Appendix 7: Facilitators of treatment accessibility

Some of the studies selected for inclusion in this scoping review explicitly reported facilitators of treatment accessibility endorsed by people with PAU, or their preferences to overcome some accessibility barriers. Analogous to our presentation of barriers in the main text of the review, these findings have been reported in the tables below, categorized by the domains of the Levesque framework[1](#_ENREF_1), and associated with the accessibility barrier that they were to overcome. Of note, other facilitators may not have been explicitly reported but could be inferred from the barriers reported; implied facilitators were not extracted for the purposes of this scoping review. For example, participants reaching an answering machine at initial contact with a service was extracted as a barrier to treatment accessibility. However, because speaking to a human at initial contact was not explicitly reported to be a facilitator, it was not extracted, although it could plausibly be inferred. Additionally, some factors such as preferences for individual or group therapy could be considered as (1) barriers, if a preference for individual therapy was reported in a study of a mutual aid group; (2) facilitators, if a preference for individual therapy was reported in a study of individual counselling; or (3) general preferences, in studies that did not focus on a specific intervention. Barriers have been reported in the main text, facilitators are reported below, and general preferences are available in the supplementary files of extracted data extraction for interested readers.

Many studies of service providers have shown insufficient service resources (e.g., funding/reimbursement, personnel, space) to be barriers to provision of care and service-level barriers, such as availability of services, lengthy wait times, and disrupted continuity of care[2-34](#_ENREF_2). However, from the service-user perspective, no studies suggested increasing resources as a means to overcome these barriers, despite increased resources being an obvious facilitator.

# Approachability

Participants in studies suggested various media for increasing the visibility of PAU services in different contexts and commented that engaging with a counselor initially by phone was instrumental in accessing a service.

**Table S7. Facilitators of treatment accessibility identified in the Approachability domain**

|  |  |
| --- | --- |
| Barrier concept | Preferred levels/facilitators |
| Visibility | **Female college students with concurrent PAU and PTSD from sexual assault** suggested publicity in every possible location (e.g., on campus, local businesses) and medium (e.g., printed flyers, emails from the university registrar)[35](#_ENREF_35)  Users of a **free, publicly funded online self-help service (Hello Sunday Morning)** indicated finding access through newspapers, other promotions etc. was useful[36](#_ENREF_36)  Campaigns in GPs offices and social media for **community-based specialist alcohol services**[37](#_ENREF_37)  Newspapers, magazines, radio were media sources that made people aware of the **online mutual aid group (Soberistas)**[38](#_ENREF_38)  People **apprehended for driving under the influence (DUI)** indicated that the police told them about treatment options[39](#_ENREF_39)  Promotional material was a key facilitator of a **pharmacy-based SBIRT** service[40](#_ENREF_40)  **Online programs for co-occurring PAU and depression** are often used as gateways to offline treatment and so should provide information regarding locally available offline treatment services[41](#_ENREF_41)  Offer **SBIRT** to Hispanic day workers in trusted community settings (e.g., day labour worker centre, where people already go to find work)[42](#_ENREF_42)  Media advertising, flyers/community announcements would increase attendance of a **“self-help group” in St. Vincent/** (presumedly through more awareness)[43](#_ENREF_43)  **Australian Indigenous women with concurrent PAU and mental health issues**: services should have a “hands-on approach” to promotion, through active presence by staff at local community groups[44](#_ENREF_44)  **Military-based confidential care model**: “better command awareness, staff briefings, and posters at the many on-post retail stores in which alcohol is sold. Many reported that personal stories from soldiers who had completed treatment and continued to advance their military careers would be highly influential[45](#_ENREF_45).” |
| Perceived effectiveness or mechanism | Some **older adults** found counselling desirable as it helped them understand why they drank[46](#_ENREF_46)  **For an online self-help service (OnTrack Alcohol and Depression)**: engagement may be encouraged if the program’s parameters were more explicit to avoid unrealistic expectations (e.g., may not work for everyone but is a great first step)[41](#_ENREF_41)  Psychotherapy gets to the root of the problems (compared to pharmacotherapy, which doesn’t)[47](#_ENREF_47) |
| Difficulties with initial contact | **For women with concurrent PAU, mental health issues, and intimate partner violence (IPV):** “Being able to speak directly to a counselor and having their calls returned was an important factor in not only coming to the treatment center but also in shaping a positive expectation about what they might gain from treatment[48](#_ENREF_48).” |

# Acceptability

Participants endorsed the anonymity provided by online treatment services and the value of safe spaces for treatment. Settings that were familiar, trusted, and that had low stigma (e.g., hospital) were preferred. Service providers or treatment groups with similar demographics or culture as the treatment seeker were preferred, especially by women, cultural minorities, and military members. Individual and group therapy served different purposes, which were appreciated by different people. Participants valued being involved in their treatment decisions and felt respected when allowed to make choices. Goals of controlled consumption were often preferred at the initial stages of treatment because they were attainable; when it was achieved, abstinence could boost self-esteem. There were varied opinions regarding the preferred level of specialization of the treatment provider, the duration and frequency of treatment, the type of treatment delivery (i.e., in-person or telemedicine), and treatment type. Although some valued the spiritual aspects of some therapies (e.g., mindfulness), many appreciated secular treatment groups and avoided Alcoholics Anonymous due to its religious focus. Several studies reported the value of the involvement of family or other supportive people in treatment. Ancillary services such as access to a gym or skills development embedded in a treatment program were appreciated by some.

