience for all parties involved in the recovery process.

Participant 4 describes a current defect and a service specific issue in the Midwest, which is preventing those with an alcohol only problem from availing of treatment, due to their age being 27 or above: *"If you're in the Midwest and you come to the HSE and you're 27 years old and you have an alcohol only problem, we can't see you."* These individuals who are already affected by living rurally and remotely are being hindered further due to this restriction in place. This places yet another limit on accessing treatment for alcohol dependence in Ireland and illustrates the prevalence of barriers throughout all areas of Ireland.

1.1.1 Inadequate pathways

In terms of referral pathways, it is clear from participants responses that the current pathways in place are highly insufficient in all areas relating to alcohol dependence. Participant 3 suggests that those who are referring client's need to be more thoroughly informed in relation to addiction services to refer their clients efficiently. They suggest the formation of links between both parties to ensure there is effective communication and awareness on both ends to ensure the client receives the most suitable form of treatment based on their circumstances: *"A lack of kind of set referral pathways, in terms of say an addiction service meets a client and they need to refer a client to a GP… there's also a lack of awareness of kind of what addiction services are and what the workers do."* It appears that the referral process is quite ambiguous and lacking in solid guidelines: *"I come up dependent in an alcohol assessment, what do I use then? As a tool or evidence to decide whether you go for residential or whether you stay in the community? You know, so that to me is left to the choice, really, maybe of the counsellor. I don't think that's appropriate… I also think though we need something that will tell us the pathway."* The suggestion of introducing guidelines for those key professionals involved in referring clients was prevalent among participants. Implementing a trauma informed approach would allow for the client to have the decision-making lead and that they should determine what they need in collaboration with their key worker. This would allow for a set pathway to be determined and the most suitable treatment to be selected

1.1.2 The wait for treatment

In Ireland, it is prevalent that there are long waiting times and lists for those wishing to access treatment. The issue of waiting for treatment was frequently mentioned by participants

throughout the interview process: "*To get into treatment there is big waiting lists… I suppose if they're waiting to get into treatment centres and then they have a relapse, that sets them back."* The waiting process is not only frustrating for the professionals involved but also their clients, some of whom may be at high risk of relapse, as mentioned by Participant 7. These lengthy waiting lists can have negative effects on one's recovery process, leading to "slips" and in some cases leading to loss of contact between all parties. Early treatment has been associated with positive outcomes; therefore, it is necessary that those seeking treatment gain access as soon as possible. Along with this, the waiting period can amplify risks further for those clients who are experiencing mental health related issues, for example depression and suicidal thoughts: *"They've threatened suicide or something and they have a huge addiction like there should be a direct route for them to be able to access treatment without coming out meeting a drug worker going through the assessments going through the waiting time."* It is suggested that these individuals at high risk should have a direct pathway that would allow them to access treatment immediately, rather than having to endure the timely procedure that exists currently.

1.1.3 Stigma and Shame

Mentions of stigma and shame permeated throughout all conversations and evidence suggests that those with alcohol dependence are often accompanied by feelings of self-stigmatisation and shame. This self-stigmatisation is a result of the negative stereotyping attributes which are associated with addiction and exacerbated by public stigmatisation. This existing stigma can have harmful effects on one's ability to access treatment, creating a sense of shame around the idea of seeking out help: *"Most people are really nervous and shameful*

about coming into group like this. It's like they're already they're beating themselves up… it was really hard to help them you know, look at themselves with a different perspective or a different lens." Participant 1 expresses how it can be difficult for those feeling shame to view themselves and their dependence without judgement, leading to feelings of nervousness in attending groups, for example. Participant 4 echoes this: *"A fear of going to groups and being seen by other people in the community is a barrier."* The existence of a negative public perception of alcohol dependence can be damaging to those who are dependent as developing a positive sense of self is a vital aspect of recovery. Oftentimes, these stigmatising attitudes can lead to the labelling of those with alcohol dependence: *"And there's always this judgmental attitude around or, you know, they're an alcoholic or they're an addict."* The use of incorrect labels with stereotypical connotations only worsens the already existing stigma. This perceived social stigma can operate as a systemic barrier when individuals to whom alcohol users turn to help react with adverse judgements.

