"Peer-based groups can add significantly to formal services because they in principle offer a 24/7 structure ..."

Turn something bad into something good

Strong national publicly-funded healthcare services are cornerstones in north-western European welfare systems. However, robust national health services are now increasingly exposed to fiscal constraints, and further expansion of services has been halted. Can anything good come out of such difficult system restraints?

To keep up with ever increasing demands, a possible option may be to re-think how services are delivered and put more focus on alternative recourses able to supplement public services. This is of particular importance in chronic illnesses and behavioural health problems, such as alcohol and drug-related disorders. There is typically a mismatch between these patients' needs and the care provided in delivery systems primarily designed for acute illness, whereas these impairments are better handled with interventions extended over longer periods.[1]

Local community-based services and voluntary agencies are key components in such continuous care concepts, but also peer-based recovery resources like the Twelve-Step groups (for example, Alcoholics Anonymous) have been recommended as promising and useful.[2] Such groups lack the bureaucratic impediments of the public services, and are freely available to everyone who needs support to cope with their problem. Peer-based groups can add significantly to formal services because they in principle offer a 24/7 structure (for example, frequent group meetings, available peer sponsors) that help attendees to acquire self-management skills that are essential in illnesses with substantial behavioural components. They can also engage members as long as they are felt to be needed.

Substance use disorders cause major health problems; for example, the harmful use of alcohol is listed as the third leading risk factor for premature deaths and disabilities in the world.[3] In a recent prevalence study, GPs reported seeing monthly a mean of 14 patients who were excessive drinkers and a mean of 8 with alcohol dependence.[4] Although further referrals to specialist services were felt needed for the majority of these patients, many were not referred with perceived difficulties in access (in other words, waiting lists) being a main reason given. For those referred, a common experience is to be on waiting lists for months with the danger of exacerbating the misuse. When appointments in the specialist services eventually occur, they are usually very time restricted.

In waiting periods, both during and after treatment, mutual aid groups could give patients valuable and needed support. However, actual recommendations from health professionals are vital for getting patients involved with such programmes. Professionals' attitudes towards peer-based fellowships have mainly been studied in the specialist services which largely display little awareness about such resources, and even professionals in specialised services rarely refer patients to them.[5,6] Little is known of how GPs and professionals in the primary care services relate to such groups.

The World Health Organization recently outlined some key global strategies to reduce the harmful use of alcohol, of which an important health service response should be to reach out to and involve a broad range of players outside the public health sector, including a greater reliance on mutual help initiatives.[7]

A greater awareness of peer-based resources would add to the options GPs could introduce to patients and possibly ease the follow-up of patient groups likely to need assistance for lengthy intervals. Recommendations from professionals followed by higher participation rates may also help to build up these resources in the local communities. In a situation where public health services face challenges like never before and service delivery may shrink, a greater involvement with mutual aid fellowships could possibly broaden our understanding on how to deliver help while our resources would be expanded without increasing our costs.

John-Kåre Vederhus,
Addiction Unit, Sørlandet Hospital, Kristiansand, Norway.

Øistein Kristensen,
Addiction Unit, Sørlandet Hospital, Kristiansand, Norway.

Thomas Clausen,
Addiction Unit, Sørlandet Hospital, Kristiansand, and Norwegian Centre for Addiction Research, University of Oslo, Oslo, Norway.

Michael Gossop,
Norwegian Centre for Addiction Research, University of Oslo, Oslo, Norway and National Addiction Centre, King's College, London, UK.

DOI: 10.3399/bjgp12X616382

ADDRESS FOR CORRESPONDENCE

John-Kåre Vederhus
Addiction Unit, Sørlandet Hospital HF, Postboks 416, 4604 Kristiansand, Norway.

E-mail: john-kare.vederhus@sshf.no

REFERENCES

1. Humphreys K, Tucker JA. Toward more responsive and effective intervention systems for alcohol-related problems. *Addiction* 2002; **97(2):** 126–132.
2. Gossop M, Stewart D, Marsden J. Attendance at Narcotics Anonymous and Alcoholics Anonymous meetings, frequency of attendance and substance use outcomes after residential treatment for drug dependence: a 5-year follow-up study. *Addiction* 2008; **103(1):** 119–125.
3. World Health Organization. *Global health risks: mortality and burden of disease attributable to selected major risk factors.* Geneva: WHO, 2009.
4. Drummond C, Oyefeso A, Phillips T, *et al. Alcohol needs assessment research project (ANARP).* London: Department of Health, 2005.
5. Day E, Gaston RL, Furlong E, *et al.* United Kingdom substance misuse treatment workers' attitudes toward 12-step self-help groups. *J Subst Abuse Treat* 2005; **29(4):** 321–327.
6. Vederhus JK, Kristensen O, Laudet A, Clausen T. Attitudes towards 12-step groups and referral practices in a 12-step naive treatment culture; a survey of addiction professionals in Norway. *BMC Health Serv Res* 2009; **9:** 147.
7. World Health Organization. *Strategies to reduce the harmful use of alcohol: draft global strategy.* Geneva: WHO, 2010.