**Table S8. Facilitators of treatment accessibility identified in the Acceptability domain**

| Barrier concept | Preferred levels/facilitators |
| --- | --- |
| Anonymity/privacy/ confidentiality | Participants like that much of what they could do in a **free, publicly funded online self-help service (Hello Sunday Morning)**, including blogging/chatting with other members could be done anonymously[36](#_ENREF_36)  “Anonymity [in **internet-based** **Alcoholics Anonymous**]… allowed me to maybe feel disguised, to be able to observe without actually having to put myself out there before I wanted to be part of it. I had the option to observe quietly. That was great, because if they were to have asked me for my last name I probably not have come again. I would have been afraid[49](#_ENREF_49).”  **Brief motivational interviewing and problem-solving therapy for people with concurrent PAU and HIV**: the opportunity “to talk in a safe, confidential, and non-judgmental space to discuss problems and concerns was highly valued”[50](#_ENREF_50)  **Online mutual aid group (Soberistas)**: Accessing support anonymously was considered especially important during early recovery; “‘Lurking’ therefore afforded participants a safe way “to read and get information”...from supportive people with similar experiences, yet preserve the secrecy that dominated this phase of recovery[51](#_ENREF_51).”  **Online mutual aid group (Soberistas)**: at least one person reported that anonymity was a reason for joining the community[38](#_ENREF_38)  Anonymity and privacy were amongst the most highly regarded traits of an **online self-help service (OnTrack Alcohol and Depression)**[41](#_ENREF_41)  **In a Confidential Alcohol Treatment and Education Pilot program (CATEP) in the military**: confidentiality reduced “the anticipated liabilities associated with traditional treatment to the point that self-referral was an appealing option[45](#_ENREF_45).”  Some hospitalized patients prefer PAU screening and brief intervention (SBI) to be done in a private room, where people in the next bed couldn’t hear them[52](#_ENREF_52) |
| Setting | **Post-detox follow-up visits with an Alcohol Specialist Nurse**: the hospital was an acceptable setting for detox follow-up treatment because it was not a specialist service for addictions (i.e., “coming to the hospital, it's a multitude of different things people are coming for”); for those who work, it would be easier to ask their employer for time off to go to the hospital than an addiction service[53](#_ENREF_53)  **Brief motivational interviewing for young adults following an alcohol-related ED visit**: some preferred to receive the BMI at the time of the ED visit rather than waiting a few days—the context could act as a trigger for change[54](#_ENREF_54)  **Brief motivational interviewing and problem-solving therapy**: service users prefer going to the hospital because they know that they can access all of the complementary services there[55](#_ENREF_55)  **Brief motivational interviewing and problem-solving therapy:** some men would have preferred counselling sessions in their homes or community rather than ART (HIV antiretroviral treatment) clinic[50](#_ENREF_50)  **Alcoholics Anonymous as part of a DUI (driving under the influence) program**: an AA group specifically for those with DUI should be offered separate from traditional AA meetings[56](#_ENREF_56)  **Liver transplant due to alcoholic liver disease**: preference for services embedded in transplant program versus need to access elsewhere[57](#_ENREF_57)  **Women veterans**: VA (Veterans Administration) services preferred over non-VA due to trust issues by 47% of participants[58](#_ENREF_58)  An existing rapport with pharmacy staff encouraged participants to use the **pharmacy-based SBIRT service**[40](#_ENREF_40)  **Latino immigrant men** would be receptive to receiving **SBIRT** at community-based organizations that they trusted and where they were already seeking other services[42](#_ENREF_42)  **Problem drug users with PAU** preferred drop-in centres over office settings for counselling appointments[59](#_ENREF_59)  **Community-based home detox/psychosocial service**: some people with PAU would have preferred psychosocial services to be offered in a different location from support for drug misuse due to the stigma attached to drug use (they had to ring a bell to be admitted and they worried that others would think that they were under treatment for drug misuse)[60](#_ENREF_60)  **SBI for hospital inpatients**: patients felt comfortable being screened while on the wards; however, some would have preferred the screening to have been conducted in a private room. Some would have like the BI to be done outside of the hospital[52](#_ENREF_52)  The rural residential care facility for **women with concurrent PAU, mental health issues, and intimate partner violence (IPV)** was considered a place of sanctuary (rural, warm, inviting), facilitating engagement[48](#_ENREF_48) |
| Language barriers and cultural/demographic sensitivity | **Women in specialty alcohol services**: “I guess I want people like me, other women, other Latina women, that have gone through the most similar thing as me to understand how I’m feeling[61](#_ENREF_61).”  **Veterans, mainly male**: Military therapist (or someone who with a good understanding of military life) preferred over non-military therapist[62](#_ENREF_62)  **Hispanic men in the US**: providers with experience in Hispanic culture and Spanish-language skills are preferred[63](#_ENREF_63)  **Older adults with PAU** preferred support (not psychotherapy) from people at the same stage of recovery or ex-alcoholics as they were seen as less likely to be judgmental about drinking and relapses. “A voluntary organisation staffed by recovering drinkers was praised because volunteers understood the problems involved but presented the example of health and stability to aspire to.” As well, younger treatment providers (assuming to be providers of psychotherapy) were felt to potentially lack knowledge of what alcohol problems were like for older adults, although many participants felt that age made no difference to them[46](#_ENREF_46).  **Women veterans**: gender-specific providers or services were preferred by 47% of participants[58](#_ENREF_58)  **Culturally adapted SBIRT**: Latino men preferred to discuss their alcohol use in Spanish; a grant-funded program administered by the county was being pilot-tested to offer SBIRT in community health centres, one of which served mostly Latino patients[42](#_ENREF_42)  **Australian Aboriginal women with concurrent PAU and mental health issues**: preferred Aboriginal health services over non-Aboriginal (mainstream) services; suggested that support groups be run at local services to provide opportunities for them to share experiences with other Aboriginal women in similar situations[44](#_ENREF_44)  **Indigenous people in the US**: “Culturally based treatment and utilization of alternative forms of help like traditional tribal healing (when it is available and accessible) may be one solution.” “The extent to which treatment programs can facilitate connections with cultural educators or traditional healers would be extremely valuable in reaching [Indigenous] populations[64](#_ENREF_64).”  **Gender and sexual orientation**: 55% of respondents reported no preference for male or female therapist, and 57% reported no preference by sexual orientation of therapist. 27% of men preferred male therapists, and 35% of women preferred female therapists (p > 0.05). 38% of heterosexual respondents preferred a heterosexual therapist and 54% of LGB respondents reported a preference for a LGB therapist (p < 0.05)[65](#_ENREF_65)  **Women-only AA meetings**: some but not all women prefer attending women-only AA meetings over mixed-sex meetings (evenly divided) “The key aspect of meeting preference is a sense of comfort and security, because that environment is essential to the honesty required by the recovery project. Some women ﬁnd that sense of ease and comfort in mixed-gender meetings, others in women-only meetings[66](#_ENREF_66).”  **Women with concurrent PAU, mental health issues, and intimate partner violence (IPV)** “felt safer at the all-female meetings as they did not have to confront their conflicted feelings regarding men[48](#_ENREF_48).” |
| Individual vs group | **Telemedicine group-based meetings during COVID-19**: some participants stated they would still like to have some options for one-on-one support[67](#_ENREF_67)  **Internet-based Alcoholics Anonymous**: “I can go to anywhere, anytime, anywhere in the world. I can go to my online support… I’m a member of a group that means I don’t have to do this alone ever again. Wherever I am, I can find someone that shares a bond[49](#_ENREF_49).”  Individual appeared to be preferred over group for **community-based specialist alcohol services**[37](#_ENREF_37)  It was unclear if individual or group therapy was preferred by **people with alcoholic liver disease**, but some benefited from sharing their own experiences and hearing others[68](#_ENREF_68)  **Liver transplant due to alcoholic liver disease**: both individual and group options were considered equally for non-alcohol-specific post-liver-transplant counselling, but individual alcohol-specific counselling was endorsed more than an alcohol group program[57](#_ENREF_57)  **Australian Aboriginal women with concurrent PAU and mental health issues**: suggested that support groups be run to provide opportunities for them to share experiences with other Aboriginal women in similar situations and to reduce their isolation[44](#_ENREF_44)  **People with PAU and concurrent tuberculosis in India**: “Most of the participants during the discussions and interviews felt that both [individual and group sessions] were important. However few opined that individual sessions would be useful only when the patient was willing to have a session as many would not like to be singled out[69](#_ENREF_69).”  **Men in residential treatment in Switzerland**: group therapy was largely not found useful by patients, while individual therapy was considered preferable in comparison[70](#_ENREF_70) |
| Loss of autonomy and power imbalance | **In a collaborative care model in primary care**, most appreciated the autonomy of patient-centred care (e.g., being given a choice between pharmacotherapy and counselling or telemedicine vs in-person)[71](#_ENREF_71)  **Swedish internet-based self-help service (Alkoholhjälpen)**: online programming was preferred because traditional public health care was thought of as being “police style” and that they would not be the one in control. Participants appreciated being able to choose when and where they worked with the program and that they could control the pace[72](#_ENREF_72).  When service users could **choose between telemedicine or in-person therapy on a visit-by-visit basis**, they felt respected “because the decision is yours (. . .) it is an element of you taking responsibility for your own treatment (. . .) which supports your sense of responsibility and independence (. . .) that means something to me[73](#_ENREF_73).”  **Suspected drunk drivers** appreciate the ability to choose their preferred treatment type[39](#_ENREF_39)  Receiving counselling from a provider of similar age and support (not psychotherapy) from people at the same stage of recovery or ex-alcoholics were preferred by **older adults** in counselling[46](#_ENREF_46).  “Patients valued being involved in decisions about their treatment.” “…enabled patients to direct treatment in a way that encouraged their independence and satisﬁed their individual treatment needs[74](#_ENREF_74)”  “…methods with a high degree of autonomy, as well as treatments that make it possible [to maintain] everyday life during treatment” were perceived to be attractive[47](#_ENREF_47)  **Alcoholics Anonymous**: “participants uniformly questioned the formal nature of the sponsor/sponsee role relationship, preferring more informal, peer-to-peer connections[75](#_ENREF_75).”  **Lifering (in-person mutual aid group)**: “While LifeRing provides no official model for sponsorship among peers, Mary Anne did note that spontaneous mentorship, similar to AA’s sponsorship model, often takes place among members in a group. However, she took care to emphasize the informal and completely voluntary nature of such connections[75](#_ENREF_75).”  **Indigenous people in the US**: “Motivational interviewing may also address concerns about autonomy and self-reliance by emphasizing personal choice within the first minutes of meeting[64](#_ENREF_64).” |