Participants particularly mentioned the overwhelming stigma women with children face as they are subjected to an already existing double standard. Many women, appear to be fearful of reaching out to treatment services because of this stigma. The overwhelming focus on women's reproductive role adds to the double standard that view women as distinct from their male counterparts. This stigma creates shame and fear among mothers who are wishing to seek out help from services. Participant 3: *"Women you know in terms of accessing supports as well, around accessing treatment say, 'Can I tell somebody that I have an alcohol problem if I have a child?'".* The shame of being an alcohol dependent mother is worsened by the fear of childcare protection services and the ambiguity of what will happen to one's child if they reach out to addiction services for assistance as mentioned by Participant 1:

"There's massive stigma in terms of being a mother and having addiction issues, and then you have the involvement of child protection services like Tusla." This acts as a frequent barrier to women accessing treatment.

1.2 Impact of the pandemic

All participants acknowledged the effect to which the COVID-19 pandemic impacted all aspects of their lives, and particularly their professional's lives. The way they provided treatment services had to change to carry on treating those with alcohol dependence, during periods of isolation and lockdown throughout the pandemic. Due to the unexpected nature of the pandemic, services and workers had to act quickly to cope with the everchanging restrictions, for example the introduction of social distancing. This posed as difficult to many participants who recognised the effect the pandemic had not only on treatment services themselves but also those who were seeking out help for alcohol dependence: *"Someone who's going to, you know, make that step to come into us and that's a big step. So, you know when that's taken off you and you're on the phone talking… It's not the same, you know. You're losing a lot."* Participant 8 acknowledges how taking the leap to reach out, in person, to a service for assistance has been taken from clients due to the social distancing restrictions which prevented many services from operating in person, and the impersonal nature of treatment that this caused as a result. Treatment services which were once welcoming and intimate in nature were now halted.

Due to the closure of pubs and bars due to the restrictions set in place by the government, participants acknowledged the rise in drinking in the home as a result. Participant 5 highlights this issue: "*I think that the alcohol, more than other things, kind of went into the home as*

opposed to the pub and I'd say we're going to see more coming back around now that have been hidden away." An issue which may have been hidden due to the isolating nature of pandemic is now expected to be coming to the forefront as the restrictions have been dismantled. Participant 6 emphasises the effect the pandemic has had on the rise of drinking in the home, particularly in women: "*I do see an increase of alcohol consumption in women and I think the old bottle of wine has replaced the put on the kettle."*

1.2.1 Overwhelmed resources

Participants noticed a spike in those looking for access to treatment, particularly residential, at the beginning of the pandemic. Participant 7 says: *"With COVID everyone wanted to go to treatment, you know, everyone just said, okay, I want to go to treatment and like it's not just as simple."* However, despite the demand for residential treatment, it was clear that it was not feasible for treatment centres to have sufficient resources, such as beds, for everyone who was attempting to access it. Participant 2: *"With COVID because beds were reduced in a lot of residential units, I would have had one person who was looking for treatment and he must have been waiting about, probably six or seven months."* It appeared that this was a consistent issue among participants due to the limited number of beds available, therefore their clients would have to endure long waiting lists and substantial delays in their recovery when attempting to access residential treatment. Therefore, lengthening the recovery process even further and putting highly vulnerable clients at risk.

Due to COVID-19 the healthcare system and its resources were under extreme pressure, not only with those suffering from COVID-19, but also those seeking out treatment for alcohol dependence. For many, group meetings could not go ahead due to strict social

distancing measures which were put in place and the lack of resources to cope with this: *"We had the pandemic so currently it runs online and via zoom we just didn't have the space to facilitate meetings safely."* Participant 1 mentions that due to these restrictions, it was not viable to carry out group meetings in a way that was safe and sufficiently socially distanced due to the lack of space to do so. Resources were not adequate for in-person and face-to-face meetings, particularly in a group setting.

