Videoconferencing-Based Versus Telephone-Based Outpatient Alcohol Detoxification: Patients' and Caregivers' Perspectives, and the Assessment of Withdrawal Symptoms

Juliëtte Balci (s1808818)
Faculty of Behavioural, Management and Social sciences, University of Twente
Positive Psychology and technology
Dr. Marloes Postel and Dr. Ing. Gert-Jan Prosman
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Abstract

Background: In 2012, the Dutch national government, health care providers, health insurers, and client organisations came to an agreement, aiming for a reduction of the number of inpatient mental health care services, and an expansion and improvement of the capacity and quality of the outpatient care. In line with this policy, a shift from inpatient alcohol detoxifications towards more outpatient alcohol detoxifications was aimed for. ***Objective:*** The rationale of the present study was to gain more insight into patients' and caregivers' perspectives on two different types of outpatient alcohol detoxification: outpatient alcohol detoxification with the use of videoconferencing and outpatient alcohol detoxification with the use of telephone contact. It was also investigated whether patients' alcohol withdrawal symptoms, which were assessed through observation by caregivers, could be accurately assessed digitally by caregivers. ***Method:*** The study was a descriptive comparative study, based on structured questionnaires and an alcohol withdrawal symptom scale. Eighteen patients with a primary alcohol use disorder took part in the study, either in the videoconferencing-based outpatient alcohol detoxification (n = 11) or in the telephone-based outpatient alcohol detoxification (n = 7). ***Results:*** The study showed that patients and caregivers were satisfied with both types of the outpatient alcohol detoxification. However, patients seemed to have a slight preference for the videoconferencing-based outpatient alcohol detoxification. Patients and caregivers also had a positive perspective on the use of videoconferencing during the outpatient alcohol detoxification. Furthermore, the study showed that caregivers believe that it is possible for them to assess patients' alcohol withdrawal symptoms digitally. ***Conclusion:*** Outpatient alcohol detoxification with the use of videoconferencing or with the use of telephone contact are good methods to expand the outpatient care with. Because patients and caregivers have a positive perspective on the use of videoconferencing and see its benefits, also for the assessment of patients' alcohol withdrawal symptoms, it is suggested to let more patients detox from alcohol through a videoconferencing-based outpatient alcohol detoxification.

Videoconferencing-Based Versus Telephone-Based Outpatient Alcohol Detoxification: Patients' and Caregivers' Perspectives, and the Assessment of Withdrawal Symptoms

The problematic consumption of alcohol is given the medical diagnosis of alcohol use disorder (AUD), if the individual meets two or more of the eleven criteria for AUD according to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013). Alcoholism is a chronically relapsing disorder and is characterised by obsessive alcohol seeking, the loss of personal control regarding consumption, and being in a negative emotional state when not consuming (Akbar et al., 2018). AUD is related to many physical, mental, social, and economic harms, such as several types of cancer (Bagnardi et al., 2015), alcohol-induced mental disorders (APA, 2013), severe family disruption (Rehm, 2001), and health care costs (Thavorncharoensap et al., 2009), respectively. In the Netherlands, the lifetime prevalence rate of AUD is 25% of the male and 7.5% of the female population (De Graaf et al., 2010). This prevalence rate had been calculated through combining data corresponding to the *DSM-IV* (APA, 1994), because the *DSM-5* merged the two *DSM-IV* disorders for alcohol (i.e., alcohol abuse and alcohol dependence) into the category AUD (Boomsma et al., 2014).

Individuals who want to tackle their problematic alcohol consumption can receive help from the general practitioner, mental health care, addiction care, or from self-help organisations. There are several treatment options: first-step interventions (i.e., minimal and short-term interventions for primary care); the use of E-mental health (i.e., the use of technology to support or improve the mental health and mental health care, such as online self-help programs); one-off and short-term interventions that consist of one or a few very short interventions; psychosocial treatments (i.e., interventions that influence alcohol use through direct or indirect communication with the patient); psychological and psychotherapeutic treatments (e.g., cognitive behavioural therapeutic interventions); drug treatments; biological treatments (i.e., neurophysiological treatments); course therapies (e.g., dance therapy); complementary and additional treatment methods (e.g., homeopathy); detoxifications; giving the patient psycho-education (i.e., information and education activities); or a combination of treatments (GGZ Standaarden, 2020).

The focus of the present study will be on alcohol detoxification. McCorry et al. (2000) defined a detoxification as "a medical intervention that manages an individual safely through the process of acute withdrawal" (p. 9). Additionally, McCorry et al. also state that a detoxification program is not designed for the purpose of resolving "longstanding psychological, social, and behavioral problems associated with alcohol and drug abuse" (p. 9).

Therefore, a detoxification is not considered a full-fledged treatment, but it is seen as a first step of the treatment that is aimed at clearing the body of the intoxicated and/or dependent user from the toxin (Substance Abuse and Mental Health Services Administration, 2015). The Substance Abuse and Mental Health Services Administration (2015) built on existing definitions of detoxification as a process that consists of three important components that can take place simultaneously or as a series of steps: evaluation, stabilisation, and fostering the patient's entry into treatment. Evaluation entails testing for the presence of alcohol in the bloodstream of the patient, and screening and assessing the patient's social situation, medical condition, and co-occurring mental and physical conditions. The stabilisation component encompasses processes of helping the patient through acute intoxication and withdrawal, making the patient acquainted with what to expect in the treatment environment, and making the patient acquainted with their role in the treatment and recovery. Fostering the patient's entry into treatment means preparing the patient for the treatment by emphasising the importance of continuing with the complete alcohol abuse treatment continuum of care.

During the alcohol detoxification, alcohol withdrawal may occur. Symptoms of alcohol withdrawal are for example, insomnia, nausea or vomiting, and anxiety. Among other things, depending on the duration and amount of consumed alcohol, the chance that alcohol withdrawal will occur increases (APA, 2013). The withdrawal symptoms that arise during the detoxification occur as a consequence of the effects that alcohol has on the body. During the detoxification, the body is looking for a new (neurobiological) balance and the withdrawal symptoms are the manifestations of this balance recovery. The severity of the withdrawal depends on the substance that is used, the co-use of other substances, the dosage of the substance, the experienced problems caused by the substance use, the user's psychiatric and somatic condition, the user's quality of sleep, and the user's age (APA, 2013, as cited in Dijkstra, Van Oort, Schellekens, et al., 2017). According to the severity of the withdrawal symptoms, the number of withdrawal symptoms check-ups, the medication, and the treatment setting are adjusted (Dijkstra, Van Oort, Schellekens, et al., 2017).

An alcohol detoxification can be performed in an inpatient or outpatient setting. Inpatient care entails an alcohol detoxification at a clinic, whereas outpatient care is an alcohol detoxification in an ambulatory setting. Outpatient care does not require the patient to stay at the clinic, so the alcohol detoxification can largely be performed in the private setting of the patient (Juergens, 2020).

In 2012, the Dutch national government, health care providers, health insurers, and client organisations came to an agreement, aiming for a reduction of the number of inpatient

mental health care services, and an expansion and improvement of the capacity and quality of the outpatient care (Trimbos-instituut, 2015). In line with this policy, a shift from inpatient alcohol detoxifications towards more outpatient alcohol detoxifications was aimed for. There is currently no clear data available regarding the ratio of inpatient and outpatient alcohol detoxifications in the Netherlands. However, in Tactus Addiction Treatment, one of the Dutch specialist addiction care institutions, the percentage of medically guided outpatient alcohol detoxifications is roughly 12%. In the past six years, Tactus had on average 300 patients per year who underwent an alcohol detoxification, which means that approximately 36 patients were medically treated in an outpatient setting every year. Although the bed capacity also has been reduced within Tactus, the expansion of the outpatient alcohol detoxifications seemed to have fallen behind (K. Van der Horst, personal communication, March, 2019).

Normally, an outpatient alcohol detoxification is combined with regular face-to-face visits by the patient to the clinic, or with visits from health professionals to the patient's home, for the assessment and management of withdrawal (Manning et al., 2018). However, through the use of technology, the possibility to make use of distance communication came into play. Two types of real-time communication over distance are the use of videoconferencing and the use of the telephone. Videoconferencing is the use of bidirectional video and audio technology (Ghodsian et al., 2018), such as Skype and FaceTime. Safe platforms that are specifically suitable for the use in health care also have been developed, such as Mobiléa (2020) and wellbee (n.d.). Telephone calls only consist of bidirectional audio transmission, and can be performed through both landline and mobile phones.