| Treatment goal | **SBIRT (“The 15 Method”)**: consumption reduction was preferred over abstinence by some[76](#_ENREF_76)  **Swedish internet-based self-help service (Alkoholhjälpen)**: both abstinence and consumption reduction should be supported[72](#_ENREF_72)  Service providers suggested controlled consumption for those who needed an intermediate goal, when abstinence wasn’t possible or considered attainable by the participant. Controlled consumption was seen as a first step toward abstinence for some or a catch-up goal in the event of relapse from abstinence. For those with abstinence goals, abstinence reinforced their self-esteem by proving to others that they were capable of quitting drinking[77](#_ENREF_77).  In an **online mutual aid group that was said to unequivocally promote complete abstinence**, some found the commitment to abstinence beneficial because it made them feel a part of the group[51](#_ENREF_51)  **CBT as part of a DUI (driving under the influence) program**: CBT sessions should be focused on preventing DUI not on abstinence from drinking[56](#_ENREF_56)  **Community alcohol services in Poland**: provision of “responsible drinking education [vs abstinence] would possibly encourage some patients to start therapy[78](#_ENREF_78)”  **Abstinence-based approaches**: Providers need to listen to people rather than telling them what to do (not further described)[79](#_ENREF_79)  **Older adults** **in treatment in primary care** preferred consumption reduction because abstinence likely couldn't be attained[46](#_ENREF_46)  Controlled consumption preferred over total abstinence by **people with AUD in Sweden**, especially for 18–34-year-olds[47](#_ENREF_47)  The **mutual aid group LifeRing** insists on abstinence as does AA and this was very important to participants; however, “LifeRing doesn't require participants to be sober, merely to have a sincere intent to achieve sobriety”...“this tolerance during an uncertain and frightening behavioral transition is essential to their continued participation in the groups and eventual achievement of stable sobriety[75](#_ENREF_75).”  **Community-based home detox/psychosocial service**: support for controlled consumption was appreciated by those who wanted it[60](#_ENREF_60) |
| Level of specialization of treatment provider | **SBIRT (“The 15 Method”)**: patients preferred to have a nurse conduct SBI rather than a GP[76](#_ENREF_76)  **People with concurrent HIV** preferred to receive **SBI** social workers or others who had previously “been in their shoes” and would be more understanding (compared to telling doctors or nurses)[80](#_ENREF_80)  **People with concurrent HIV or diabetes** felt that doctors and nurses should NOT provide **psychosocial treatment for PAU**. A lay counsellor should provide PAU treatment, whether it was their existing lay counsellor who conducts chronic disease treatment adherence counselling or a different “specialist” lay counsellor. Some felt the workload of their existing lay counsellor may be too great and that quality of care may be reduced due to lack of time[81](#_ENREF_81).  **Older adults** with PAU preferred to receive alcohol-related advice following screening (**SBIRT**) from their GP rather than being referred[46](#_ENREF_46).  In a **pharmacy-based SBI**, 22% of service users preferred to discuss alcohol with their GP (30% disagreed)[82](#_ENREF_82)  **Pharmacy-based SBIRT**: some people may be more likely to engage with pharmacists because they have an existing rapport with them[40](#_ENREF_40)  **People with concurrent PAU and mental health disorders in hospital PAU treatment**: “Patients with complex needs valued general inpatient services, as they ‘broke the cycle of drinking’. Some patients in non-specialized settings (i.e. inpatients in hospital) described a desire to be transferred to a specialized service, explaining that they would feel more accepted[74](#_ENREF_74).”  Specialist clinics were considered positively due to perception that expert knowledge is required to deal with PAU[47](#_ENREF_47).  **Problem drug users with PAU** felt that GPs should be more proactive in the management of PAU at a primary care level and that primary care can play an important role in their treatment[59](#_ENREF_59)  GPs preferred by some over specialists by **Aboriginal Australians**; some Aboriginal people with PAU felt that Aboriginal health workers (not GPs or nurses) lacked the authority and influence to offer advice[83](#_ENREF_83) |
| Treatment duration and frequency | **Swedish internet-based self-help service (Alkoholhjälpen)**:some would have preferred more than three months of counselling[72](#_ENREF_72).  **Brief motivational interviewing and problem-solving therapy for** **people with concurrent PAU and HIV**: four sessions over two days was sufficient for low-risk drinking, but those with higher-risk drinking would have preferred more sessions, possibly offered as booster sessions to be accessed on an as-needed basis[50](#_ENREF_50).  **Psychosocial interventions for people with PAU and concurrent HIV or diabetes**: 2–3 sessions were suggested to be preferred, but the participants had not yet engaged in the treatment, so this is presumed. They also suggested that those who are working may prefer once a month sessions[81](#_ENREF_81" \o "Myers, 2018 #46)  **Outpatient therapy** less than three times per week was preferred[78](#_ENREF_78) |
| Spiritual/religious component | **Swedish internet-based self-help service (Alkoholhjälpen)**: some chose the online program to avoid the religious influences of Alcoholics Anonymous[72](#_ENREF_72)  **For residents at a therapeutic rehabilitation center in Thailand**, meditation was considered to have moral or religious significance as a good act[84](#_ENREF_84)  Some users of an **online program for co-occurring PAU and depression (OnTrack Alcohol and Depression)** “were impressed that the program did not employ ‘religious’ aspects[41](#_ENREF_41).”  ‘Spirituality’ was important, but no referring to religion: “Patients also discussed the importance of spirituality by engaging in behaviours that connected oneself to an inner goodness[74](#_ENREF_74).”  **Alcoholics Anonymous**: “members spoke vigorously to the importance of being free to choose a secular support group format, which struck them as highly preferable to trying to put aside their misgivings in order to participate in AA”[75](#_ENREF_75)  **LifeRing in-person mutual aid group**: “participants were quite diverse and far from dogmatic in their personal relationships to religion and spirituality, but they all agreed about the importance of keeping such concerns private”[75](#_ENREF_75)  **Most women with concurrent PAU, mental health issues, and intimate partner violence (IPV)** valued the spirituality component of the non-religious rural residential care program[48](#_ENREF_48). |
