Trial of a telephone-delivered intervention for problem alcohol use (Ready2Change): Baseline characteristics and a latent class analysis of barriers to alcohol treatment

JASMIN GRIGG[1,2,3], VICTORIA MANNING[1,2,3], ALISON CHEETHAM[1,2,3], ISABELLE VOLPE[1,2,3], PETA STRAGALINOS[1,2,3], KATE HALL[4,5], AMANDA L BAKER[6], PETRA K STAIGER[4,5], JOHN REYNOLDS[7], ANTHONY HARRIS[8], JONATHAN TYLER[1], DAVID BEST[9], GEORGE YOUSSEF[4,5,10], DAN I LUBMAN[1,2,3]

[1]Turning Point, Eastern Health, Melbourne, Australia, [2]Eastern Health Clinical School, Monash University, Melbourne, Australia, [3]Monash Addiction Research Centre, Monash University, Melbourne, Australia, [4]School of Psychology, Deakin University, Geelong, Australia, [5]Centre of Drug, Addictive and Anti-social Behaviour Research (CEDAAR), Deakin University, Melbourne, Australia, [6]School of Medicine and Public Health, University of Newcastle, Callaghan, Australia, [7]Faculty of Medicine, Nursing and Health Sciences, Monash University, Melbourne, Australia, [8]Centre for Health Economics, Monash University, Melbourne, Australia, [9]Department of Criminology, University of Derby, Derby, United Kingdom, [10]Centre for Adolescent Health, Murdoch Children's Research Institute, Melbourne Australia.

Presenter's email: jasmin.grigg@monash.edu

Introduction/Aims: Telehealth has considerable potential to overcome many of the barriers to accessing treatment for alcohol use problems. Yet, little is known about the characteristics and prior treatment barriers of people seeking this type of support. This study described the baseline characteristics of participants in the Ready2Change randomised controlled trial of a telephone-delivered intervention for alcohol use problems, and identified subgroups of participants based on their reported prior barriers to seeking alcohol treatment.

Design/Methods: This was a retrospective analysis of trial screening/baseline data. Latent Class Analysis (LCA) was performed to identify distinct latent participant classes based on prior barriers to alcohol treatment (15 barriers/five domains).

Results: 344 participants were randomised, mean age was 39.9 years (SD=11.4, 18-73 years), 51.5% were male. Under one-third (29.4%) had previously sought alcohol treatment, despite a mean Alcohol Use Disorders Identification Test (AUDIT) score of 21.5 (SD=6.3) and 63.4% scoring in the probable dependence range. LCA revealed a two-class model: the 'low-barriers' class (43.1%) moderately endorsed readiness-for-change and attitudinal barriers. The 'high-barriers' class (56.9%) strongly endorsed stigma, structural, attitudinal and readiness-to-change barriers, and was predicted by female sex (adjusted OR=0.45, 95% CI 0.28, 0.72) and higher psychological distress (adjusted OR=1.13, 95% CI 1.08, 1.18).

Discussion/Conclusion: The majority of people accessing this telephone-delivered intervention were new to treatment, though with advanced alcohol problem severity. A large subgroup experienced heightened treatment barriers, who were more likely to be female and experiencing higher psychological distress, suggesting the telephone modality could be overcoming barriers to care for this group.

Practice/Policy Implications: This study provides important information on a population who are willing to engage in this alternative model of treatment for alcohol problems, for whom targeted telehealth service promotion/engagement approaches are warranted.

Disclosure of Interest Statement: This work was supported by a National Health and Medical Research Council (NHMRC) Project Grant (APP1125026).