Several studies regarding the satisfaction with, and/or perspectives on videoconferencing-based treatments for alcohol related problems have been performed. For example, a study on videoconferencing open-group therapy sessions for patients with a diagnosis of alcohol abuse or dependence reported high levels of satisfaction with, and acceptance of the videoconferencing service delivery mode (Frueh et al., 2005). Furthermore, the study of Tarp and Nielsen (2017) revealed patients' perspectives on the optional use of videoconferencing-based sessions during treatment for AUD. Patients' perspectives were diverse. On the one hand, videoconferencing was found relevant when: patients found it positive to have a treatment choice, no differences between videoconferencing and face-to-face sessions were registered, flexibility and patients' sense of security were enhanced, attending treatment was encouraged, and treatment was blended care. On the other hand, videoconferencing was found irrelevant when: patients desired intimacy or had concerns regarding the technical equipment, and a treatment form was offered that was not suitable for

videoconferencing. Also, Ghodsian et al. (2018) mentioned that alcohol detoxification treatment with the use of videoconferencing, as a substitute for face-to-face treatment at a physical location, is restricted to individuals who are able to use the equipment.

As far as I know, there have not been previous studies regarding the satisfaction with, and/or perspectives on telephone-based treatments for alcohol related problems. Kruse et al. (2020) performed a review in which they included articles published between 2009 and 2018 regarding the treatment of AUD through the use of telemedicine. The review included, among other things, literature regarding patient satisfaction resulting from the use of telemedicine in the management of alcohol abuse, addiction, and patient rehabilitation. After the authors performed data extraction, they identified various potential outcomes that were used for the measurement of the effectiveness of telemedicine. For patient satisfaction, the review only included studies about the increase in patient satisfaction. Three studies regarding increased patient satisfaction were found. Although the review also included videoconferencing, two of the three studies were about mobile applications, and the remaining study was about interactive voice response.

The rationale of the present study is to gain more insight into patients' and caregivers' perspectives on two different types of outpatient alcohol detoxification: outpatient alcohol detoxification with the use of videoconferencing and outpatient alcohol detoxification with the use of telephone contact. The rationale is based on Tactus' search for the best method to expand their outpatient care with. Both types are currently being applied in addiction care institutions, although much less than is being pursued. Although telephone contact has been around for some time, videoconferencing is relatively new. To be able to use videoconferencing on a larger scale, departments of Tactus must be facilitated for this purpose. Before investing time and money in this, Tactus likes to know how both types of outpatient alcohol detoxification are valued by both patients and caregivers. Moreover, Tactus also likes to investigate whether patients' alcohol withdrawal symptoms, which are assessed through observation by caregivers, can be accurately assessed digitally by caregivers. This is important, because there are still questionable aspects regarding this subject, such as whether it is possible to assess the alcohol withdrawal symptoms in an outpatient setting and whether videoconferencing can be a meaningful addition to this. Insight herein could help convince caregivers to detox more patients in an outpatient setting. The research questions of the present study are: "What are patients' and caregivers' perspectives on a videoconferencing-based and a telephone-based outpatient alcohol detoxification?" and "Can patients' alcohol

withdrawal symptoms, which are assessed through observation by caregivers, be accurately assessed digitally by caregivers?"

Method

Design

The study was a descriptive comparative study, based on structured questionnaires and an alcohol withdrawal symptom scale. Patients who completed the outpatient alcohol detoxification, and caregivers, were asked to give their opinion on the outpatient alcohol detoxification and on the (possible) use of videoconferencing during the outpatient alcohol detoxification. Furthermore, during the outpatient alcohol detoxification, patients' alcohol withdrawal symptoms were scored on an alcohol withdrawal symptoms scale by the caregivers. The recruitment of patients, the execution of the outpatient alcohol detoxification, and the filling in of the evaluation questionnaires were performed from 15 May 2019 until 31 October 2019 by Tactus. The study was approved by the Scientific Committee of Tactus Addiction Treatment.

Patients

In total, 18 patients with a primary AUD took part in the study. Eleven patients received the videoconferencing-based outpatient alcohol detoxification (videoconferencing group) and seven patients received the telephone-based outpatient alcohol detoxification (telephone group).

The inclusion criteria were: (a) the patient needed to have an indication for an outpatient alcohol detoxification, and in order to be eligible for an outpatient alcohol detoxification, caregivers of Tactus needed to expect that only mild to moderate alcohol withdrawal symptoms will occur, and caregivers of Tactus needed to indicate drug support and medical monitoring; (b) the patient needed to meet the outpatient detoxification criteria as outlined in the detoxification guideline (Dijkstra, Van Oort, Schellekens, et al., 2017); (c) the patient needed to agree with an outpatient alcohol detoxification; and (d) the patient in the videoconferencing group needed to be in possession of a smartphone, tablet, or personal computer, with internet connection, and to be able to work with this device. The patient in the telephone group needed to be in possession of a landline or mobile phone.

Lastly, all patients participated voluntarily in the study and did not receive a reward for taking part.

Caregivers

Caregivers from Tactus took part in the study. Caregivers were nurses, nurse specialists, and addiction doctors. The videoconferencing group consisted of five nurses, three nurse specialists, and one addiction doctor; the telephone group consisted of two nurses and one addiction doctor. In both treatment groups, the nurses and nurse specialists were women, and the addiction doctors were men. Furthermore, there were no inclusion criteria in order to take part in the study. Lastly, caregivers also did not receive a reward for taking part in the study, but simply received their normal salary.

Intervention

Outpatient Alcohol Detoxification

The outpatient alcohol detoxification consisted of a registration procedure, predetoxification phase, and detoxification phase. After the registration procedure and the predetoxification phase, individual agreements were made between a caregiver and the patient regarding face-to-face contact, and videoconferencing or telephone contact. The agreements were tailored to personal needs, because every patient reacts differently to a detoxification. Every patient received at least two home visits from a caregiver during the detoxification phase; the other contacts consisted of videoconferencing or telephone contact. Patients in the videoconferencing group had videoconferencing contact next to home visits and patients in the telephone group had telephone contact next to home visits. Besides these appointments, all patients also had the opportunity to make telephone calls to nurses and nurse specialists from Tactus, during office hours, for questions or support. Outside office hours, all patients could ask questions by making telephone calls to a general practice center, so that the general practitioner could contact the medical night shift or medical weekend shift of Tactus in case of complications. Furthermore, if the patient had signed a declaration of consent, the support system of the patient (i.e., the individual from the home environment of the patient who takes part in the outpatient alcohol detoxification as a caregiver) was allowed to make contact with the caregivers throughout the whole week and vice versa. What could be discussed between the support system and the caregivers was agreed upon in advance with the patient in the declaration of consent.

For all patients, the detoxification phase started on a Monday or Tuesday, lasted seven to ten days, and was then terminated by a nurse or the addiction doctor. On every weekday the patient had contact with a caregiver. Which caregiver had contact with the patient was dependent on which of the caregivers was working. During these contacts, the alcohol

withdrawal symptoms were checked, the alcohol craving was discussed, the patient was monitored for complications, and the patient's mood problems were estimated. During face-to-face contact, the patient's blood alcohol concentration, blood pressure, and pulse rate were also measured. During all contacts, several relevant topics were also discussed with the patient: the general condition of the patient; the course of the outpatient alcohol detoxification (based on complaints); the use of other substances; a possible relapse; the possible (side-)effects of the medication; the non-specific complaints; how the patient could, and/or should deal with existing complaints; the advantages and disadvantages of alcohol use and the abstinence of alcohol use; and the starting point of the alcohol detoxification.

Mobiléa

Mobiléa (2020) was the software that was used for the videoconferencing contact. Mobiléa works on smartphones, tablets, and computers, and gives users the opportunity to videoconference, chat, and exchange information and files with each other. Mobiléa is easy to use: With one or two clicks, the user can have contact through videoconferencing. Therefore, Mobiléa was also suitable for individuals with little digital knowledge.

Measures

Although more measures were used in the study, I only describe parts of measures that were used for the present study.

Baseline Questionnaire

The baseline questionnaire was developed by the researcher of Tactus. Patients reported their surname and date of birth. Based on the prefix (Mr. or Mrs.) before the reported surname, the patient's gender (male or female, respectively) was deduced. The patient's age was deduced on the basis of their date of birth and the request date for an alcohol detoxification.

