Substance Use Disorder Screening and Treatment Barriers in Ayder Specialized Hospital: a Phenomenological Study on Poly Substance Users

Kahsay Weldeslasie[1]
Department of Psychology, Mekelle University, Ethiopia, Email: kasweld@gmail.com

Welday Hagos
Department of Psychiatry, Mekelle University, Ethiopia, Email: weldaypsycho@gmail.com

Abstract:

Substance use disorder (SUD) screening is reported to be very challenging, and it needs careful evaluation of patients' behavior by highly experienced professionals in that particular area. The current study was primarily intended to identify the implementation of SUD screening and treatment barriers in the hospital care. For the sake of assessing participants' lived experiences and subjective realities, the researchers used a phenomenological research design. Furthermore, 26 participants(twenty poly substance users and six mental healthcare providers) were selected purposefully in order to address the intended information from the target individuals using a semi-structured interview. Accordingly, participants' reports were analyzed, putting them into four categories (thematic areas) i.e., patient level factors, healthcare provider level factors, family level factors and system level factors were among the substance use screening and treatment barriers. Based on the findings, awareness creation activities should be made on SUD screening and treatment; healthcare providers should receive continuous short and long term trainings, and the therapeutic environment should be inviting for patients.

Keywords: Healthcare providers, Phenomenological study, Poly substance users, Screening and treatment, Substance use disorder

[1] *Corresponding Author*

Introduction

Substance use disorder is the leading causes of morbidity and mortality that frequently go unidentified in medical settings (McNeely, et al., 2018). It is among the top ten causes of preventable deaths in the United States (Dowell, et al., 2017) but it is greatly under treated in the specialty addiction treatment system (Substance Abuse and Mental Health Services Administration -SAMHSA, 2017), and under recognized in medical settings (Rehm et al., 2016). Yet, despite over a decade of concerted efforts to integrate substance use screening and interventions into mainstream medical care (Babor et al., 20017), primary care patients are rarely screened or treated for SUD (Rieckmann et al., 2015).

Substance use disorder does not only affect the substance user, but it can also affect the social ecology at large. Lim and his colleagues (2012) revealed that SUD is among the leading risk factors, contributing to the global burden of disease. About 3.3 million people die each year because of alcohol consumption; this represents 5.9% of all deaths worldwide (WHO, 2017). SUD also contributes more than 200 disease and injury conditions, accounting for 5.1% of the global burden of disease and injury. Substance use harm increases exponentially with the average daily consumption (Rehm et al., 2017). Therefore, even small reductions can substantially decrease the risk of dying due to alcohol.

Kaner (2010) revealed that a quality screening is a keystone to make an effective intervention for any problem. Consequently, for the quality of SUD screening and treatment, the cooperation among families, community, patients, healthcare providers and the government is very essential (Nilsen, 2010). However, making quality SUD screening and treatment in the absence of patients' trust on their therapists (Rehm et al., 2016), permissive therapeutic environment (McNeely et al., 2018), screening tools, and professional competence is very difficult (Mertens et al., 2015). Additionally, lack of patients' readiness to seek help for their problems; inability to recognize SUD as a physical and psychosocial illness were found to be among the screening & treatment barriers (Williams et al., 2011).

In order to make accurate diagnoses and provide appropriate preventive care and rehabilitation, healthcare providers need to know about the patient's substance use behaviors (Berger& Bradley, 2015). In SUD screening process, some patients failed to disclose their substance use behaviors to their doctors for fear of being negatively judged and negative reactions from their doctors following the disclosure (Wu et al., 2012). The excessive patients' ego protection was also among the SUD screening and treatment challenges reported in another cohort study (Walton, et al., 2010). The triggering factors of SUD are multifaceted and complex by their nature (Hettemaet al., 2012). Consequently, the screening process and therapeutic techniques become very challenging. In the SUD screening processes, the psychosocial determinants should

be clearly identified (Derges et al., 2017). However, if patients are not cooperative in addressing the determinants, it may negatively affect the therapeutic outcome (Korcha et al., 2013). Moreover, the continuous professional development and context wise screening instruments are very essential elements (U.S. Preventive Services Task Force: Screening for Alcohol Misuse, 2018) for the effectiveness of SUD screening and treatment. Similarly, patients need a very private and safe therapeutic environment so as to freely communicate their emotions with their doctors (Polcin et al., 2012). Not only this, substance rehabilitation centers should be accessible at every locality for patients with SUD (Coloma et al., 2015)

Statement of the Problem

Nowadays, many adolescents are poly substance users (using many substances) for different reasons. Even though some adolescents know the adverse effects of substance abuse on their well-being, they delay seeking professional help (Korcha et al., 2013; Polcin et al., 2012). As the researchers observed, adolescents come to the hospital for screening and treatment reasons after using substances for a long period of time. Not only this, these adolescents visit the hospital with minimum interest to abstain from it, and some adolescents even relapse to substances use after few months of treatment.