| In person vs telemedicine | Some people with PAU said they'd still like some options for in-person treatment over telemedicine **during the COVID-19 pandemic**[67](#_ENREF_67)  **Older adults** with PAU preferred in-person therapy over telemedicine during the COVID-19 pandemic, although online peer support was very much valued and needed during lockdowns[85](#_ENREF_85)  For those accessing **specialist alcohol services in England**, the full suite of services is only available to those who come in person for treatment[37](#_ENREF_37)  Several people with PAU receiving **treatment by telemedicine** preferred face-to-face over virtual treatment[86](#_ENREF_86).  When participants could **choose between telemedicine or in-person therapy on a visit-by-visit basis,** some preferred virtual, while others preferred in-person given the “human factor,” better relationship with therapist, potential for deeper conversations. “…several patients experienced that videoconferencing minimized their need for cancellations and improved their attendance[73](#_ENREF_73).” |
| Involvement of partner or family | **Liver transplant due to alcoholic liver disease:** “We [the authors] recommend the following to promote the use of alcohol services and reduce barriers to treatment… Involvement of patients' supports, especially partners, so that they can better understand AUDs and how to foster abstinence”[87](#_ENREF_87)  Some **older adults with cognitive impairments at memory clinics** may need/want to have family members present during in-person PAU screening[88](#_ENREF_88)  People with PAU in a **“self-help group” in St. Vincent/Grenadines** preferred to have family involved[43](#_ENREF_43)  People with PAU and **concurrent tuberculosis in India** “expressed the need for family members to be included in the intervention programme[69](#_ENREF_69" \o "Thomas, 2011 #179)” |
| Outpatient vs inpatient | Inpatient therapy was seen as a time-out from the struggles of everyday homeless life and provided a sense of stability, but was not perceived as an effective form of therapy to maintain abstinence because it didn’t provide strategies for managing craving and avoiding relapse upon exit[79](#_ENREF_79)  Inpatient therapy was seen as a last resort by treatment seekers[47](#_ENREF_47)  36% of people with PAU preferred professional outpatient treatment, and 4% preferred professional inpatient treatment[65](#_ENREF_65) |
| Ancillary services offered within the treatment program | Some people with PAU who regularly attended the ED (emergency department) felt that employment training or having free access to a gym were valuable components of a **specialty alcohol service**[89](#_ENREF_89)  People with PAU “emphasized the importance of learning a variety of skills to assist them in a number of areas of functioning. Patients who had previously sought treatment believed that to recover from addiction were life-long work and expressed a desire for tools that encouraged their on-going personal growth[74](#_ENREF_74).” |
| Treatment type | **People with alcohol-related liver disease** preferred problem-solving or skill-building approaches, such as found in CBT[68](#_ENREF_68)  Of 11 people with **PAU who regularly attended the ED and wanted alcohol-specific support**, four wanted pharmacotherapy (specifically Librium), two wanted residential rehabilitation, two wanted drink-related advice, one wanted professional detox, one wanted access to a community drug and alcohol team, and one wanted a alcohol/drug worker to visit him at home to talk and alleviate some of his loneliness so he wouldn't drink so much[89](#_ENREF_89)  **People who attend in-person mutual aid groups** preferred alternatives to 12-step programs (including Women for Sobriety (WFS), LifeRing, and SMART Recovery (SMART)) over 12-step programs[90](#_ENREF_90)  **Older adults receiving primary care SBIRT** preferred alternatives to medication, if available; some preferred therapy that was not alcohol specific because they wouldn't come in contact with others who drank, which would encourage relapse. “Groups were appreciated more when they were not focused solely on drinking,” including relaxation and alternative therapies (e.g., arts classes), where people could fill their day and meet new people. Drop-in centres were also appreciated for this reason (sustained support, socialization, filling the day).[46](#_ENREF_46)  Some **women veterans** preferred psychosocial therapy vs mutual aid group, but preferences varied across participants[58](#_ENREF_58)  **People with concurrent PAU and severe mental health symptoms** preferred psychosocial interventions for alcohol and MH over pharmacological interventions[74](#_ENREF_74)  People with PAU perceived Alcoholics Anonymous as second class treatment or not part of the legitimate treatment services available[91](#_ENREF_91)  People with PAU who used online PAU treatment was preferred to Alcoholics Anonymous (AA). AA was perceived to be stigmatizing and as catering to alcoholics (i.e., their problem was not severe enough and they did not identify with the types of people AA targeted). Online PAU treatment was seen as suited to their level of need, did not interfere with their everyday lives, and was personal to them. “There was also a concern that by attending a service geared towards the more dependent drinker that this would trivialize their problem[92](#_ENREF_92).”  People with PAU preferred psychotherapy to pharmacologic therapy, “Personal meeting” preferred over internet-based or telephone help line (Internet/help line were considered suitable first steps before entering treatment both for screening and to receive guidance on available treatments)[47](#_ENREF_47).  Problem drug users had some hesitancy toward pharmacologic PAU treatment if they were already on methadone[59](#_ENREF_59)  Pharmacotherapy was less desirable for veterans[93](#_ENREF_93)  Text messaging was preferred by **college students** over in-person therapy because participants did not like to be judged for disclosing their drinking behaviour[94](#_ENREF_94)  College students were more likely to endorse informal resources (friends/family) over anonymous resources (internet search/book/computer program), and anonymous resources were preferred over formal resources (specialist/counsellor/clergy/AA). Women rated anonymous help seeking higher than men did, but there were no significant differences by ethnicity[95](#_ENREF_95).  40% of people with PAU preferred professional/specialty treatment, 29% preferred mutual aid groups (self-help support groups), 16% preferred computerized treatment either online or with computerized sessions, and 15% preferred a self-help book. There were no significant differences in treatment modality preference by gender or sexual orientation[65](#_ENREF_65). |