Revised Clinical Institute Withdrawal Assessment for Alcohol Scale

The Revised Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar) is a 10-item symptom scale that assesses the severity of alcohol withdrawal. The CIWA-Ar is a valid scale and has demonstrated high inter-rater reliability ($r > .80$; Sullivan et al., 1989).

During the detoxification phase, the CIWA-Ar was administered by the caregiver to the patient at least on the first three days and was continued if necessary, until alcohol withdrawal symptoms decreased. The scoring of the CIWA-Ar was also done by the caregiver. Most of the patients were assessed through a version of the CIWA-Ar whereby the CIWA-Ar was administered once a day; however, three patients of the telephone group were

assessed through an elaborated version of the CIWA-Ar that could be administered four times a day at specific timepoints (i.e., 9 a.m., 1 p.m., 5 p.m., and 10 p.m.). The reason for this exception is unknown. It is unclear whether the CIWA-Ar was administered during face-to-face, videoconferencing, or telephone contact.

The three symptoms of the CIWA-Ar that were used in the present study were: tremor, paroxysmal sweats, and agitation. All three symptoms were scored on a Likert scale ranging from 0 to 7 (see Sullivan et al., 1989, for more detail), whereby the scores were only based on the observation of the caregiver.

Evaluation Questionnaires

The evaluation questionnaires were also developed by the researcher of Tactus. The majority of the patients and caregivers received the same evaluation questionnaires. Only one patient of the videoconferencing group and her caregiver received a different evaluation questionnaire. The reason for this exception is unknown. From these different evaluation questionnaires, only questions that were identical to the questions of the majority of the evaluation questionnaires were used in the present study.

Caregivers reported their name; because there were no unisex names, the gender of the caregivers was deduced from their first name. Furthermore, patients and caregivers were asked both multiple-choice and open-ended questions. There were in total four different questionnaires (see Appendices A–D), because there were two treatment groups (i.e., videoconferencing group and telephone group) and two respondent groups (i.e., patients and caregivers). The questionnaire of the patients and caregivers in the videoconferencing group consisted of 17 and 19 questions respectively; the questionnaire of the patients and caregivers in the telephone group consisted of 12 and nine questions respectively. Taken together, the main themes in the evaluation questionnaires were: the previous alcohol detoxification of the patient; (the satisfaction with) the outpatient alcohol detoxification; the contact between patients and caregivers; the perspectives on, and experiences with videoconferencing; and the videoconferencing software.

Procedure

Patients who registered themselves for an alcohol detoxification at Tactus in the Dutch cities Almelo and Zutphen were first checked on the inclusion criteria by a nurse specialist or the addiction doctor. If patients matched the inclusion criteria, they were asked to participate in the study. Patients who agreed to participate in Almelo were asked to take part in the videoconferencing group; patients who agreed to participate in Zutphen were asked to take

part in the telephone group. After signing informed consent, the patient was able to start with the outpatient alcohol detoxification. Patients in the videoconferencing group who did not have a smartphone, tablet, or personal computer, could borrow a tablet from Tactus after signing a specific agreement form. At the end of the outpatient alcohol detoxification, the patient and a random caregiver filled in the evaluation questionnaire.

Data Analysis

Statistical analyses were performed using IBM SPSS Statistics (Version 25).

Firstly, baseline characteristics were reported as numbers, means, and standard deviations for continuous variables, and as numbers and percentages for categorical variables. Due to the small number of patients, patients' baseline characteristics were reported at an individual level. Where possible, missing data was supplemented by the researcher of Tactus, based on data from patients' electronic health records of Tactus and based on general verbal comments.

Secondly, the evaluation questionnaires were analysed. Per respondent group, treatment groups were compared on a number of identical questions. Here, for both treatment groups, sample sizes, means and standard deviations were presented, with independent samples *t*-tests for group comparisons. A *p*-value of .05 (two-tailed) was considered statistically significant. Remaining multiple-choice questions were analysed including numbers, means, standard deviations, and percentages. The answers on the remaining open-ended questions were primarily clustered in self-made categories based on the respondents' general intentions, and where possible, were provided with the number of respondents who mentioned these subjects. Some answers of these open-ended questions were reported verbatim.

Lastly, the three symptoms of the CIWA-Ar were evaluated. For each patient with the elaborated CIWA-Ar, for each symptom, first the mean score per day was calculated. Then, for each symptom, per treatment group the mean scores over time during the outpatient alcohol detoxification were descriptively evaluated. The patient's first day of the outpatient alcohol detoxification was set as Day 1. Furthermore, information from the evaluation questionnaires and general verbal comments from the researcher of Tactus were mentioned.

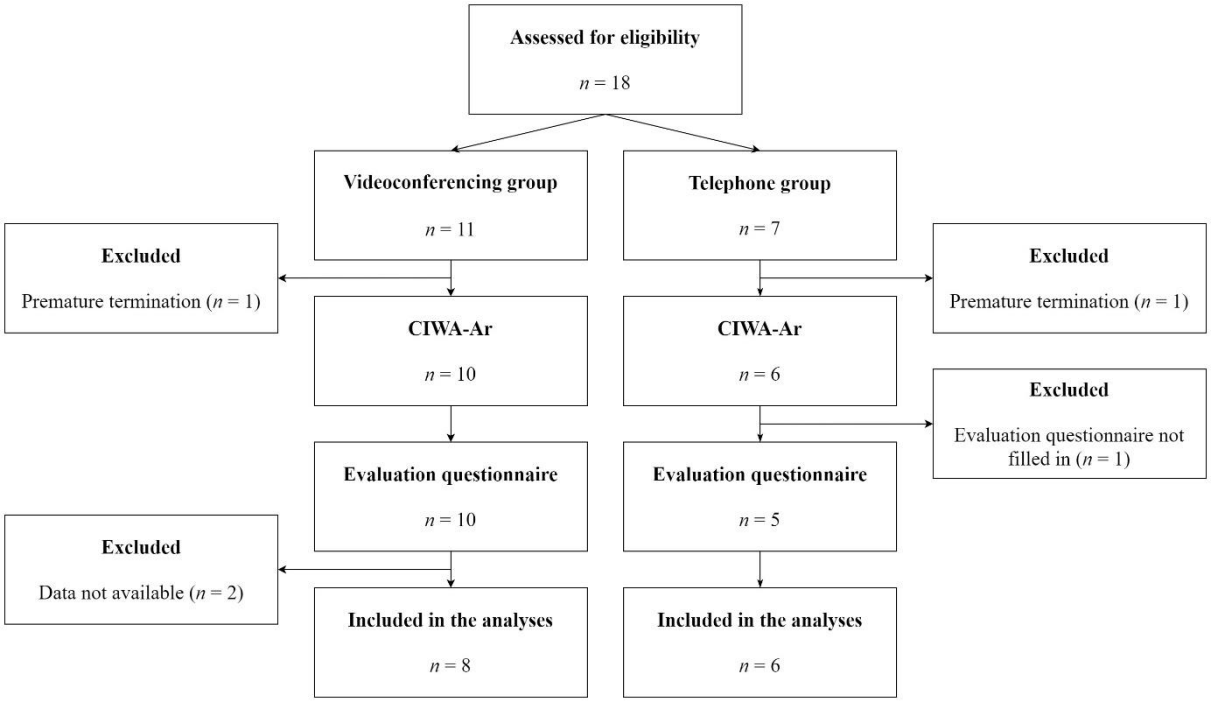
Results

Patients' Characteristics

Eighteen patients who matched the inclusion criteria took part in the study, either in the videoconferencing group (n = 11) or in the telephone group (n = 7). Figure 1 provides an overview of the patient flow. Eventually, data from 14 patients was available and only the data of these patients was included in the analyses.

Figure 1

Patient Flow



In Table 1, the baseline characteristics of the patients are presented. Of the patients in the videoconferencing group, the gender of four patients and the age of three patients were not reported. Of the remaining patients in the videoconferencing group (n = 5, M = 43.6 years, SD = 11.1), two patients were men and two patients were women. Patients in the telephone group were all men (n = 6, M = 52.8 years, SD = 10.9). Furthermore, less patients in the videoconferencing group received previous alcohol detoxification (n = 4, 50%), compared to the telephone group (n = 5, 83.3%).