In Mekelle city (the capital city of the National and Regional State of Tigari-Ethiopia), there are significant numbers of poly substance users who did not seek help and could not be also a reason for others to visit doctors for their problem; this is some of the patients' reports who came to the hospital for substance screening and treatment purpose. According to the substance users' report, the main reason to visit doctors for their problem was due to family pressures. Therefore, the primary objective of the of this research is to pinpoint the substance screening and treatment barriers

In many occasions, patients were found with other co-morbidities after diagnosis for the SUD. The psychiatric co-morbidities of patients often make the substance use treatment ineffective in the hospital. From this viewpoint, the researchers need to look over for the screening barriers in making effective diagnosis.

The other objective was to find out the implications for intervention from the outcome of the research. A research by its nature is not an end by itself; instead, it gives clue or directions for stakeholders on how to intervene in the problem. Developing program designs to the problem following the identification of the substance screening and treatment barriers will be the next step of this research.

Additionally, even though previous researches (Carmona et al., 2017; Williams et al., 2016) have examined the SUD screening and its treatment barriers, the methodology, and participants'

culture determine its outcome. There is a knowledge gap on the factors that can greatly affect SUD screening and treatment in Ethiopia particularly in Tigray, Mekelle city, Ayder hospital; for these and related reasons this research was timely and sensible.

Methods and Materials

A qualitative approach using a phenomenological research design was employed to collect data from twenty poly substance users and six mental healthcare providers. The data collected using the semi-structured interviews was audio recorded and participants' ideas were transcribed verbatim. Having addressed the SUD screening and treatment barriers in the hospital care system, it was analyzed thematically.

Research Area

The research was conducted in Mekelle, northern Ethiopia. The research area is 780 kms far from Addis Ababa to the north. It is the only specialized hospital in the region with disproportionate doctor-patient ratio; in average, a doctor treats 12 patients per day (1:12). This indicates there is scarcity of mental health professionals in the region. The hospital delivers all-rounded services for patients with different physical and mental health problems in its inpatient and outpatient departments.

Table 1

Socio-demographic Variables of Participants

Variables	**Categories**	***f***	**Variables**	**Categories**	***f***
Sex	Male	20		Illiterate	0
	Female	0	Educational Status	1-8 Grades	4
Age	18-28	13		9-12 Grades	14
	29-40	5		Diploma & above	2
	41 &above	2	Work Conditions	Employed	4
Duration of substance use	1-5 years	0		Unemployed	16
	6-10 years	6	Marital Status	Single	11
	10-15 years	9		Married	3
	>15 years	5		Divorced	6

*Own Survey Data on Substance Users at Ayder Hospital, 2018/19

Procedures

Ethical issues were taken into considerations, and participants were purposefully selected from the whole clinical population who visited the hospital for SUD screening and treatment and

healthcare providers in the outpatient department. Through the semi-structured interview, in-depth information was collected about the substance screening and treatment barriers from the substance users and healthcare providers, using their respective language. Finally, the result was transcribed verbatim into English language and analyzed thematically. While doing so, each participant is represented by the letter and code number given for the sake of confidentiality.

Results

The socio-demographic variables of the 20 poly substance users are clearly stated in Table-1. Additionally, mental health professionals participated in the interview for data triangulation purpose. Generally, a total of 26 individuals participated in the study. Sixty-five per cent of the substance users were found in the age ranges of 18-28 and all of the participants were males. There were no female participants in the study due to lack of appropriate and separate space to accommodate them at the rehabilitation center after screening. Establishing a proper site for female rehabilitants was reported to be in progress. About 70% of the participants were found in the educational level of 9-12 grades. Furthermore, 80% and 55% of the substance users were unemployed and unmarried respectively. These socio-demographic characteristics of the participants may provide insight on how to intervene for this particular socio-demographic group. Therefore, researchers are invited to investigate the problem in relation to different socio-demographic variables.

