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Seeking mental health care from private health practitioners among individuals with alcohol dependence/abuse; results from a study in the French general population

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A B S T R A C T

Introduction: Better knowledge of the factors that have an impact on pathways to mental health care may contribute greatly to organizing optimum health-care delivery. However, surveillance systems concerning alcohol problems in the French general population are suboptimal. The objectives of this study were to investigate: 1) the prevalence of mental health-care seeking in individuals with alcohol abuse/dependence in France, 2) which category of medical practitioner was consulted, and 3) psychological and socio-environmental factors associated with mental health-care seeking.
Methods: A total sample of 22,138 individuals was interviewed in a telephone survey. Individual data on alcohol dependence/abuse and other mental health disorders were collected using the Composite International Diagnosis Interview – short form. Mental health-care seeking was assessed, together with data on living conditions, deprivation, and self-reported drinking problems. Only respondents meeting criteria for alcohol dependence/abuse were included in analyses.
Results: Less than half of the 722 respondents with alcohol abuse/dependence had sought mental health care in the preceding 12 months, of whom 90.5% consulted their general practitioner (GP) (56.1%), or both a general practitioner and a psychiatrist (34.4%). Mental health-care seeking was associated with female sex, previous alcohol discussion with a doctor, and the presence of psychiatric comorbidities arising in the preceding 12 months. Living environment, socio-economic status, or self-reported drinking problems had no influence.
Discussion: A minority of people with alcohol abuse/dependence sought mental health care, mainly in relation to psychiatric comorbidities. In addition, most people consulting a GP were not referred to a psychiatrist. However, social deprivation and living in rural areas did not hinder mental health-care seeking among respondents. Adequate protocols to treat alcohol disorders could be implemented among private health-care providers to improve management of alcohol problems in France.

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1. Introduction

In France, alcohol accounted for 49,000 deaths in 2009, mainly from cancer, circulatory and digestive system disease, and from external causes such as injury and suicide (Guerin, Laplanche, Dunant, & Hill, 2013). Alcohol treatment in France is provided by two systems: a specialized addiction treatment system, and a general care system. Health services dealing with alcohol dependence/abuse are mostly based in specialized outpatient centers offering consultations for alcohol disorders. These centers treat 88,000 clients a year, representing 2–4% of the estimated prevalence of people with alcohol-related problems (Verdoux, 2007). The general addiction-care system based on hospital-based care is organized on three levels. First-level care manages withdrawal and organizes consultations, the second level supplements health-care provision through more complex residential care, and the third level expands services to include research, training, and regional coordination (SFA., 2015).

Other salient information concerning health-care provision for alcohol disorders should be highlighted. Notably, 20% of inpatients

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in a general hospital, excluding those from addiction or emergency departments, had alcohol-related problems. Half of these patients were alcohol dependent, one-fourth were diagnosed as alcohol abusers, and one-fourth had an alcohol-related problem that was not identified during their stay (Reynaud, Malet, Facy, & Glanddier, 2000). The private sector, comprising general practitioners (GPs) and half the psychiatrists practicing in France, is also concerned, since one in five adults receives help from GPs for alcohol-related risk factors or disorders (Verdoux, 2007).

GPs are often the point of entry to the mental health-care system, and 95% of the French population lives within 15-minutes' travel distance of a general practitioner (Coldefy, Com-Ruelle, & Lucas-Gabrielli, 2001). In addition, all French residents are automatically enrolled with an insurance fund based on their occupational status, and gaining access to GPs and psychiatrists is relatively easy as compared to other countries (Rodwin, 2003). The private sector could therefore constitute one of the best resources to deal with untreated alcohol problems in the French general population. However, even in countries with universal health-care coverage, there are a number of factors that may affect the management of alcohol problems. People with alcohol disorders tend to underuse treatment programs, and personal characteristics such as a history of past disorder and treatment, perceived need, deprivation, and lower education level may affect health-care seeking (Grant, 1996; Wallhed Finn, Bakshi, & Andréasson, 2014). In France, specifically, there is little collaboration between GPs and mental health specialists in dealing with complex alcohol problems. Nevertheless, most people with mental health disorders are treated by their GPs (Kovess-Masfety et al., 2007). A minority of GPs have a satisfactory relationship with private psychiatrists, public psychiatrists, and social workers, and these GPs refer their patients to specialized professionals (Younes et al., 2005).