Table 1

Patients' Characteristics at Baseline

Patient	Treatment group	Gender	Age	Previous alcohol detoxification
1	Videoconferencing	Woman	47	Outpatient (unclear how many times)
2	Videoconferencing	Man	44	Inpatient (n = 4) and outpatient (n = 1)
3	Videoconferencing	–	62	Unclear
4	Videoconferencing	–	–	Inpatient (unclear how many times)
5	Videoconferencing	–	–	None
6	Videoconferencing	–	–	Outpatient (unclear how many times)
7	Videoconferencing	Woman	36	None
8	Videoconferencing	Man	29	None
9	Telephone	Man	65	Inpatient and outpatient (unclear how many times)
10	Telephone	Man	40	Inpatient (unclear how many times)
11	Telephone	Man	45	Unclear
12	Telephone	Man	70	Inpatient (unclear how many times)
13	Telephone	Man	46	Inpatient and outpatient (unclear how many times)
14	Telephone	Man	51	Inpatient and outpatient (unclear how many times)

Note. Data that was not reported is shown as a dash.

Caregivers' Characteristics

For every patient, a random caregiver filled in the evaluation questionnaire. All caregivers (n = 8) in the videoconferencing group were women. One caregiver had filled in two evaluation questionnaires. From three evaluation questionnaires it was unclear who had filled them in, however, the researcher of Tactus mentioned that all evaluation questionnaires from the videoconferencing group were filled in by women. Furthermore, in the telephone group (n = 6), two caregivers were women and one caregiver was a man. The male caregiver had filled in four evaluation questionnaires.

Satisfaction With the Outpatient Alcohol Detoxification

Table 2 shows patients' and caregivers' satisfaction with the outpatient alcohol detoxification. For both patients and caregivers, there were no significant differences in any of the satisfaction items between both treatment groups. Patients and caregivers in both treatment groups were on average satisfied with the outpatient alcohol detoxification. However, for patients there appeared to be a trend in the direction of higher satisfaction in the videoconferencing group regarding satisfaction in general and the grade of the outpatient alcohol detoxification.

Furthermore, all patients reported that they had been well informed about the method of the outpatient alcohol detoxification (n = 13), that the assistance was easily accessible (n = 12), and that the number of contacts with the caregivers was sufficient (n = 12). Also, all caregivers found that the number of contacts with the patient was sufficient (n = 13) and that it was easy to get in touch with the patient (n = 14).

Table 2

Satisfaction With the Outpatient Alcohol Detoxification, by Treatment Group

Variable	Videoconferencing group			Telephone group			*p*
	n	*M*	*SD*	*n*	*M*	*SD*	
Patients							
Satisfaction in general [a]	8	4.75	.71	5	4.20	.45	.15
The guidance [a]	8	4.75	.46	5	4.60	.55	.61
The result [a]	8	4.13	1.13	5	4.00	.71	.83
The grade [b]	8	8.44	.90	5	7.80	1.10	.28
Caregivers							
The course [a]	7	4.14	1.07	6	4.33	.52	.70
The result [a]	8	4.25	1.04	6	4.33	1.21	.89
The method [a]	8	4.63	.52	6	4.50	.55	.67

Note. [a] Based on a Likert scale ranging from 1 (*very dissatisfied*) to 5 (*very satisfied*).

[b] Based on a scale ranging from 0 (*very bad*) to 10 (*excellent*).

Videoconferencing Group

During the outpatient alcohol detoxification, on average 5.43 videoconferencing contacts (SD = 2.51, n = 7) were held per patient. For the patient who received the different evaluation questionnaire, the question regarding the number of videoconferencing contacts during the outpatient alcohol detoxification was not included in the evaluation questionnaire. Table 3 presents patients' and caregivers' perspectives on the use of videoconferencing during the outpatient alcohol detoxification. On average, patients and caregivers had a positive perspective on the use of videoconferencing during the outpatient alcohol detoxification.

Table 3

Perspectives on the Use of Videoconferencing During the Outpatient Alcohol Detoxification

Variable	*n*	*M*	*SD*
Patients			
Satisfaction in general [a]	8	4.88	.35
Pleasant experience videoconferencing [b]	7	4.71	.49
Ease of videoconferencing [c]	7	4.00	.82
Positive contribution of videoconferencing [d]	7	4.43	.98
Caregivers			
Satisfaction in general [a]	7	4.57	.54
Positive contribution of videoconferencing [d]	7	4.43	.79

Note. [a] Based on a Likert scale ranging from 1 (*very dissatisfied*) to 5 (*very satisfied*). [b] Based on a Likert scale ranging from 1 *(not at all*) to 5 (*very pleasant*). [c] Based on a Likert scale ranging from 1 (*very difficult*) to 5 (*very easy*). [d] Based on a Likert scale ranging from 1 (*not at all*) to 5 (*very*).

Patients' Perspectives

All patients (*n* = 7) found videoconferencing a good substitute for face-to-face and telephone contact. Furthermore, patients mentioned one or more aspects they liked about videoconferencing. Patients mentioned how fast they could reach the caregivers, and how quickly and properly they were helped. Patients also stated that they liked how much videoconferencing made sure that they could have a proper conversation with the caregivers, in which they could also see each other. Additionally, one patient stated that she liked the fact that she did not need to go to Tactus for every appointment, and one patient mentioned that the contact through videoconferencing is better compared to telephone contact.

When patients had to report what they did not like about videoconferencing, six patients did not give (specific) comments, one patient mentioned that patients could not be monitored, and another patient stated that she disliked that she herself came into view during videoconferencing.

Caregivers' Perspectives

All caregivers were satisfied with the quality of the connection (*n* = 6), reported that the software was easy to operate for the patient and themselves (*n* = 7), found videoconferencing a good substitute for face-to-face or telephone contact (*n* = 7), found that the treatment got more effective through the use of videoconferencing (*n* = 7), thought that videoconferencing saved time (*n* = 7), and mentioned that videoconferencing is a good tool to generally increase the number of patients who need to detox (*n* = 7).

Caregivers also gave one or more comments regarding the positive aspects of videoconferencing and how videoconferencing increased the effectiveness of the treatment. Caregivers mentioned that they could respond to, and contact the patients very quickly. They also mentioned that they could speak with more patients in a short time than they could otherwise. Furthermore, caregivers stated that they liked the fact that they also had direct visual contact with the patient and that they could properly keep an eye on the patient. Lastly, some caregivers also mentioned that they liked that the contact with the patient was short, intensive, and effective.

When caregivers had to report limitations of videoconferencing, six caregivers did not, or could not give an answer, and two caregivers mentioned internet connection related problems.

Telephone Group

During the outpatient alcohol detoxification, only three out of the five (60%) patients had telephone contact with a caregiver. For the patient who had not filled in the evaluation questionnaire, this and other data was not available. It is remarkable that during the outpatient alcohol detoxification, two out of the five (40%) patients did not make use of the option to have telephone contact with a caregiver next to home visits. Reasons for this were also not available.

Patients' Perspectives

None (n = 5) of the patients did have telephone contact with a caregiver on times where they would have preferred to see the caregiver in person.

If videoconferencing would have been an option, two patients definitely would have liked to use it, two patients maybe would have liked to use it, and one patient certainly would not have liked to use it. The patients who would definitely have liked to use videoconferencing, mentioned as reasons that "everyone does it" and that "it would be nice to see a face", and one of the patients who mentioned to maybe have liked to use videoconferencing, stated as a reason that he is quite digitally illiterate.

Caregivers' Perspectives

None (n = 6) of the caregivers found the travel distance between them and the patient an obstacle to face-to-face contact, and none (n = 5) of the caregivers have made contact by phone that they would rather have done face-to-face.

If videoconferencing would have been an option, three caregivers would have liked to make use of it, two caregivers maybe would have liked to make use of it, and one caregiver

would not have liked to make use of it. The three caregivers who would have liked to make use of videoconferencing gave either no explanation, or gave an explanation that was unspecified or unclear. Of the two caregivers who maybe would have liked to make use of videoconferencing, one caregiver explained that “the language skills of the patient were slightly limited” and the other caregiver gave the explanation “if there would be no time”. The caregiver who would not have liked to make use of videoconferencing, explained that the patient did not want this.