Based on the content of the data, the findings are presented thematically as follows. The healthcare providers stated that, knowing about a patient's substance use behavior is critical in the SUD screening and intervention processes. The SUD is similar to other psycho-social and physical determinants of health that impact disease risk and response to treatment. Some healthcare providers also discussed the specific ways in which the knowledge of SUD can affect the diagnoses and care plans. Two healthcare providers reported as:

> It is impossible to develop treatment plans without reaching at a sound diagnosis and with limited information about patient's problem. For this reason, patients' indisputability and cooperation are the vital elements in the SUD screening processes" [C-MHS$_5$].
> …From my point of view, in the SUD screening process, three things are very important to look over. Firstly, patients' commitment and cooperation to disclose their problem honestly; secondly, healthcare providers' substance screening and therapeutics kills; finally, updated and context wise screening instruments are the three critical elements [C-MRY$_3$].

The findings of this study were presented by categorizing into four thematic areas i.e., patients' level factors, healthcare providers' level factors, family's level factors, and system level factors. Based on these themes the findings are presented below:

Patients' Level Factors

Patients' inability to disclose their problems to the healthcare providers was among the SUD screening and treatment barriers in the current study. Some patients do not trust their care providers, thinking they may disclose their information to a third person, like relatives and friends. A healthcare provider stated his concern as follows:

> Some patients in fact want to be helped; however, they do not ask for help unless someone initiates them to visit doctors. That is why they are here for screening & treatment reasons. But they do not tell you honestly about their problems for fear of confidentiality and to protect their own ego[C-MHS5].

Patients' reluctance or ignorance of having a SUD can also pose a barrier to substance screening and treatment. A patient needs to be ready and honest with himself/herself about the SUD before disclosing it to the healthcare providers. Patients who are not ready and willing to receive help will not disclose their substance use behaviors; in such kinds of patients, the substance screening and treatment becomes ineffective. Two participants reported that:

> If a person is substance addicted but he/she denies his/her addiction, the screening for the SUD will be ineffective. To the contrary, if a person becomes ready to accept and communicate his/her feelings honestly, it is easy to bring behavior change in his/her life…otherwise it is impossible to bring change in one's behavior, hiding the reality" [P-ZNA17].
>
> …I am here but, still I'm not sure if I want to continue with my doctor. I came here due to my family's and friends' pressure. Previously, I had the cognition that I could manage my problem if I have the commitment to do so. However, when time went everything became out of my control. That is why my family forced me to come here [P-HTG14].

Some patients felt that identifying the causes for SUD is just like counting the uncountable which is very difficult to finish. Being able to bring the causal factors of the SUD into the therapeutic room is very exhaustive. As one participant explained:

> When I think to report all the causal factors of my drinking and smoking behaviors, I feel fatigue and annoyance. And even I feel confused what to report and where to begin because there are lots of psychosocial reasons for abusing substances … you know why, I could not even finish counting all the causal factors to my doctor [laughing][P-MGK6].
>
> …Like other people who have co-morbidities with their mental illnesses, there are psychosocial co-morbidities with my drinking and smoking behaviors. Therefore, for a quality diagnosis, it really needs dedication in visiting a doctor continuously [P-SKW2].

Confidentiality issue was among the SUD screening barriers that most participants reported during the interview sessions. Patients feel uncomfortable when they communicate their substance use behaviors with their healthcare providers for fear of confidentiality breach. Two participants reported their idea as follows:

> I am not confident enough to tell all my substance use behaviors to my doctor during the screening process. I would feel humiliated if a doctor discloses my behavior to somebody else especially to my parents and friends … for this reason I prefer to keep silent [P-HTG14].
> …During the screening process, my relatives or friends sat with me in the therapeutic room. Consequently, I felt frustrated to disclose all my drinking behaviors to my doctors … You know why? How can I disclose my substance use behaviors in front of my family? If I would order my doctor to tell them waiting me outside, they may suspect as if I have something bad that I need to tell to my doctor only [P-MGK6].

Some patients were worried to disclose their substance use behaviors to the healthcare providers for fear of negative reactions from the professionals following the disclosure. The participants stated that patients feel uncomfortable to disclose their behaviors for fear of being judged negatively by their healthcare providers. They noted that the patient-healthcare provider relationship is an important determinant whether patients would feel comfortable or not. Three participants recounted their experience in the following ways:

> I was afraid to disclose my behaviors because my doctor would negatively judge me if I honestly communicate all my behaviors. That is why most patients prefer to hold their feelings for themselves only. Actually, the relationship someone has with his/her doctor matters in the therapeutic relationship [P-SWH7].
> …Can you imagine… how can I continue in the treatment for my problem if the reaction of my doctor is out of my expectation? When I think about that I'm always in a debate with myself whether to disclose all my substance use behaviors or not; the same is true for my friends for the delay to seeking help for the same problem [P-AHG10and P-HTG14].