# Availability

Participants endorsed telemedicine, online treatment programs, and treatment embedded in existing medical services (e.g., primary care or liver transplant clinic) because either no transportation was required or they were already attending the service for other reasons. Telemedicine and online treatment programs were also endorsed because of the flexibility in appointment timing or use of the program and in the lack of need for childcare. Several studies reported alternative appointment hours for in-person treatment (e.g., weekends, off-duty hours). Facilitators to navigate complex care pathways included having referring practitioners make initial appointments with specialist care rather than leaving it up to the treatment seeker, embedding treatment in primary care, cell phones for better communication between treatment providers and referring practitioners, and third-party facilitators of care pathway navigation and coordination of care, such as volunteers or charities.

**Table S9. Facilitators of treatment accessibility identified in the Availability domain**

|  |  |
| --- | --- |
| Barrier concept | Preferred levels/facilitators |
| Geographic location and transportation barriers | **PAU telemedicine:** virtual services were not associated with logistical hassles such as driving to and from meetings. Some enjoyed being able to attend meetings from locations around the world virtually. At least one felt meetings outside of the home were easier to attend because they could not find a quiet space in their home[67](#_ENREF_67).  **A collaborative care model in primary care:** offering the program opportunistically during routine medical visits in the primary care practice (PCP) and having an integrated program under one roof supported successful engagement into treatment; most liked that the program was integrated into their PCP because it was convenient (they could come in for other appointments at the same time)[71](#_ENREF_71)  During COVID-19, **phone appointments** were highly accessible[85](#_ENREF_85)  **Swedish internet-based self-help service (Alkoholhjälpen)**: online programming preferred because some had trouble accessing traditional treatment due to geographical reasons[72](#_ENREF_72)  **When service users could choose between telemedicine or in-person therapy on a visit-by-visit basis**: “If it had not been for videoconferencing, I would no longer have been in treatment because I was living so far out in the countryside that it would have taken me too long to get here.” “several patients experienced that videoconferencing minimized their need for cancellations and improved their attendance[73](#_ENREF_73).”  People with **PAU and an alcohol-related liver disease transplant** preferred services embedded in the transplant program versus needing to access them elsewhere[87](#_ENREF_87)  For people accessing **mutual aid groups**, AA’s wide availability was an asset, particularly for those needing support who live in regions without alternative formats[75](#_ENREF_75)  **Australian Aboriginal women with concurrent PAU and mental health issues**: locate services to address the lack of cost efficient and reliable transportation options[44](#_ENREF_44).  **For women with concurrent PAU, mental health issues, and intimate partner violence (IPV)** who were accessing a rural residential care facility, transportation was offered by van from the local bus station[48](#_ENREF_48) |
| Inconvenient or inflexible appointment hours | **PAU telemedicine**: some preferred online options because they were available any time of the day or night[67](#_ENREF_67)  During COVID-19, **phone calls** offered a greater degree of flexibility and more frequent contact[85](#_ENREF_85)  **Afree, publicly funded online self-help service (Hello Sunday Morning)**: At least one participant like the flexibility of online options because he knew he would be unable to make face-to-face meetings[36](#_ENREF_36)  **Swedish internet-based self-help service (Alkoholhjälpen)**: many participants were drawn to the online program because they could not attend mainstream therapy appointments due to work (irregular work hours, can't be absent during work hours)[72](#_ENREF_72)  **Brief motivational interviewing for people with concurrent PAU and HIV**: People with comorbid HIV suggested offering weekend hours[50](#_ENREF_50)  “Participants who were **currently employed** suggested Saturdays as the preferred date since it did not interfere with their work schedules.” Those who were **unemployed** appeared to prefer middle of the week because they needed the contingency management incentive money for transportation or food[96](#_ENREF_96).  People with **concurrent PAU and HIV** suggested options for appointments in late afternoons or Saturday mornings, and no Mondays due to increased risk of hangover symptoms etc.[80](#_ENREF_80)  **Employed people** may want weekend appointments[81](#_ENREF_81)  When service users could **choose between telemedicine or in-person therapy on a visit-by-visit basis**, telemedicine was often preferred: “…convenient not to have the stress factor of having to show up at the clinic if something unexpected came up, like if they were called in to work, if they had a changing irregular work schedule, if they did not know when they could get off from work, or if they wanted to take the session from work” “…several patients experienced that videoconferencing minimized their need for cancellations and improved their attendance”[73](#_ENREF_73)  **Australian Aboriginal women with concurrent PAU and mental health issues** suggested to be open after business hours and offer same-day appointments (necessary at times of crisis); greater flexibility in appointment times, generally[44](#_ENREF_44)  **Military-based confidential care model**: off-duty hours were preferred (e.g., evenings and weekends)[45](#_ENREF_45) |