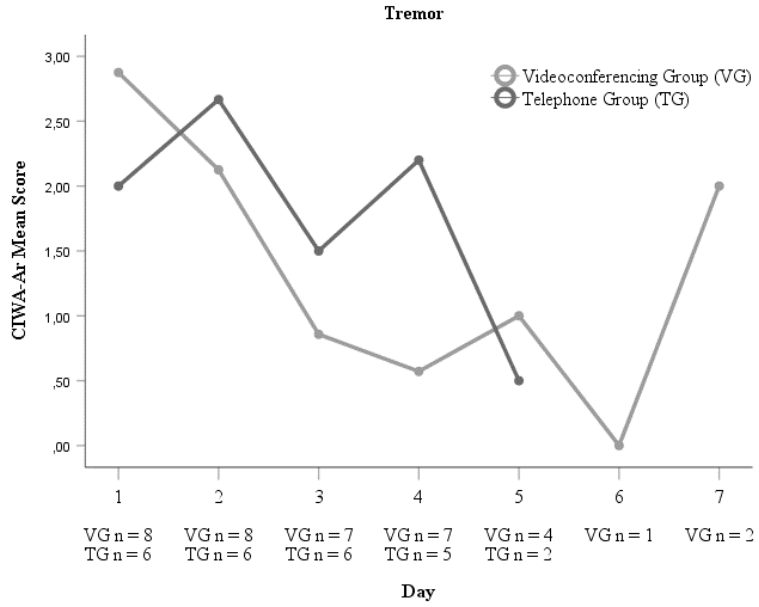
Alcohol Withdrawal Symptoms

The CIWA-Ar mean scores for the three symptoms are shown in Figure 2. The figure shows that caregivers observed differences in symptom severity over time. The mean scores per treatment group on all three symptoms decreased over time, with some fluctuation during this decrease for the symptoms tremor and agitation. Furthermore, whether videoconferencing contact stopped after the first seven days and telephone contact stopped after the first five days of the outpatient alcohol detoxification is unclear. From those days onward, it was only known that the CIWA-Ar was not scored anymore.

Furthermore, caregivers in both treatment groups did not mention negative comments in the evaluation questionnaires regarding administering the CIWA-Ar through videoconferencing or the telephone. Caregivers from the videoconferencing group however, mentioned to the researcher of Tactus that the connection and picture quality of Mobiléa (2020) were good enough to be able to assess patients’ alcohol withdrawal symptoms in general through videoconferencing, and that administering the CIWA-Ar through videoconferencing saved time and therefore could have been administered more often. Caregivers in the telephone group and patients in both treatment groups made no remarks towards the researcher of Tactus. Altogether, caregivers, mostly from the videoconferencing group, seemed quite positive about digitally assessing patients’ alcohol withdrawal symptoms.

Figure 2

CIWA-Ar Mean Scores Over Time During the Outpatient Alcohol Detoxification



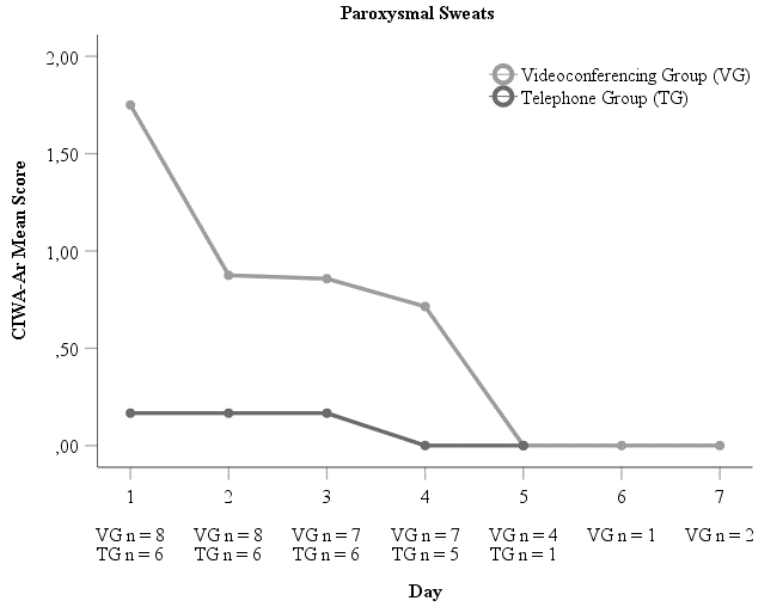
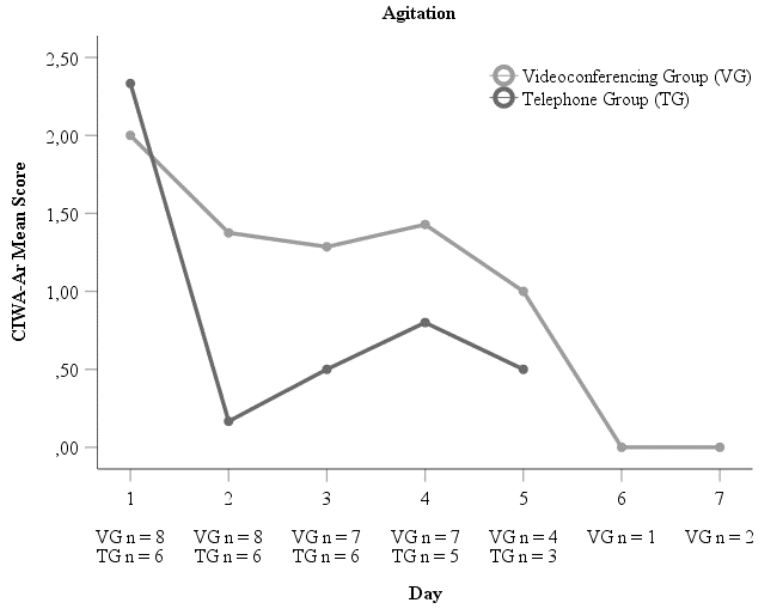


Figure 2 *(continued)*

CIWA-Ar Mean Scores Over Time During the Outpatient Alcohol Detoxification



Discussion

Main Results

The aims of the present study were to gain more insight into patients' and caregivers' perspectives on a videoconferencing-based and a telephone-based outpatient alcohol detoxification, and to investigate whether it is possible for caregivers to accurately assess patients' alcohol withdrawal symptoms digitally. The study showed that patients and caregivers were satisfied with both types of the outpatient alcohol detoxification. However, patients seemed to have a slight preference for the videoconferencing-based outpatient alcohol detoxification. Patients and caregivers also had a positive perspective on the use of videoconferencing during the outpatient alcohol detoxification. Furthermore, the study showed that caregivers believe that it is possible for them to assess patients' alcohol withdrawal symptoms digitally.

Regarding the satisfaction with both types of outpatient alcohol detoxification, to my best knowledge no previous research on this subject is known. Therefore, no statements can be made as to how the current findings relate to previous research regarding outpatient alcohol detoxification. However, in a related study field, Richter et al. (2015) researched the difference between videoconferencing and telephone counselling for smoking cessation, and showed that participants' satisfaction with the study was high. The only difference in

satisfaction between the two treatment groups was that the videoconferencing group was significantly more likely to recommend the treatment to their social group, compared to the telephone group. Through combining these results, it is apparent that treatments in which videoconferencing or the telephone is used, are assessed as satisfactory. However, it seems that videoconferencing adds something more to the treatment, because the treatments that included videoconferencing were assessed more positively or were more likely to be recommended than the treatments that included the telephone. This raises some questions, such as whether this implies that videoconferencing is more attractive than telephone contact, or whether videoconferencing adds more to the treatment than telephone contact.

Related to these questions, the present study also showed that all patients in the videoconferencing group had videoconferencing contact with a caregiver, whereas not all patients in the telephone group had telephone contact with a caregiver. Furthermore, the study showed that both patients and caregivers found videoconferencing a good substitute for telephone contact. Regarding the difference between videoconferencing and telephone contact, a previous qualitative study about videoconferencing consultation in primary care noticed several advantages of videoconferencing over telephone contact: being able to notice non-verbal cues, having a reduced risk of miscommunication, and being more personal, reassuring, formal, and focused (Donaghy et al., 2019).

Patients and caregivers were also positive about the use of videoconferencing during the outpatient alcohol detoxification. Furthermore, patients and caregivers found that videoconferencing contributed fairly positively to the outpatient alcohol detoxification, and caregivers also found that the outpatient alcohol detoxification got more effective through the use of videoconferencing. The positive perspectives on the use of videoconferencing are in line with previous research. Frueh et al. (2005) studied videoconferencing open-group therapy sessions for patients with a diagnosis of alcohol abuse or dependence. The study found that high levels of satisfaction with, and acceptance of the videoconferencing service delivery mode were reported by patients. Furthermore, Richardson et al. (2009) mentioned in their review in which they included studies about videoconferencing in mental health, several studies wherein clinicians reported to be satisfied with videoconferencing technology after using it, even though they had concerns before using it.