Another way in which SUD screening and treatment become very challenging to the healthcare providers was patients' inability to recognize the SUD as a health risk until the problem comes to defeat their life. Some individuals even perceived themselves as they have the power to control the SUD. This is evidently stated by a participant:

> Sometimes I don't even realize that I need help until the problem comes to limit my life. I don't know how much I really drink or how much I really smoke unless someone asks me about that. Most of the time, I consider my behavior as normal and everybody may practice

> it in his/her life. But when I think about it, my life is with full of distress and my daily activities are disturbing me when time goes[P-GRB3].

Some patients do not have awareness about SUD treatability like other physical and mental illnesses. Most patients come to treatment after using the substances for a long period of time. The main reason for delaying to seek help is due to lack of awareness about SUD treatability. A participant explained the situation in the following way:

> I swear! I had not any information where to seek help till my friends told me about this service. Previously, I didn't consider addiction as treatable like other physical illnesses; this is because I consider SUD as a behavioral problem not as a disease like cancer. Even if SUD is a behavioral problem, there is pharmacological treatment like other diseases in addition to the psychotherapy [P-AMT8].

Some patients felt that having SUD history could potentially impact their job, social relationships and status. Additionally, the societies considered the substance rehabilitation center as a place for treatment of psychiatric illnesses only. This was also the perception of some substance users as well. For this reason, patients prefer to stay home even if they had desires to seek help. Three patients have reported their feeling as follows:

> Frankly speaking, even if I had interest to seek help from the substance rehabilitation center, I was frustrated thinking the reaction of the society towards me. Not only this, I felt frustrated by how I would live together with those who have mental disorders; this is because my perception towards the rehab center was negative. This was my primary reason that delayed me in seeking help in addition to other reasons [P-MAT1].
>
> …When I think about SUD, there is a stigma which is always attached with it. Most people do not consider the SUD as other disorders like mental and physical ailments; instead, SUD is a disorder that develops due to the bad behaviors of users [laughing]. For this reason, people strictly condemn such behaviors through stigmatizing the substance users[P-AHG10].
>
> …When I guess the societal expectations, I just presume that it would be a pretense for me…you know why? No one would trust me in my social relationships, and it would be difficult to have a job if people know my behavior. Let alone others, I would really dislike myself if I evaluate my behaviors through the eyes of the society; for this reason, I prefer to keep my behaviors for myself only [P-KYA18].

Some patients prefer the traditional healing techniques to seeking help from mental health professionals. For example, about nine of the participants visited holy water and other religious and cultural healing sites for their SUD.

Healthcare Providers' Level Factors

Some healthcare providers reported that they did not have specific skills about SUD screening and treatment. Like other diseases, they had no adequate knowledge and skills on the substance screening and treatment. As a result, they felt poorly prepared to address the problem. Four participants reported as:

> The main barrier in the SUD screening and treatment is lack of substance specific therapeutic skills. Actually, I have better knowledge in the theoretical aspects of SUD, but I am not confident enough on how to screen and manage patients' problem. In some cases, I feel confused when I think how to manage my patients' problem. … Oh! Sometimes I feel doubt whether the screening process fits with a particular patients or not [laughing][C-GMH1].
>
> ..Sometimes, we (healthcare providers) face difficulty to screen patients' problem due to limited educational preparation on the particular field. As you know, we are psychiatric nurses and clinical psychologists that independently do screening for the problem; it would be better if the screening is conducted in coordination with psychiatric doctors and SUD specialists [C-WZF2, C-MRY3].
>
> …For some cases, I have better knowledge and skill in helping my patients. And I counsel them fairly often. But I am not confident enough to say I have all the skills & knowledge to the patients' cases … you know, sometimes I feel confused where to refer my patients for better screening and treatment responses[C-HZW6].
>
> …Oh! I do not believe that my colleagues have all the skills that enable them screen and manage their patients' problems[C-MHA20].