1.2.2 Moving to an online medium

The topic of moving services online was a common theme among all interviews. Due to the pandemic, many services had no choice but to move to an online outlet to carry out meetings and calls if they wanted to continue providing support and outpatient treatment and communicating with client's and colleagues as face-to-face interactions quickly diminished as a result of social distancing restrictions. Participant 3: *"It's been much less easy to get you know face to face interaction with other mental health workers or support workers."* All participants appeared to have a preference for in-person meetings and interactions, Participant 6 mentions how the online setup has not been appropriate in all cases when working with client's, particularly for those experiencing a time of crisis or mental health difficulties: *"I do see that there is a place for it, but I do also see that nothing replaces the one-to-one face contact given what you're presented with, so like people in crisis or chronic anxiety, or maybe depression, it's not really appropriate to be doing the zoom"*. However, responses were quite varied, Participant 6 recognised that there may be a suitable place for online services in terms of providing psycho education online and for carrying out check-ins with clients who have stabilized and are no longer in a crisis: *"For things like doing psycho*

education and, you know, doing check-ins and when people are stabilized, it's really good for that."

It appeared that virtual communication had a limited reach in relation to clients who had difficulty accessing technology and were incapable of having a private space to do so due to their personal circumstances. For example, those who were experiencing homelessness or staying in homeless accommodation during this time may have had difficulties accessing treatment because of this: *"Staying in homeless accommodation maybe didn't have smartphones, didn't have access to and didn't have access to smartphones, Internet, or most of all didn't have access to a private space to actually do it."* However, the move to an online and virtual service was not all negative, Participant 4 illustrates the beneficial aspect of working with clients online. For those who live in remote areas of the country, for example in rural areas of the Midwest region, it is often difficult to seek out services that are close in proximity to their home. Therefore, the availability of online treatment made it possible for these individuals to seek out services: *"We're the Midwest region there are some very kind of remote pockets that are very difficult to get to… often people would need to wait for us to have two or three people in that region in order to justify the resource, now they don't have to wait if they can connect with somebody like this."* Therefore, this made treatment accessible to clients from any part of the country, increasing the ease of access for those living in remote areas.

1.2.3 Isolation & loneliness

Due to the pandemic, feelings of loneliness appeared to be highly prevalent for many people due to many services shutting its doors for months on end and due to periods of self-

isolation. Participant 7 describes the isolating nature of addiction, which was only worsened by the pandemic, with the consumption of alcohol in the home rising, along with the increase in mental health issues as a result: "*Alcohol consumption, it had risen quite drastically, and mental health and mental health issues had risen as well… It was hand in hand a lot of people who are struggling with isolation and loneliness… Addiction in itself is isolating."* Participant 8 illustrates the way which many of those attending group meetings, would not only attend to receive help but also for the social aspect of these meetings. Socialising and conversing with others, whilst dealing with alcohol dependence, appears to be just as important in one's recovery process as reducing consumption: *"I would have clients for example, now just say one client that I would have would be in her 60s… and have a cup of tea and a biscuit that was just as important as it was for her to be coming off the alcohol."* As in most cases addiction can be a lonely and isolating time in one's life, the pandemic appeared to worsen this for many individuals who had no choice but to isolate in their home for the duration of the lockdowns.

1.3 Self care

Participants spoke of the importance of their own self-care whilst working in the areas of addiction and alcohol dependence. As professionals are often working in the context of others' significant trauma, it is important that they can access the care they need for themselves to function optimally. Self-care is critical under these circumstances as oftentimes burnout (Gudzinskiene et al., 2022) and stress (Skinner & Roche, 2021) adversely affects these workers. Therefore, the importance of maintaining an effective self-care plan was emphasised throughout all interviews: *"It's really important that you can look after yourself*

in terms of self-care that you can manage yourself in between appointments. I have been burnt out in the past, I've had to learn how to manage myself and manage that when people are coming into the room. It's not just the addiction, it's so much more." Participant 3 mentions the importance of self-care and reflects on feelings of experiencing burn out in the past. They highlight its importance by referring to self-care as something that must be prioritised: *"I do use self-care like I would have to prioritise it."*