Although the perspectives on the use of videoconferencing were positive, one limitation of videoconferencing was pointed out, which was internet connection related problems. Therefore, it is suggested that a precondition for the use of videoconferencing is that the internet connection should be good. Bad internet connection could, for example, lead

to bad quality of the visual and auditory information transmission, which has already been reported as a barrier in using videoconferencing (Bywood et al., 2013).

Next, the present study showed that caregivers did score the alcohol withdrawal symptoms of the CIWA-Ar, that caregivers observed differences in symptom severity over time, and that caregivers found videoconferencing suitable to assess patients' alcohol withdrawal symptoms in general. However, it is unclear whether the assessment of the alcohol withdrawal symptoms was done accurately. As far as I know, there have not been previous studies regarding the accurate assessment of withdrawal symptoms in substance abuse treatment through videoconferencing or telephone contact. Therefore, no statements can be made about findings of previous research. To examine whether it is possible to accurately assess alcohol withdrawal symptoms digitally, a research suggestion will be proposed in the Future Research section. Furthermore, in the present study it was assumed that the CIWA-Ar was administered during videoconferencing or telephone contact, but as mentioned before, this was unclear. This also became apparent, because the two patients in the telephone group who had no telephone contact with a caregiver, were administered with the CIWA-Ar too. Consequently, the results of the telephone group should be interpreted with caution.

Strengths and Limitations

The study had several strengths. Firstly, the study was carried out within the everyday setting of the addiction care, with a complex target group. Secondly, data has been collected from both patients and caregivers. Thirdly, according to the researcher from Tactus, caregivers in the videoconferencing group liked the use of videoconferencing so much, that they did not want to stop with this pilot. Lastly, patients in the videoconferencing group all used the same software for the videoconferencing contact. In this way, factors that could be associated with different kinds of videoconferencing software, such as the ease of use of videoconferencing, could be accounted for.

Although the study yielded interesting results, there are also limitations that should be acknowledged. Firstly, although the study was carried out before the Corona crisis, the Corona crisis has had an impact on the present study, because caregivers of Tactus had no time to invest in side issues, such as sorting out missing data of the study. Secondly, this study was dependent on data that was collected by the researcher of Tactus. In the collected data there were data gaps. The evaluation questionnaires of the telephone group were lacking questions about the perspectives on the use of the telephone during the outpatient alcohol detoxification. Also, there was no data available regarding during which contacts the CIWA-

Ar was administered. Consequently, investigating whether alcohol withdrawal symptoms could be assessed digitally could not properly be tested. This data could probably have been sorted out, but due to the Corona crisis it was not. Thirdly, the chat function of Mobiléa (2020) was also used by the patients, although the researcher of Tactus decided to not make use of the function and therefore had not informed the patients about its use. A consequence is that patients' opinions on the entire evaluation questionnaire could be biased, because they could have evaluated the chat function as (part of) videoconferencing. Fourthly, conducting research in daily practise was difficult. The researcher of Tactus mentioned that although caregivers were glad to help with the study, as soon as something happened, the study was the last thing caregivers spent time on. As a consequence, the collected data was incomplete and unclear. The overarching point of the second, third, and fourth limitations is that the types of research that are carried out in daily practice by professionals are very valuable, because they are current and relevant, but that these types of research are often insufficiently prepared and carried out too hastily, and therefore their limitations become apparent afterwards. Fifthly, the study had small patient and caregiver sample sizes, and little gender variety in the caregiver sample. Finally, there have been aspects of the study that should have been done differently. Suggestions will be made in the Future Research section.

Future Research

The next step is to, on a larger scale, collect data regarding the difference between face-to-face, videoconferencing, and telephone contact during a complete outpatient alcohol detoxification. It is recommended to use various extensive evaluation questionnaires and semi-structured interviews in order to collect patients' and caregivers' opinions on the satisfaction with, perspectives on, and effectiveness of the three types of outpatient alcohol detoxification. It is also important to investigate what specific aspects of the three treatment delivery modes are of added value to the outpatient alcohol detoxification. In order to collect unbiased perspectives and opinions, this study should also be carried out in daily practice.

Furthermore, in order to examine whether alcohol withdrawal symptoms can accurately be assessed digitally, the inter-rater reliability of the CIWA-Ar should be evaluated. In order to evaluate the inter-rater reliability, the correlation between the scores on the CIWA-Ar of two caregivers should be calculated. Two caregivers should administer and score the CIWA-Ar after each other: One of the caregivers should administer the CIWA-Ar to the patient face-to-face, while the second caregiver should only observe and interact with the same patient through videoconferencing or the telephone. Because conducting the CIWA-Ar

face-to-face has already been proven reliable, it is essential to compare the digitally performed assessments with the face-to-face assessments in order to confirm whether these digital delivery modes are accurate. In order to measure the difference between the treatment delivery modes instead of the difference between caregivers, caregivers' subjectivity in scoring the symptoms must be minimised. This can be achieved by training caregivers in how to accurately score the symptoms of the CIWA-Ar.

For Tactus, it will be interesting to investigate whether more alcohol detoxifications have been carried out in the outpatient setting due to the Corona crisis, and to compare the results of the present study with patients' and caregivers' opinions regarding the use of videoconferencing and the telephone during the outpatient alcohol detoxification during the Corona crisis.

Implications

For Tactus, it is suggested to let more patients detox from alcohol in an outpatient setting, because both patients and caregivers are satisfied with the two types of outpatient alcohol detoxification. It is also suggested to make use of videoconferencing for all patients during the outpatient alcohol detoxification, because patients and caregivers have a positive perspective on the use of videoconferencing and see its benefits. Through the use of videoconferencing, caregivers can have short, intensive, and effective contact with patients, whereby patients are helped quickly and properly. By saving time, the number of patients to whom detoxification can be offered, can be increased. Furthermore, visual contact is available, through which the caregiver can keep an eye on the patient. Also, the patient can have contact with the caregiver in the comfort of their home environment. Patients who are digitally illiterate, should however first be taught how to use the videoconferencing device and software.

Conclusion

Outpatient alcohol detoxification with the use of videoconferencing or with the use of telephone contact are good methods to expand the outpatient care with. Because patients and caregivers have a positive perspective on the use of videoconferencing and see its benefits, also for the assessment of patients' alcohol withdrawal symptoms, it is suggested to let more patients detox from alcohol through a videoconferencing-based outpatient alcohol detoxification.

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Appendix A

Evaluation Questionnaire Videoconferencing Group – Patient

U heeft een ambulante alcohol detox gehad. Deze vragenlijst is onderdeel van een onderzoek naar uw tevredenheid hierover. Het invullen hiervan kost 3 minuten. / ***You have had an outpatient alcohol detox. This questionnaire is part of a study about your satisfaction about this. It takes 3 minutes to complete it.***

Cliëntnummer: / *Patient number:*

Datum: / *Date:*

1. Heeft u eerder een alcohol detox gehad? / *Have you had an alcohol detox before?*
    - Ja / *Yes*
    - Nee / *No*

1A. Zo ja, was dit toen ambulant of klinisch (meerdere antwoorden mogelijk)? / *If so, was this outpatient or inpatient (multiple answers possible)?*

- Ambulant / *Outpatient*
- Klinisch / *Inpatient*

2. Hoe tevreden bent u over deze ambulante detox? / *How satisfied are you with this outpatient detox?*
    - Zeer tevreden / *Very satisfied*
    - Tevreden / *Satisfied*
    - Neutraal / *Neutral*
    - Ontevreden / *Dissatisfied*
    - Zeer ontevreden / *Very dissatisfied*
3. Bent u goed geïnformeerd over de werkwijze van deze ambulante detox? / *Have you been well informed about the method of this outpatient detox?*
    - Ja / *Yes*
    - Nee / *No*
    - Een beetje / *A little*
4. Hoe tevreden bent u over de begeleiding door uw hulpverleners bij de ambulante detox? / *How satisfied are you with the guidance by your caregivers in the outpatient detox?*
    - Zeer tevreden / *Very satisfied*
    - Tevreden / *Satisfied*