Better knowledge of the factors that have an impact on pathways to mental health care may contribute greatly in the designing of education campaigns and in organizing optimum health-care delivery. Indeed, the official French Public Health advisory body (the *Haut Conseil de la Santé Publique*) stated in 1998 that a surveillance network was needed to monitor alcohol consumption and alcohol-related problems in the general population, adding that existing data were fragmented and suffered from a lack of consistency (HCSP, 1998). Some 16 years later, the same institution stated that, despite some progress, data collection systems were still fragmented, resulting in, among other drawbacks, irregular updates of key indicators (HCSP, 2014). The aim of this present study is to compare characteristics of persons meeting DSM-IV criteria for alcohol abuse/dependence who sought mental health care in the preceding 12 months and those who did not, using data collected from a large telephone survey in the French general population. Objectives were to determine: 1) the prevalence of mental health-care seeking in individuals with alcohol dependence/abuse, 2) which category of medical practitioner was consulted, and 3) the relationship between mental health-care seeking and psychological and socio-environmental factors.

2. Materials and methods

A telephone survey was conducted in 2005 by a large private polling institute (IPSOS) under the auspices of four regional health authorities and a university-linked research unit, and was supported by the French Ministry of Health (DGOS and DGS). In order to reach both listed and unlisted telephone numbers, a list-assisted sampling method was used. For each region, a random list of telephone numbers was extracted from the publicly available telephone directory. Both listed and unlisted numbers were then obtained by replacement of the last digit by a randomly chosen digit. This procedure resulted in the selection of 32,351 contacted households. Of these, 28,238 (87.3%) provided sufficient information to proceed to random selection of one potential participant. Five thousand fifty households could not be reached, due to lack of reply after fifteen calls. Among the 23,188 individuals who could be contacted, 20,077 completed the full interview, corresponding to a participation rate of 86.6% and an overall response rate of 71.1%.

Additional participants were subsequently selected if they had a non-business mobile phone number and their household was not equipped with a landline phone. Among the 3698 subjects thus contacted, 2061 completed the full interview, corresponding to a participation rate of 55.7%. Students, single people, and professionally active young men were overrepresented as compared to those equipped with a landline phone. However, no differences were found regarding psychiatric problems, including alcohol disorders or mental health-care seeking. Based on available statistics (INSEE., 2006a), weights were applied to account for the rate of people equipped only with a mobile phone at the time of the study. They were merged with the landline telephone sample, resulting in a total sample of 22,138 individuals. Studies using data from this survey have been published elsewhere (Messiah et al., 2008).

2.1. Mental health assessment and selection of participants

Respondents from the survey were selected in the study if they met criteria for alcohol dependence/abuse according to the CIDI-SF (Composite International Diagnosis Interview – short form) (Kessler, Andrews, Mroczek, Ustun, & Wittchen, 1998). This questionnaire may be rapidly completed and provides prevalence of the most frequently diagnosed mental disorders. The CIDI-SF was designed for epidemiological surveys and has been used in several large studies (Bulloch, Lavorato, Williams, & Patten, 2012; Kessler et al., 2003), and a number of cross-national surveys (Carta et al., 2013; Vilagut et al., 2013; Younes, Hardy-Bayle, Falissard, Kovess, & Gasquet, 2008). The CIDI-SF has been demonstrated to be reliable, although it may slightly overestimate the prevalence of major depression (Aalto-Setala et al., 2002; Gigantesco & Morosini, 2008). The CIDI-SF provides -12-month prevalence rates for major depressive disorder (MDD), most anxiety disorders (phobia, panic disorder, generalized anxiety disorder [GAD], obsessive-compulsive disorder [OCD], and post-traumatic stress disorder [PTSD]), and substance-use disorders defined according to the DSM-IV classification. In order to facilitate data collection consistency and completeness, screening questions covering all diagnoses were placed at the beginning of the interview.

2.2. Living environment and individual characteristics

The following data were collected during interview: sex, age in years, living status (living alone; living with a partner); level of education (no high school diploma; high school diploma or more); professional status (professionally active; retired/unemployed/student), and living environment (rural; urban: <20,000; 20,000–100,000, and >100,000 inhabitants). Additionally, respondents were asked if they had already discussed alcohol problems with a medical doctor. Social deprivation was assessed by collecting indicators on several social benefits (yes/no), namely, housing subsidy, disabled adult allowance, universal health coverage, and income support. These state benefits are granted to individuals based on defined socio-economic criteria.

2.3. The CAGE questionnaire

The Cut-down, Annoyed, Guilt, Eye-opener (CAGE) questionnaire is an alcohol assessment tool for individuals to uncover

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