Some healthcare providers fail to carefully examine the psychiatric disorders and substance induced psychotic symptoms. Having screened out for patients' SUD, the healthcare providers immediately send their patients into the nearby substance rehabilitation center for treatment. However, when patients are admitted into the substance rehabilitation center, they start to display other psychiatric problems that have no relationship with the SUD. A healthcare provider remembered his experience in this way:

> Oh! It was crazy! As you know …following screening, we admitted our patients into the substance rehabilitation center if the diagnosis is SUD only. A patient well knows that as individuals who have other psychiatric co-morbidities do not admit into the substance rehabilitation center for treatment; for this reason, a patient was not interested to disclose his other psychiatric problems during the screening time in order to get admitted in the substance rehabilitation center… simply hid his psychotic co-morbid symptoms till he admitted as a rehabilitant in the center. Following this, I immediately send him into the substance rehabilitation center for treatment; …in the first night, he disturbed the whole rehabilitants during the sleep time due to his psychotic symptoms like delusional power and

> greatness, and hallucination. OMG! ... his voice was very disturbing and horrific for the other patients and healthcare providers around there[C-MHS5].

Family Level Factors

Relatives bring their substance user family members into the hospital for substance screening and treatment purpose. Mostly, relatives initiate a greater interest and responsibility to visit doctors for screening and treatment than the patients themselves. Some parents do not even disclose the other psychiatric problems of their patients in order to get admission in the substance rehabilitation center for further treatment. A healthcare provider recalled his experience in this way:

> Oh! It was very tricky; one of the patients' relatives had interest to admit his patient into the rehab center fulfilling the screening requirements for the SUD. Both the relative and patient hid the patient's psychiatric co-morbidity in order to let the patient admit into the substance rehab center. Following this, I sent the patient into the other room for substance detoxification purpose before he gets admission for rehabilitation in the center. When the patient enters for detoxification, he started to display his psychotic symptoms. Finally, I did not allow him to get admission for treatment in the substance rehabilitation center because the rehab center demands those who have SUD only. [C-WZF2]

System Level Factors

A number of system level barriers were identified and reported by healthcare providers and patients. Healthcare providers felt strongly that screening for SUD should be done in a private room. Most of them reported that they did not have privacy in their workspace or therapeutic room, and screening under these conditions would be uncomfortable to patients. A healthcare provider explained that screening in the current therapeutic space makes patients feel uncomfortable.

> The therapeutic space is too tight and limited… in a therapeutic room there are about 5 students who attend the screening and treatment process for their practical attachment works in their degree program. Oh! Can you imagine that a patient could freely talk his/her problems to his/her doctor in such condition? Not only that; even relatives of a patient sit together in the same therapeutic room during the screening process[C-MHS5].
> …How can a patient freely talk about his/her substance use and related behaviors in a place where many people are around? Sometimes it becomes very difficult to ask some questions in relation to patients' substance use behaviors. How can you ask that kind of question to a patient in front of such significant persons for a patient? … I mean, patients need private and permissive therapeutic environment for the effective screening and treatment outcome[C-HZW6].

Better healthcare system is very essential for delivering effective screening and treatment responses to patients with SUD; and this needs to be in place before initiating a screening and treatment program. Even though healthcare providers have interest to be screened, there are no adapted tests in the hospital; for this reason, they feel that they are delivering the service below their expected potential. A healthcare provider reported:

> It is difficult even to imagine making a good screening result without sufficient and context wise screening tools for a problem. Is that possible for a farmer to harvest without farming equipment [laughing]? The same is going on in our hospital[C-GMH1].