- Neutraal / *Neutral*
- Ontevreden / *Dissatisfied*
- Zeer ontevreden / *Very dissatisfied*

5. Hoe tevreden bent u over het resultaat van de ambulante detox? / *How satisfied are you with the result of the outpatient detox?*
    - Zeer tevreden / *Very satisfied*
    - Tevreden / *Satisfied*
    - Neutraal / *Neutral*
    - Ontevreden / *Dissatisfied*
    - Zeer ontevreden / *Very dissatisfied*
6. Was de hulpverlening goed bereikbaar? / *Was the assistance easily accessible?*
    - Ja / *Yes*
    - Nee / *No*
7. Was het aantal keer dat u contact had met een hulpverlener voldoende? / *Was the number of times you had contact with a caregiver sufficient?*
    - Ja / *Yes*
    - Nee, liever minder / *No, rather less*
    - Nee, liever vaker / *No, rather more often*
8. Hoe tevreden bent u over het gebruik van beeldbellen in deze behandeling? / *How satisfied are you with the use of videoconferencing in this treatment?*
    - Zeer tevreden / *Very satisfied*
    - Tevreden / *Satisfied*
    - Neutraal / *Neutral*
    - Ontevreden / *Dissatisfied*
    - Zeer ontevreden / *Very dissatisfied*
9. Heeft u het beeldbellen als prettig ervaren? / *Have you experienced the videoconferencing as pleasant?*
    - Heel erg prettig / *Very pleasant*
    - Nogal prettig / *Quite pleasant*
    - Een beetje / *A little*
    - Nauwelijks / *Barely*
    - Helemaal niet / *Not at all*

    Toelichting … / *Explanation …*
10. Vond u het beeldbellen moeilijk? / *Did you find the videoconferencing difficult?*

- Heel erg moeilijk / *Very difficult*
- Nogal moeilijk / *Quite difficult*
- Een beetje moeilijk / *A little bit difficult*
- Makkelijk / *Easy*
- Zeer makkelijk / *Very easy*

11. Vindt u beeldbellen een goede vervanger van een echt contact? / *Do you consider videoconferencing a good substitute for real contact?*
    - Ja / *Yes*
    - Nee / *No*
12. Vindt u beeldbellen een goede vervanger van een telefonisch contact? / *Do you consider videoconferencing a good substitute for telephone contact?*
    - Ja / *Yes*
    - Nee / *No*
13. Heeft het beeldbellen positief bijgedragen aan de behandeling? / *Did the videoconferencing contribute positively to the treatment?*
    - Heel erg / *Very*
    - Behoorlijk / *Fairly*
    - Een beetje / *A little*
    - Nauwelijks / *Barely*
    - Helemaal niet / *Not at all*
14. Kunt u omschrijven wat u prettig vond aan het beeldbellen? / *Can you describe what you liked about the videoconferencing?*
15. Kunt u omschrijven wat u niet prettig vond aan het beeldbellen? / *Can you describe what you did not like about the videoconferencing?*
16. Zou u het beeldbellen ook op andere momenten in de behandeling prettig vinden? / *Would you also like the videoconferencing at other times in the treatment?*
17. Welk cijfer zou u aan de ambulante detox willen geven? Een score van 0 tot 10, waarbij een 0 ‘heel erg slecht’ betekent en een 10 ‘uitstekend’. / *What rating would you give the outpatient detox? A score from 0 to 10, where 0 means ‘very bad’ and 10 means ‘excellent’.*

Hartelijk dank voor uw medewerking! / *Thank you for your cooperation!*

Appendix B

Evaluation Questionnaire Videoconferencing Group – Caregiver

Deze vragenlijst is onderdeel naar een onderzoek over ambulante alcohol detox met beeldbellen. Vul per cliënt deze lijst in aan het eind van iedere detox. / *This questionnaire is part of a study about outpatient alcohol detox with videoconferencing. Complete this list per patient at the end of each detox.*

Naam hulpverlener: / *Name caregiver:*

Cliëntnummer: / *Patient number:*

Datum: / *Date:*

1. Hoe tevreden bent u over het algemeen over het verloop van het ambulante detox traject bij deze cliënt? / *How satisfied are you in general with the course of the outpatient detox procedure for this patient?*
    - Zeer tevreden / *Very satisfied*
    - Tevreden / *Satisfied*
    - Neutraal / *Neutral*
    - Ontevreden / *Dissatisfied*
    - Zeer ontevreden / *Very dissatisfied*
2. Hoe tevreden bent u over het resultaat van de ambulante detox? / *How satisfied are you with the result of the outpatient detox?*
    - Zeer tevreden / *Very satisfied*
    - Tevreden / *Satisfied*
    - Neutraal / *Neutral*
    - Ontevreden / *Dissatisfied*
    - Zeer ontevreden / *Very dissatisfied*
3. Hoe tevreden bent u over de werkwijze van het ambulante detox traject? / *How satisfied are you with the method of the outpatient detox procedure?*
    - Zeer tevreden / *Very satisfied*
    - Tevreden / *Satisfied*
    - Neutraal / *Neutral*
    - Ontevreden / *Dissatisfied*
    - Zeer ontevreden / *Very dissatisfied*

4. Was het aantal keer dat u contact had met de cliënt voldoende? / *Was the number of times you had contact with the patient sufficient?*
    - Ja / *Yes*
    - Nee, liever minder / *No, rather less*
    - Nee, liever vaker / *No, rather more often*
5. Was het makkelijk om contact te krijgen met de cliënt? / *Was it easy to get in touch with the patient?*
    - Ja / *Yes*
    - Nee / *No*
6. Hoe tevreden bent u over het gebruik van beeldbellen in deze behandeling? / *How satisfied are you with the use of videoconferencing in this treatment?*
    - Zeer tevreden / *Very satisfied*
    - Tevreden / *Satisfied*
    - Neutraal / *Neutral*
    - Ontevreden / *Dissatisfied*
    - Zeer ontevreden / *Very dissatisfied*
7. Hoe vaak is er tijdens de ambulante detox een beeldbelcontact geweest? / *How many times has there been videoconferencing contact during the outpatient detox?*
   … keer / *... times*
8. Was u tevreden over de kwaliteit van de verbinding? / *Were you satisfied with the quality of the connection?*
    - Ja / *Yes*
    - Nee / *No*
9. Was de software voor de cliënt makkelijk te bedienen? / *Was the software easy to operate for the patient?*
    - Ja / *Yes*
    - Nee / *No*
10. Was de software voor u makkelijk te bedienen? / *Was the software easy to operate for you?*
    - Ja / *Yes*
    - Nee / *No*
11. Heeft het beeldbellen positief bijgedragen aan de behandeling? / *Did the videoconferencing contribute positively to the treatment?*
    - Heel erg / *Very*

- Nogal / *Quite*
- Een beetje / *A little*
- Nauwelijks / *Barely*
- Helemaal niet / *Not at all*

Toelichting … / *Explanation …*

12. Was het beeldbellen een goede vervanger van een face-to-face contact in deze behandeling? / *Was the videoconferencing a good substitute for face-to-face contact in this treatment?*
    - Ja / *Yes*
    - Nee / *No*
13. Was het beeldbellen een goede vervanger van een telefonisch contact in deze behandeling? / *Was the videoconferencing a good substitute for telephone contact in this treatment?*
    - Ja / *Yes*
    - Nee / *No*
14. Wordt de behandeling effectiever door inzet van beeldbellen? / *Does the treatment get more effective through the use of videoconferencing?*
    - Heel erg / *Very*
    - Nogal / *Quite*
    - Een beetje / *A little*
    - Nauwelijks / *Barely*
    - Helemaal niet / *Not at all*

    Toelichting … / *Explanation …*
15. Denkt u dat het beeldbellen in deze behandeling tijdbesparing heeft opgeleverd? / *Do you think that the videoconferencing in this treatment has saved time?*
    - Ja / *Yes*
    - Nee / *No*
16. Is het beeldbellen een goed hulpmiddel om het aantal te detoxen cliënten in het algemeen mee te vergroten? / *Is the videoconferencing a good tool to generally increase the number of patients that need to detox?*
    - Ja / *Yes*
    - Nee / *No*
17. Kunt u omschrijven wat u prettig vond aan het beeldbellen? / *Can you describe what you liked about the videoconferencing?*

18. Kunt u omschrijven wat beperkingen zijn van het beeldbellen in het algemeen? / *Can you describe the limitations of videoconferencing in general?*
19. Zou u andere behandelingen kunnen bedenken waarin u het beeldbellen toe zou kunnen passen? / *Can you think of other treatments in which you could apply the videoconferencing?*

Hartelijk dank voor uw medewerking! / *Thank you for your cooperation*!