Participants mentioned the benefits of clinical supervision in relation to self-care. Clinical supervision allows for these professionals to seek out help if it is necessary as they can request support and assistance from their supervisor. Supervision is a key tool in supporting one's professional growth and embracing reflective practice. Having a supervisor to turn may be necessary in times of uncertainty and can provide these professionals with the necessary guidance: *"I find clinical supervision extremely effective… if I have an issue that presents at work in relation to a client and I carry it with me, because you don't know the answers to everything… it's just really important that you can get onto your supervisor and ask for support and ask for direction."* Participant 8 echoes the importance of the support of a clinical supervisor as apart of maintaining a self-care plan: *"We'd have clinical supervision once a month. It's very important… So, you would have your clients and you will be supporting the issues that they come with and then you'd have a clinical supervisor who would support you and your issues."*

Whilst supporting clients with their alcohol dependence professionals can be met with many different issues in relation to trauma. Therefore, it is essential that they take the correct steps in looking after themselves to ensure that they can communicate and work with the client, without allowing it to impact their own wellbeing. Participant 6 illustrates the

importance of attending counselling as a method of caring for one's own wellbeing: *"You have to really seriously have a good self-care plan and then if I had my way, there'd be no counsellor counselling that wasn't in counselling… 'cause they're still human. Like the best counsellors are still only human."* Participant 4 reiterates the necessity of not letting client's circumstances and progress in recovery alter the quality and wellbeing of one's personal life: *"I deeply care how our clients do, but it's not going to change the quality of my personal life if they don't respond to the evidence-based interventions. So, my commitment is doing a good job. It's not to ensure that people change."* It is suggested that in order to maintain this divide between one's personal wellbeing and the client's, it is necessary to strictly work within professional boundaries when communicating with the client. This is a way of protecting oneself as mentioned by Participant 4: *"The way you engage with the client it is the basis on which you do that in the professional boundaries that are in place there, that is part the protective mechanism… it's the quality of how you actually take it in in the 1st place"*

1.4 Addressing the deficits

The subject of deficits in relation to the treatment and treatment process involved in the area of alcohol dependence was voiced throughout the interviews. All participants believed the current state of available treatments and their accessibility was inadequate in relation to the education and awareness surrounding them, and the lack of individualised care that services offer.

Participant 4 illustrates the current status of services and the deficit of alcohol-specific services. The participant explains that most are not alcohol-specific services, but rather dual diagnosis services which focus on a multitude of issues such as drugs and alcohol: *"Now you have dual diagnosis services and trauma informed dual diagnosis services that it's not*

necessarily attending to alcohol addiction as much as it was, as an exclusive thing and then alcohol is even further down." The participant highlights the lack of exclusively alcohol dependent treatment services available currently. Participant 3 echoes the issues associated with a lack of alcohol specific services: *"A huge stigma with attending a service where primarily they might work with people who were using benzos or primarily with people who are using heroin, there's that kind of I don't want to attend an addiction service because I'm only drinking alcohol, so there's that kind of an association."* Many individuals may not wish to attend group meetings in which they are treating drug users alongside alcohol users, they often see their alcohol use as lesser than. Therefore, there is a necessity for the introduction of more alcohol-specific services for those who are alcohol dependent only.

A network of alcohol treatment services that are trauma informed is essential in treating those with alcohol dependence, however some services are still lacking in knowledge of this area. Participant 1 illustrates the effect not being trauma-informed can have: "*You know both those who aren't enlightened about trauma don't really understand and can be quite judgmental, but I really try and explain where the women are coming from".* Participants across all interviews emphasise the importance of trauma informed care: *"It's not only beneficial but essential, and I think if you are not working with trauma awareness today, you're missing something significant and it's so important. We're never just working with addiction, there's a reason that people are struggling with addiction."* Participant 4 expresses the necessity of trauma informed care in working with those who are alcohol dependent, highlighting that there is more to the problem than just alcohol. Participant 6 reiterates this, describing the use of alcohol as a coping mechanism for a deeper issue, one that is rooted in their trauma: "*Alcohol is not the issue. And I think what happens is we spend too much time*

focusing on the alcohol. Whereas the alcohol is just a means to an end… When you have somebody in the room you're dealing with their trauma."