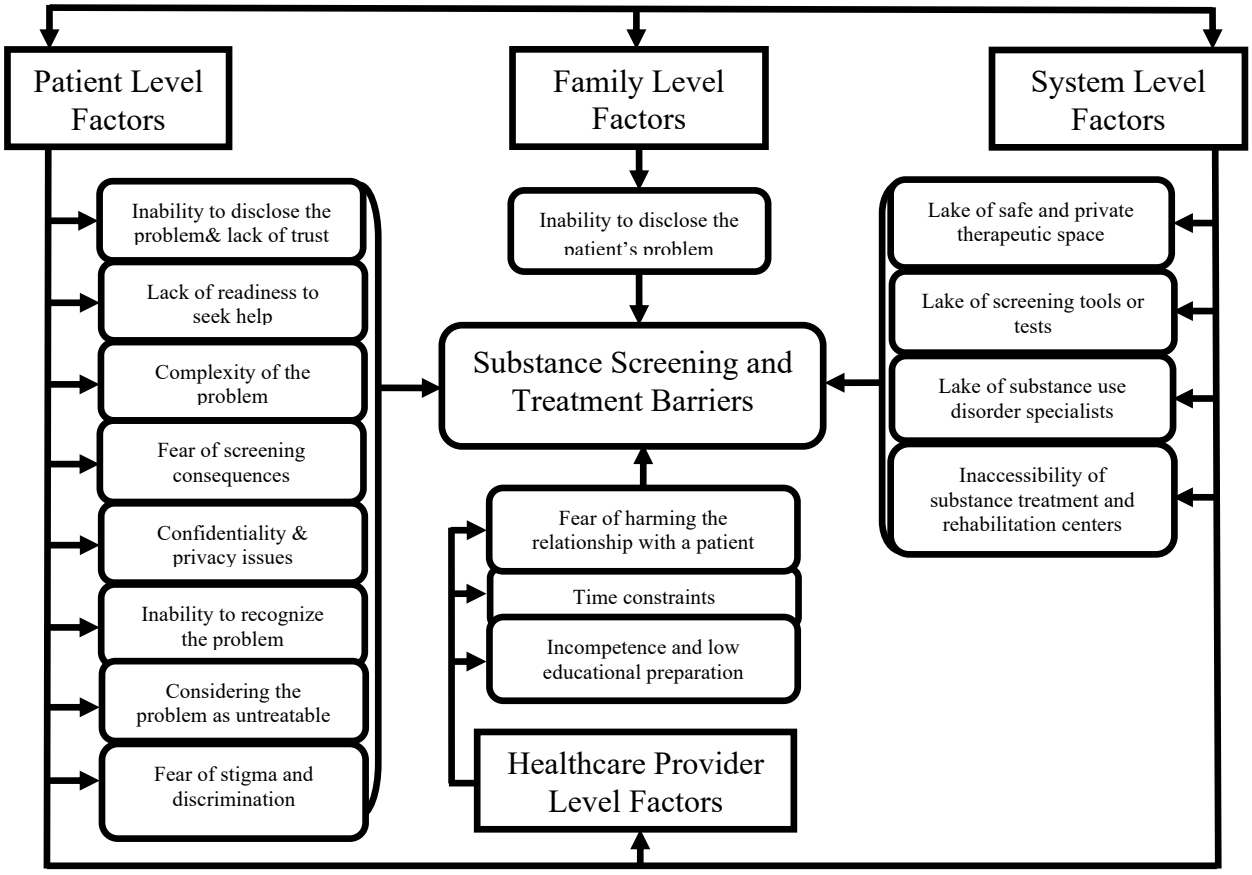
Insufficient SUD specialists and tight schedule were also among the SUD screening and treatment barrier in the hospital care. The doctor-patient ratio was 1:12 in a day, which is very disproportionate. Two participants reflected as:

> A Hospital with limited professionals is very discouraging to visit and consult doctors for one's problem. You know … how can a doctor evaluate a patient's problem in detail while many patients are expecting outside the door to receive treatment from the same doctor? [P-MHA20]
>
> …In our hospital a healthcare provider is expected to teach students, to conduct research, to provide community services, and to make screening and treatment for other psychiatric illnesses in addition to the substance screening and treatment. There are two days only in a week that a doctor make visits for substance use screening. In this very brief time, it is difficult to have quality screening and treatment in a crowd clinical population[C-HZW6]

Generally, the overall findings and variables pinpointed under this research are illustrated in the following diagram:

Figure 1

Summary of Findings



Discussions

An effective substance use screening and treatment requires patients' commitment to bring behavior change, professionals' knowledge and therapeutic competencies, parents' attitude toward SUD, and permissive therapeutic environment (Fankhänel et al., 2014). However, these preconditions for the SUD screening and treatment outcome were reported to be reversed in the present study. Previous findings recounted that the lack of professional therapeutic skills in implementing screening and interventions and patients' awareness on the impact of substance use on health (Fankhänel et al., 2014) attitudes toward SUD treatability had been cited as barriers of substance use screening and treatment implementation (Broyles et al., 2012;Nilsen, 2010).

Patients in the current study delayed to seek substance screening and treatment for the following reasons which are very similar with the previous research findings (Tsai et al., 2010): lack of awareness about the associated risks of SUD, resistance to change, and the fear of being labeled as an "addict" were among the reasons. Such kinds of patients do not seek treatment for their problem till they had been defeated by the adverse effects of the substance consumption (Korcha et al., 2013; Polcin et al., 2012).

Some participants in the current study did not freely communicate about their problems with the healthcare providers for fear of confidentiality issue and ego protection. Furthermore, patients had no awareness about the effects of substance use on their physical and mental health; for this reason, they were reluctant to freely report their problem; this is very similar with the previous findings (Coloma et al., 2015; Polcin et al., 2012).