Appendix C

Evaluation Questionnaire Telephone Group – Patient

U heeft een ambulante alcohol detox gehad. Deze vragenlijst is onderdeel van een onderzoek naar uw tevredenheid hierover. Het invullen hiervan kost 3 minuten. / ***You have had an outpatient alcohol detox. This questionnaire is part of a study about your satisfaction about this. It takes 3 minutes to complete it.***

Cliëntnummer: / *Patient number:*

Datum: / *Date:*

1. Heeft u eerder een alcohol detox gehad? / *Have you had an alcohol detox before?*
    - Ja / *Yes*
    - Nee / *No*

1A. Zo ja, was dit toen ambulant of klinisch (meerdere antwoorden mogelijk)? / *If so, was this outpatient or inpatient (multiple answers possible)?*

- Ambulant / *Outpatient*
- Klinisch / *Inpatient*

2. Hoe tevreden bent u over deze ambulante detox? / *How satisfied are you with this outpatient detox?*
    - Zeer tevreden / *Very satisfied*
    - Tevreden / *Satisfied*
    - Neutraal / *Neutral*
    - Ontevreden / *Dissatisfied*
    - Zeer ontevreden / *Very dissatisfied*
3. Bent u goed geïnformeerd over de werkwijze van deze ambulante detox? / *Have you been well informed about the method of this outpatient detox?*
    - Ja / *Yes*
    - Nee / *No*
    - Een beetje / *A little*
4. Hoe tevreden bent u over de begeleiding door uw hulpverleners bij de ambulante detox? / *How satisfied are you with the guidance by your caregivers in the outpatient detox?*
    - Zeer tevreden / *Very satisfied*
    - Tevreden / *Satisfied*

- Neutraal / *Neutral*
- Ontevreden / *Dissatisfied*
- Zeer ontevreden / *Very dissatisfied*

5. Hoe tevreden bent u over het resultaat van de ambulante detox? / *How satisfied are you with the result of the outpatient detox?*
    - Zeer tevreden / *Very satisfied*
    - Tevreden / *Satisfied*
    - Neutraal / *Neutral*
    - Ontevreden / *Dissatisfied*
    - Zeer ontevreden / *Very dissatisfied*
6. Was de hulpverlening goed bereikbaar? / *Was the assistance easily accessible?*
    - Ja / *Yes*
    - Nee / *No*
7. Was het aantal keer dat u contact had met een hulpverlener voldoende? / *Was the number of times you had contact with a caregiver sufficient?*
    - Ja / *Yes*
    - Nee, liever minder / *No, rather less*
    - Nee, liever vaker / *No, rather more often*
8. Waren er telefonische contacten? / *Was there telephone contact?*
    - Ja / *Yes*
    - Nee / *No*
9. Waren er telefonische contacten op een moment dat u liever de hulpverlener persoonlijk had gezien? / *Has there been telephone contact at a time when you would have preferred to see the caregiver in person?*
    - Ja / *Yes*
    - Nee / *No*

    Toelichting … / *Explanation …*
10. Stel dat beeldbellen (bellen met videoverbinding) een optie was geweest, had u daar dan gebruik van willen maken? / *Suppose videoconferencing (calling with video connection) had been an option, would you have liked to use it?*
    - Zeer zeker / *Definitely*
    - Misschien / *Maybe*
    - Zeker niet / *Certainly not*

    Toelichting … / *Explanation …*

11. Heeft u nog opmerkingen? / *Do you have any comments?*
12. Welk cijfer zou u aan de ambulante detox willen geven? Een score van 0 tot 10, waarbij een 0 ‘heel erg slecht’ betekent en een 10 ‘uitstekend’. / *What rating would you give the outpatient detox? A score from 0 to 10, where 0 means ‘very bad’ and 10 means ‘excellent’.*

Hartelijk dank voor uw medewerking! / *Thank you for your cooperation*!

Appendix D

Evaluation Questionnaire Telephone Group – Caregiver

Deze vragenlijst is onderdeel naar een onderzoek over ambulante alcohol detox met beeldbellen. Vul per cliënt deze lijst in aan het eind van iedere detox. / *This questionnaire is part of a study about outpatient alcohol detox with videoconferencing. Complete this list per patient at the end of each detox.*

Naam hulpverlener: / *Name caregiver:*

Cliëntnummer: / *Patient number:*

Datum: / *Date:*

1. Hoe tevreden bent u over het algemeen over het verloop van het ambulante detox traject bij deze cliënt? / *How satisfied are you in general with the course of the outpatient detox procedure for this patient?*
    - Zeer tevreden / *Very satisfied*
    - Tevreden / *Satisfied*
    - Neutraal / *Neutral*
    - Ontevreden / *Dissatisfied*
    - Zeer ontevreden / *Very dissatisfied*
2. Hoe tevreden bent u over het resultaat van de ambulante detox? / *How satisfied are you with the result of the outpatient detox?*
    - Zeer tevreden / *Very satisfied*
    - Tevreden / *Satisfied*
    - Neutraal / *Neutral*
    - Ontevreden / *Dissatisfied*
    - Zeer ontevreden / *Very dissatisfied*
3. Hoe tevreden bent u over de werkwijze van het ambulante detox traject? / *How satisfied are you with the method of the outpatient detox procedure?*
    - Zeer tevreden / *Very satisfied*
    - Tevreden / *Satisfied*
    - Neutraal / *Neutral*
    - Ontevreden / *Dissatisfied*
    - Zeer ontevreden / *Very dissatisfied*

4. Was het aantal keer dat u contact had met de cliënt voldoende? / *Was the number of times you had contact with the patient sufficient?*
    - Ja / *Yes*
    - Nee, liever minder / *No, rather less*
    - Nee, liever vaker / *No, rather more often*
5. Was het makkelijk om contact te krijgen met de cliënt? / *Was it easy to get in touch with the patient?*
    - Ja / *Yes*
    - Nee / *No*
6. Was de reisafstand tussen u en cliënt een belemmering voor een face-to-face contact? / *Was the travel distance between you and the patient an obstacle to face-to-face contact?*
    - Ja / *Yes*
    - Nee / *No*
7. Heeft u contacten telefonisch gedaan die u liever face-to-face had willen doen? / *Have you made contact by phone that you would rather have done face-to-face?*
    - Ja / *Yes*
    - Nee / *No*

7A. Zo ja, wat heeft u gemist in het telefonische contact (meerdere antwoorden mogelijk)? / *If so, what did you miss in the telephone contact (multiple answers possible)?*

- Ik kon geen controles doen / *I could not perform any checks*
- Ik kon geen goed beeld krijgen van de staat van de woning / *I could not get a good idea of the state of the house*
- Ik miste oogcontact / *I missed eye contact*
- Ik miste non-verbale communicatie / *I missed non-verbal communication*
- Ik miste fysiek contact / *I missed physical contact*
- Anders, nl. / *Other, namely*

7B. Wat was de reden dat dit geen face-to-face contact was (meerdere antwoorden mogelijk)? / *What was the reason this was not face-to-face contact (multiple answers possible)?*

- Cliënt was niet in staat om te komen naar Tactus locatie / *Patient was not able to come to the Tactus location*
- Hulpverlener was niet in staat om op huisbezoek te gaan (vervoersprobleem) / *Caregiver was not able to go on a home visit (transportation problem)*

- Hulpverlener was niet in staat om op huisbezoek te gaan (tijdsinvestering te groot) / *Caregiver was not able to go on a home visit (time investment too large)*
- Er was maar een kort contact nodig / *Only a short contact was needed*
- Het contact was ongepland / *The contact was unplanned*
- Anders, nl. / *Other, namely*

8. Als u de mogelijkheid tot beeldbellen (telefonisch contact met videoverbinding) had gehad, zou u daar dan gebruik van hebben gemaakt? / *If you had had the option of videoconferencing (telephone contact with video connection), would you have liked to make use of it?*
    - Ja / *Yes*
    - Nee / *No*
    - Misschien / *Maybe*

    Toelichting … / *Explanation …*
9. Heeft u nog opmerkingen? / *Do you have any comments?*

Hartelijk dank voor uw medewerking! / *Thank you for your cooperation*!