1.4.1 Education and Awareness

The theme of education and awareness was discussed through the interviews, with participants mentioning the lack of awareness surrounding available treatment services. Education and awareness around the topic of alcohol dependence and treatment is essential, not only among those who are seeking out treatment, but also those professionals involved in the referral process. Participant 1 illustrates the way lack of awareness of services can influence professionals in their recommendation of treatment, therefore affecting the client's pathway of recovery: *"Sometimes what happens is the GP might think the residential is the best option and that might be just because they're not as informed about a community detox approach… we would try and say look there is other options. They can try and manage their triggers and do relapse prevention work with ourselves to try and help them cope in a real world setting."* The participant describes alternative methods to residential treatment which can be used such as relapse prevention work and educating the client on ways of managing their triggers.

Participant 3 suggests that linking in between GPs and addiction services is necessary to inform these healthcare professionals of the different services which are available. This would also involve informing them of the roles of key workers within these services and what work is carried out within them: *"We need to create that awareness. So, it would be right we need to start, maybe creating links between GPs and addiction services in the local area, informing GPs. This is what a key worker dose. This is what a group is. This is what this*

group does. Creating names, saying this is a person from this service. Really, trying to create that dialogue." Creating this dialogue and conversation with other professionals would have a ripple effecting as the client would also be fully informed of the treatment services that are available to them. This would give alcohol dependent individuals the adequate knowledge to make an informed decision on what treatment would be most suited to them, therefore, improving their overall pathway to recovery.

Participant 3 highlights the lack of awareness those who are alcohol dependent may have of existing treatment services. *"There's a lot of people who don't know where to get their support ... it is about that conversation and that encouragement that it's not just, here is a number, ring them, see you later. That it's like this kind of compassionate piece that needs to be happening and that encouragement piece."* The participant describes the need to provide an encouragement piece to those seeking out treatment who may not be aware of the available services, once again, highlighting the importance of education and awareness.

1.4.2 Client individualism

Participants identified the lack of an individualised treatment system, often describing the current system as inconsistent. The system that is currently in place was criticised by Participant 2 as an attempt of being an all-purpose solution to a problem that is unique and distinct to each person: *"There are very few guidelines, and you refer people, and you have to wait for a couple weeks to get group therapy, and then if they stick to a group they get one-*

on-one but most of them hate groups to start off with. Just one shoe fits all. Yeah, just awful really." The participant describes the process as one that attempts to be applicable to all, however this is not effective in all cases as each client has specific needs and different circumstances. With guidelines that are uncertain and nonspecific, this can cause ambiguity when choosing the most suitable method of recovery.

Participant 5 describes the dynamic nature of client's dependence. The participant explains the factors which influence one's most suitable treatment option: *"It depends where they're at and how dependent they are and what stage they are in in in. And accepting that they need treatment. So, there's a lot in that and really, I think it changes anyway, so they might start off going no, I want to do it then outpatient and then find out that they you know that that doesn't work."* What determines the most effective treatment is subjective as what is most suitable for each client differs based on their level of dependence, their stage of recovery, and their personal circumstances. It appears from the interviews that the process which exists is not suitable in factoring in client's specific circumstances: *"I work in a fairly niche area of people with homelessness, and I realized the problems are difficult, and are different and need different approaches in different areas."* Participant 2 reiterates the individualistic nature of each client and their circumstances and how different approaches are needed to adequately deal with each person's distinct situation.

1.5 Motivation for change

The importance of motivation for change was a prevalent topic of discussion amongst the interviews. Participants spoke of the importance of a clients reasoning for seeking out treatment and beginning the process of recovery. Participant 7 describes the impact one's motivation for recovery can have on their recovery process and its level of success: *"People*

do go in and leave. They can't cope with it, you know, or they're not ready. They're just doing it for somebody else. They're not ready to actually do the job what they need to be doing, you know which is hard work, you know." Those who enter the recovery process in attempts to appease external motivations, often are not prepared to carry out the necessary work that needs to be done to do so and generally have a lower interest in recovery. Typically, individuals under these circumstances are not yet ready to begin the recovery process and underestimate the level of work involved, as it goes beyond achieving abstinence or reducing consumption.