| Complexity of the care/referral pathway | For **community-based therapy referral from primary care**, managers saw the use of cellphones/apps as a facilitator of coordination of resources and management of care through better communication amongst different services[55](#_ENREF_55).  **A collaborative care model in primary care**: Offering the program opportunistically during routine medical visits in the primary care practice and having an integrated program under one roof supported successful engagement into treatment[71](#_ENREF_71)  **People with PAU who had attended the ED or were in hospital** suggested that hospital and community services communicate and work together to form an effective pathway[97](#_ENREF_97)  Outreach hubs and in-reach into hospitals facilitated engagement with potential service users prior to formal enrolment in **community-based specialist alcohol services**[37](#_ENREF_37)  For **people with comorbid PAU and mental health issues**: “sometimes it’s embarrassing to ask for help, it might be better if they actually said: ‘we’ve set up a meeting for you at eleven o’clock’. Yesterday I got given a scrap of paper, with ‘this is the phone number for AUD service.’ Give me something tangible—maybe set up meeting, maybe a contact name as opposed to phone number[98](#_ENREF_98)”  For **veterans in the UK**, third-sector charities (i.e., those run to help ex-offenders and/or veterans) were suggested to provide “the most consistent support and helped in the communication with multiple services across sectors, ensuring participants received the ‘right care.’” These services coordinated care and made connection easier for service users[62](#_ENREF_62).  Access to treatment for **people with DUI** was facilitated by referral by the police to treatment services[39](#_ENREF_39)  **Women veterans identified with PAU in primary care** prefer any kind of support from GP, such as information of services beyond AA, to aid in transitioning to alcohol-related care. Some preferred GP making appointment (linking) with treatment service[58](#_ENREF_58).  “Patients described that more coordination in treatment lessened their confusion and made them more willing to engage,” although coordination of care after discharge from inpatient services was important for some but not for others[74](#_ENREF_74).  For US Hispanic men with PAU, the **culturally adapted SBIRT** program developed as part of the research identified agencies that provided low- or no-cost services in Spanish that would accept referrals from the “promotores” (community-based screening)[42](#_ENREF_42)  Volunteers for **Alcoholics Anonymous** acted as linkages to treatment for **incarcerated women post-release**. The familiarity of the AA volunteer was thought to facilitate engagement in AA[99](#_ENREF_99).  **Australian Aboriginal women with concurrent PAU and mental health issues** suggested that outreach service in a community centre could simplify access[44](#_ENREF_44).  People with PAU in Sweden preferred a simple pathway to treatment[47](#_ENREF_47)  **People with PAU and concurrent mental health issues** should be automatically connected to AUD/drug services group and not have it left up to them[98](#_ENREF_98)  **LifeRing** should be included in the referral pathway by clinicians, allowing service users choice amongst mutual aid groups[75](#_ENREF_75)  **For women with concurrent PAU, mental health issues, and intimate partner violence (IPV)** there is a need to be connected with someone who understands the system and can help find the services needed within the system (case management). “The need for information and practical support in accessing treatment came up again in the focus group where the idea of an Access Group was suggested. This type of group could meet weekly in varied locations to help women who were seeking treatment but who could not access either an outpatient or residential program. The staff in the access group could help them find sources of help, before and after treatment and it would also be a place to connect to while they were on the waiting list[48](#_ENREF_48).” |
| Wait time to access treatment | People with PAU circumvented treatment wait times by presenting at hospital on an emergency basis[97](#_ENREF_97)  Some **outpatient community-based PAU services** prioritized some individuals with specific needs, including pregnant women and those at risk of suicide[37](#_ENREF_37)  **People with DUI** found it important to receive a call from the treatment service as quickly as possible, although some required a few days to sober up/sleep, etc., before they could engage in treatment[39](#_ENREF_39)  **Women with concurrent PAU, mental health issues, and intimate partner violence (IPV)**: some participants mentioned that wait times were shorter for those paying out of pocket compared to those relying on government insurance[48](#_ENREF_48). |
| Lack of childcare | **Swedish internet-based self-help service (Alkoholhjälpen)**: people with PAU did not need to find a babysitter to engage in the online program[72](#_ENREF_72)  **Australian Aboriginal women with concurrent PAU and mental health issues** suggested more child care options for those seeking help from inpatient treatment services[44](#_ENREF_44). |
| No treatment program available | **People with PAU and an alcohol-related liver disease transplant** felt that a PAU treatment program should be embedded within the transplant program, where currently none existed[87](#_ENREF_87).  **Problem drug users**: opiate-dependent individuals with PAU need an alcohol-specific service[59](#_ENREF_59) |
| Mental health and PAU treatment silos | **Australian Aboriginal women with concurrent PAU and mental health issues** suggested more integration of MH and AOD services, along with greater collaboration with other relevant services (e.g., housing, education, prison, and community services) [44](#_ENREF_44).  Some **people with concurrent PAU and mental health issues** wanted both conditions handled concurrently, while others preferred separate phases of treatment[98](#_ENREF_98).  **For people with concurrent PAU and mental health issues**, coordination among services for PAU and mental illness was important[74](#_ENREF_74). |
| Accessibility for the physically disabled | Provide wheelchair lifts or platforms for **people with physical disabilities** to reach the facility[78](#_ENREF_78). |
| Technology-based therapy: Lack of hardware | People with PAU using a **Location-Based Monitoring Invention for Alcohol Use Disorders app** were provided phones with the app installed, but many would prefer the app to be installed on their own phone rather than have a separate phone[100](#_ENREF_100). |
| Technology-based therapy: Lack of or poor internet | None reported |
| Technology-based therapy: Low technology literacy or comfort | Some **older adults completing AUD screening** preferred to have a hard copy of the tool in front of them for reference[88](#_ENREF_88).  35% of **people who attended the ED and engaged in SBIRT** preferred to have a computer ask the questions, 16% a person, and 49% had no preference[101](#_ENREF_101) |
| Technology-based therapy: Inability to communicate effectively | Some people with PAU engaged in **internet-based CBT** would prefer phone over email; some would prefer video sessions[102](#_ENREF_102) |
| Technology-based therapy: Technical issues | People with PAU who used **telemedicine during COVID-19** suggested that tech support should be available to handle glitches[67](#_ENREF_67) |