The unexpected reaction and being negatively evaluated by one's doctor following screening, fear of negative consequence of screening (i.e., stigma or confidentiality issues), were also reported to be among the barriers of substance use screening and treatment implementation in the present finding. Previous findings also confirmed that fear of stigmatizing or victimizing people unnecessarily was perceived to be determinant to screening practice (Rosario et al., 1017; Tripodi et al., 2010) and might offend or worse still, keep the patient away (Fankhänel et al., 2014) from SUD treatment.

At a systemic level, lack of updated screening and treatment instruments, lack of substance use disorder specialists, tight schedule, poor government support, lack of safe and private working space or therapeutic room were reported to be the barriers for the quality substance use screening and treatment outcomes. Johnson and colleagues (2011) stated that, lack of resources and training compounded by heavy staff workloads are the main barriers to the effective substance use screening implementation and treatment (Johnson et al., 2011); additionally, professional roles and managing heavy workloads in the context of competing interests from other urgent health issues were also highlighted as a barrier in other findings (Derges et al., 2017). Interrupting the flow of interactions with patients both in terms of affecting doctor-patient relationships and getting in the way of completing busy ward schedules (Broyles et al., 2012) were also among the systemic level factors that highly affect substance use screening and treatment implementation.

Implications of the Study

The substance screening and treatment barriers are versatile by their nature; therefore, it should be managed using the holistic approach. Creating awareness on the society at large and the substance users in particular about the nature and dimensional impacts of SUD is expected from

every stakeholder in the substance use treatment. Low level of patients' awareness about the nature and consequences of SUD and its treatability leads to delayed help seeking from professionals. The causes for SUD are very subjective to users' context; consequently, it needs to know the subjective realities (phenomena) of the substance users. Substance use screening and treatment needs continuous training and specialization in the particular area. In contrary, low educational competency of professionals may affect the substance use screening implementation and treatment outcome. Moreover, researchers are advised to conduct their research on the area so as to come up with firm solutions.

Limitation and future Research

This research was carried out in a few participants; it would be better if it conducts in a large population using a mixed approach in order to make generalization and collect adequate data. Moreover, this research was conducted in Mekelle city only more or less in a homogeneous population. However, the substance screening and treatment barriers might be different from area to area because culture and social cognitions have its own contribution in the risk and protection of substance abuse disorder. Therefore, further research may be important in a large and diversified population in order to fill the research gaps.

Cite this article as:

Kahsay Weldeslasie & Welday Hagos. (2020). Substance Use Disorder Screening and Treatment Barriers in Ayder Specialized Hospital: a Phenomenological Study on Poly Substance Users. *Journal of Educational and Behavioral Sciences*, *3*(1), 19-34.

References

Babor, T. F., et al. (2017). Screening, Brief Intervention, and Referral to Treatment (SBIRT): toward a public health approach to the management of substance abuse. *Subst Abuse, 28*(3), 7–30.

Berger, D., & Bradley, K. A., (2015). Primary care management of alcohol misuse. *Med Clin N Am. 99*(5), 989–1016.

Broyles, L. M., et al., (2012). A qualitative study of anticipated barriers and facilitators to the implementation of nurse delivered alcohol screening, brief intervention, and referral to treatment for hospitalized patients in a Veterans affairs medical center. *Addict Sci Clin Pract*. 2012;7(1):7. Published 2012 May 2. doi:10.1186/1940-0640-7-7

Camona C., Carball J., & Gonalez T. (2017). Barriers for identification and treatment of problem drinkers in primary care.PUB. Med. PMID 27751647, 32(2), DOI 10.1016/j.gaceta.2016.07.009

Coloma-Carmona, A., Carballo, J. L., &García-Rodríguez, O., (2015). Willingness to change and help-seeking in problem drinkers. *Health Addict Drog*,*15*, 127–36.

Derges, J., Kidger, J., Fox, F., Campbell, R., Kaner, E., & Hickman, M., (2017). Alcohol screening and brief interventions for adults and young people in health and community-based settings: a qualitative systematic literature review *Public Health*, 17(562), 103-106.doi 10.1186/s12889-017-4476-4

Dowell, D., et al. (2017). Contribution of opioid-involved poisoning to the change in life expectancy in the United States, 2000–2015. *JAMA*; 318(11), 312-323

Fankhänel, T., Julia, L., Stephanie, P., et al. (2014). Screening and brief intervention in primary care: barriers against an early intervention for patients with alcohol misuse. *Psychother Psychosom MedPsychol*, 64(9-10),405-408

Hettema, J. E., et al. (2012). A SBIRT curriculum for medical residents: development of a performance feedback tool to build learner confidence. *SubstAbus*, *33*(3), 241–50.