Participant 8 states that you cannot push or coerce a client into recovery: *"You can't force someone into treatment 'cause if you're doing that, they're going in for the wrong reason."* It is important that clients choose to enter treatment because of their own internal motivations, rather than the expectations someone has placed upon them. Participant 4 illustrates the effect pushing a client into changing can cause: *"If you tend to push for change a little bit. If you kind of over care, if that's not to of a crossed term and you tend to push for change a little bit, and when you push for change, people push back so it's really, it's bad for you and bad for your clients if you start to do that."* Pushing for one to begin their recovery process can have negative consequences and lead to the client having a negative perception of treatment and the process of recovery itself. Therefore, it is essential that client's seeking out treatment are doing so with personal intent and internal motivation.

Discussion

The current study examined the roles and experiences of professionals who support those with alcohol dependence accessing treatment. The main objective was to gain an insight to

the roles of these professionals and how they navigate the pathways to treatment and if there are barriers. The use of thematic analysis was effective in obtaining themes in relation to the research question as it successfully allowed for the exploration of personal experiences of the participants and as stated in the literature it provided rich and in-dept information (Braun & Clark, 2019; Scharp & Sanders, 2019). The thematic analysis which was carried out generated five core themes: barriers to accessing treatment, the impact of the pandemic, self-care, addressing the deficits, and recovering for oneself. These themes were analysed with the support of relevant sub themes and related quotes were extracted from the interview transcripts. The findings identified the factors which are affecting individual's ability to access treatment services and highlighted what is involved in the role of those key professionals, along with the deficits that are prevalent among current services. A consensus among all participants was the inefficiency of available services and the difficulty of accessing them.

The findings indicate that alcohol dependence in Ireland is a major public health issue in which its treatment is currently inadequate in nature. There are a significant number of those who are dealing with a dependence on alcohol but not receiving any support or treatment (Irish Medical Organisation, 2015), the findings indicate that this is a result of the many barriers which exist in accessing treatment. The urgency for structured treatment pathways is evident due to the prevalence of the issue of people not seeking out treatment. The current status of treatment pathways was questioned and criticised by participants as being inefficient in nature and lacking in a solid structure. These already unclear pathways are worsened by the long waiting lists to accessing treatment services. Being on a waiting list and its negative effects has been explored throughout the literature (Stanojlović & Davidson, 2021),

participants echoed this suggesting that lengthy waiting lists are a major barrier to treatment currently. Empirical research back up these findings, indicating a link between waiting time and pre-treatment dropout (Blevins et al., 2018; Papamalis, Dritsas & Knight, 2021). The stigmatisation that is prevalent in relation to alcohol dependence is undoubtably a prominent barrier in accessing treatment, and the participants responses reiterated this. Stigma exists both internally and externally, hindering those who wish to ask for help due to a fear of external judgement, and feelings of internal shame. The public judges at risk drinkers, and individuals seeking out treatment for alcohol dependence negatively (McGinty & Barry, 2020). This public stigma that exists appears to affect those alcohol dependent individual's own self-stigma. This causes an internalisation of public reactions and opinions; this can lead to a negative impact on one's self esteem and self-efficacy. Therefore, stigma acts as a significant barrier to accessing treatment.

The delivery of treatment was challenging for professionals and their client's due to the effects of the COVID-19 pandemic. The findings revealed many specific issues relating to the pandemic and accessibility to treatment, as well as how the restrictions of lockdown exacerbated already-existing challenges in the provision of treatment services. Research has identified the increase in cases of alcohol dependence during the isolation period of the pandemic (de Silva & Testino, 2020; Kim et al., 2020). Although the true effect is currently unknown, research has shown that even among those who are long-term abstainers, the effects of pandemics and accompanying public health measure can raise negative emotions, such as loneliness, which have been connected to substance use and relapse (Da, Im & Schiano, 2020; Rajkumar, 2020). Therefore, coupled with the COVID-19 pandemic, resources became saturated as a heightened number of individuals attempted to access