# Affordability

Free treatment, low-fee online programs, and treatment embedded in primary care were reported to increase the affordability of PAU treatment.

**Table S10. Facilitators of treatment accessibility identified in the Affordability domain**

|  |  |
| --- | --- |
| Barrier concept | Preferred levels/facilitators |
| Financial barriers | **A collaborative care model in primary care** was affordable, which facilitated access[71](#_ENREF_71).  The membership fee for an **online mutual aid group (Soberistas)** was affordable[38](#_ENREF_38).  Free treatment for some **women veterans** facilitated treatment accessibility[58](#_ENREF_58)  For **Hispanic men in the US**, a grant-funded program administered by the county was being pilot-tested to offer SBIRT in community health centres, one of which served mostly Latino patients. Those requiring treatment were eligible for free or low-cost treatment if referred[42](#_ENREF_42). |

# Appropriateness

Maintaining continuity of care was stressed to be important to ensure trust between treatment provider and service user and so that service users did not have to reiterate their complex stories to multiple providers.

**Table S11. Facilitators of treatment accessibility identified in the Appropriateness domain**

|  |  |
| --- | --- |
| Barrier concept | Preferred levels/facilitators |
| Not meeting eligibility criteria | None reported |
| Poor continuity of care | For **female college students with concurrent PAU and PTSD from sexual assault**, having the same therapist for both in-person counselling and coaching calls was positive[35](#_ENREF_35)  **Underhoused people with PAU in a harm-reduction program** recommended having more consistency in providers to ensure trust-building and a more secure therapeutic alliance[79](#_ENREF_79)  Contact with the same staff person was important over time because that person would already understand their story and complex past treatment history and needs, especially for those with concurrent PAU and mental health issues[74](#_ENREF_74). |

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