Johnson, M. et al., (2011). Barriers and facilitators to implementing screening and brief intervention for alcohol misuse: a systematic review of qualitative evidence .*J of Public Health,33(3)*:412–21.

Kaner, E., (2010). Brief alcohol intervention: time for translational research. *Addiction*, 105(6), 960–1.

Korcha, R. A., et al. (2013). Pressure and help seeking for alcohol problems: trends and correlates from 1984 to 2005.*Addict Behav*, 38(3),1740–6.

Lim, S. S., et al. (2012). A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010.*Lancet,* 380(9859):2224-60. 1740-1746, doi: https://doi.org/10.1016/S0140-6736(12)61766-8

McNeely, J., et al. (2018). Barriers and facilitators affecting the implementation of substance use screening in primary care clinics: a qualitative study of patients, providers, and staff.BioMed central, *Addiction Science & Clinical Practice,13(1),* DOI: 10.1186/s13722-018-0110-8

Mertens, J. R., et al., (2015). Physician versus non-physician delivery of alcohol screening, brief intervention and referral to treatment in adult primary care: the ADVISe cluster randomized controlled implementation trial. *Addict Sci Clin Pract*, 10(1),102-104

Nilsen, P., (2010). Brief alcohol intervention where to from here? Challenges remain for research and practice. *Addiction*,105(6),954–9.

Polcin, D. L., et al. (2012). Pressure to reduce drinking and reasons for seeking treatment.*Contemp Drug Probl*, 39(4),:687–714

Rehm, J., et al. (2016). Alcohol use disorders in primary health care: what do we know and where do we go?Alcohol,*51*(4):422–7.

Rehm, J., Gmel, G., Probst, C., & Shield, K. D., (2017). *Lifetime-risk of alcohol attributable mortality based on different levels of alcohol consumption in seven European countries. Implications for low-risk drinking guidelines.* Toronto, On, Canada. Centre for Addiction and Mental Health. DOI: 10.1111/add.13827

Rieckmann, T., et al. (2015).A longitudinal study of state strategies and policies to accelerate evidence-based practices in the context of systems transformation .*Health ServRes*, *50*(4),1125–45.

Rosario, F., Wojnar, M., & Ribeiro, C., (2017). Can doctors be divided into groups based on their attitudes to addressing alcohol issues in their patients? Analyses from a survey of Portuguese general practitioners. *Subst Use Misuse*, 52(2),233-9. DOI: 10.1080/10826084.2016.1225092. 367-369

Substance Abuse and Mental Health Services Administration, (2017).*NSDUH data review: receipt of services for substance use and mental health issues among adults: results from the 2016 national survey on drug use and health.* Rockville: Substance Abuse and Mental Health Services Administration.

Tripodi, S. J., et al. (2010). Interventions for reducing adolescent alcohol abuse: a meta-analytic review. *Archives of pediatrics & adolescent medicine*,*164*(1), 85–91.

Tsai, Y. F., et al. (2010). Facilitators and barriers to intervening for problem alcohol use. *JAdvNurs,* 66(7),1459–68. DOI: 10.1111/j.1365-2648.2010.05299. x.

U.S. Preventive Services Task Force: Screening for Alcohol Misuse. [http:// www.ahrq.gov/clinic/uspstf/uspsdrin.htmretrived, 2018].

Walton, M. A., et al. (2010). Effects of a brief intervention for reducing violence and alcohol misuse among adolescents: a randomized controlled trial.*JAMA*,*304*(5), 527–35.

Williams, E. C., et al. (2016). Local implementation of alcohol screening and brief intervention at five Veterans Health Administration primary care clinics: perspectives of clinical and administrative staff. *J Subset Abuse Treat*, 60: 27–35. DOI: 10.1016/j.jsat2015.07.011.

Williams, E. C., et al. (2011). Strategies to implement alcohol screening and brief intervention in primary care settings: a structured literature review. *Psychol Addict Behav, 25*(2),206–14.

WHO, (2017). *Global status report on alcohol and health 2014.* Available from: http://apps.who.int/iris/bitstream /10665/112736/1/9789240692763

Wu, L. T., et al. (2012). Alcohol and drug use disorders among adults in emergency department settings in the United States. *Annals of Emergency Medicine*,*60*(2), 172–80.