treatment. For participants, this led to several major changes including the movement of many services to an online medium due to the social distancing measures, with some being temporarily discontinued altogether. This posed some difficulties for client's, particularly for those who did not have a computer or mobile phone, and for those unable to access a private space to carry out treatment. However, the move to online services appeared to be beneficial for individuals living in remote rural areas, who typically have difficulties accessing treatment due to their location (Warfield et al., 2021). There will likely be increasingly informed conclusions relating to online services as further studies emerge as there is currently limited data. The subject of self-care was highly prevalent within the findings, as all participants spoke of the importance of self-care whilst working in the area of addiction. Self-care is acknowledged as an essential and necessary part of counsellor wellbeing in the literature (Corey et al., 2020; Norcross & VandenBos, 2018). Professionals face their share of challenges, such as fatigue, burnout, and stress. Self-care is a preventive measure that is essential in ensuring that burnout risk factors do not have an impact on professionals' care experiences, as this can make it difficult to create an effective care relationship with clients (Reyre et al., 2017) and the current study reflects these findings. In times of uncertainty and high stress, it is essential that these professionals feel supported to safeguard their own wellbeing.

Based on the findings, it is clear that there are a multitude of inadequacies and deficits which exist in accessing treatment for alcohol dependence. Alcohol dependence is a complex issue which goes beyond just the consumption of alcohol and achieving abstinence. Individuals seeking out treatment have unique issues which are oftentimes related to trauma. Therefore, it is essential that a more individualistic system and process, which is trauma

informed, is introduced to allow treatment to be applicable to each client, rather than an attempt at a whole solution. Within the literature it is understood that one's motivation for beginning the recovery process has implications that are significant in relation to both initiating and sustaining their recovery (D'Agostini, 2020; Helm, 2019; Kalema et al., 2021). The findings of this study support this in highlighting the importance of one's reasoning for starting treatment for alcohol dependence. Overall, participants spoke of the negative implications pressuring a client into treatment can have. Therefore, it is necessary that clients can make their own decision in relation to treatment, where they are capable of doing so, to ensure that it is a process that is based on internal motivation and self-decision making.

Conclusions and Implications

This paper highlights the current inefficiencies which exist in the pathway to accessing treatment that must be addressed to improve accessibility to treatment and future delivery of services. The barriers to accessing treatment are palpable and require adequate policies as well as significant expenditures to increase the availability of services with the fewest obstacles and blockages. Furthermore, clear pathways and referral structures are needed to reduce wait times. This is essential as wait times have been found to decrease the probability of completing treatment sessions and increasing missed appointments (Daye et al., 2018).

To reduce the prevalent stigma and shame that exists surrounding alcohol dependence and receiving treatment, evidence based public health campaigns need to be formed. The literature recommends that campaigns which focus on social influences rather than individual causes of substance use may be effective (McGinty & Barry, 2020) This is due to the cognitive bias which exists among humans. Furthermore, the language used to describe social and health issues reflects the attitudes one holds about them therefore, it is essential that campaigns include language that is non-stigmatising in nature (Kelly, Saitz & Wakeman, 2016).

Although semi-structured interviewing was effective in collecting data, this study could be enhanced by using focus groups in future research. This would involve the researcher taking on a peripheral role of moderator rather than investigator. Using focus groups would allow for a flexible group discussion and would generate debate in relation to the research question (Nyumba et al., 2018). Also, under circumstances where there is a limited time frame, focus groups would be efficient as the research and participants would all be available at one time

in one location. This would extend the findings from the current study by building discussion on a group dynamic to explore the research question in-dept.

Overall, the current structure of treatment accessibility for those who are alcohol dependent is unsatisfactory and flawed. However, it is important to acknowledge the important role of professionals who work to assist alcohol dependent individuals in accessing treatment, despite the unfavourable circumstances and adversities they may face.

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Appendix

Appendix 1.

Interview Schedule

1. Can you tell me about your role?

2. Do you support alcohol dependent people in outpatient treatment or residential or both?

3. Which approach is best?

4. Are they any challenges involved supporting someone with alcohol dependence?

5. Do you have experience with treatment centres? If so, can you share some of your experiences?

6. Are they any barriers you find are affecting accessibility to treatment currently? Was it like this before COVID?

7. In your experience have you found barriers prevent clients from seeking help or set back their recovery?

8. Are they any changes you would make to the system in place to improve both your experience and the client's?

Anything else you would like to add?

Appendix 2.

Information Statement

Thank you for considering participating in this research project. The purpose of this document is to explain to you what the work is about and what your participation would involve, so as to enable you to make an informed choice.

The purpose of this study is to interview a range of professionals regarding their experiences of supporting those who require access to professional treatment for alcohol dependence, e.g., residential treatment. Should you choose to participate, you will be asked to take part in a one-to-one interview. This interview will be audio-recorded and is expected to take 30-45 minutes to complete.

Participation in this study is completely voluntary. There is no obligation to participate, and should you choose to do so you can refuse to answer specific questions, or decide to withdraw from the interview at any time. Once the interview has been concluded, you can choose to withdraw your details at any time in the subsequent two weeks.

All the information you provide will be kept confidential and anonymous, and will be available only to the researcher, Andrea McSweeney, and the research supervisor, Dr. Sharon Lambert. The only exception is where information is disclosed which indicates that there is a serious risk to you or to others. Once the interview is completed, the recording will immediately be transferred to an encrypted laptop and wiped from the recording device. The

interview will then be transcribed by the researcher, and all identifying information will be removed. Once this is done, the audio-recording will also be deleted and only the anonymized transcript will remain. This will be stored on the University College Cork OneDrive system and subsequently on the UCC server. The information you provide may contribute to research publications and/or conference presentations. The information provided will be used in a research report.

We do not anticipate any negative outcomes from participating in this study. We do not intend to cause any stress to participants as some of the topics broached in the interview are of a sensitive nature, you can choose not to answer specific questions, or choose to bring the interview to an end at any given time. At the end of the procedure, I will discuss with you how you found the experience and how you are feeling. Should you experience distress arising from the interview, the contact details for support services provided below may be of assistance: You can contact my supervisor Sharon.lambert@ucc.ie, use your organisations supervision support structure or employee assistance programme (EAP) where relevant or find a psychologist https://www.psychologicalsociety.ie/ and find a psychotherapist use link for https://iacp.ie/.

This study has obtained ethical approval from the UCC School of Applied Psychology Ethics Committee.

If you have a concern about how we have handled your personal data, you are entitled to this raise this with the Data Protection Commission.

https://www.dataprotection.ie/

If you have any queries about this research, you can contact the researcher, Andrea McSweeney at 119383333@umail.ucc.ie or research coordinator, Dr. Sharon Lambert, at sharon.lambert@ucc.ie.

If you agree to take part in this study, please sign the consent form overleaf.

Appendix 3.

Consent Form

I……agree to participate in Andrea McSweeney's research study.

The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily.

I give permission for my interview with Andrea McSweeney to be audio-recorded.

I understand that I can withdraw from the study, without repercussions, at any time, whether before it starts or while I am participating.

I understand that I can withdraw permission to use the data within three weeks of the interview, in which case the material will be deleted.

I understand that anonymity will be ensured in the write-up by disguising my identity.

I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below:

(Please tick one box:)

I agree to quotation/publication of extracts from my interview □

I do not agree to quotation/publication of extracts from my interview □

Signed: ……. Date: ……..

PRINT NAME: …….

Appendix 4.

Coded Transcript Example

Possible Themes	Transcript	Coding
Impact of the pandemic Overwhelmed resources Digital divide Barriers - Technology Digital divide Barrier - Waiting time	Interviewer: And would COVID have worsened that? Then on top of it, do you think? Interviewee: Of course, it did absolutely 100% sure services went off the radar for a while. So, if services go off the radar for a while, then the community services which are ourselves are the ones that come under savage pressure. And then your restricted because you can't do a one to one and you're speaking to someone on the phone. And if they're lucky to have a laptop, which the majority of mine wouldn't have, you know, and we might be able to zoom or something with them, but. The block is definitely the waiting time. Another block as well. I suppose I find as well is finance. You could have someone who comes to you and who's presenting with an issue and might need, you know, might need residential centre, but they could be working full time and still	COVID worsened issue Some services off radar Community services - services overwhelmed Under pressure Restricted Speaking on phone Many clients no access to laptop Barrier – waiting time Barrier – finance Presenting w/issue – needing residential care Working full time Struggling w/finance Means testing