

# Help-seeking behaviour and attitudes towards alcohol reduction in men

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| <p><b>To Cite:</b> Kennedy L. Help-seeking behaviour and attitudes towards alcohol reduction in men. JHD. 2021;6(2):405–415.<br/><a href="https://doi.org/10.21853/JHD.2021.138">https://doi.org/10.21853/JHD.2021.138</a></p> <p><b>Corresponding Author:</b><br/>Lauren Kennedy<br/>Melbourne, VIC<br/>Australia<br/><a href="mailto:laurenmaekennedy@gmail.com">laurenmaekennedy@gmail.com</a></p> <p><b>Copyright:</b><br/>©2021 The Authors. Published by Archetype Health Pty Ltd. This is an open access article under the <a href="https://creativecommons.org/licenses/by-nc-nd/4.0/">CC BY-NC-ND 4.0 license</a>.</p> | <p><b>SUMMARY</b><br/>This survey of the literature aims to provide a summary of men's help-seeking behaviour to reduce their alcohol intake and synthesise identified barriers and motivators to this action. Using the Health Belief Model, this review addresses personal variables, individual beliefs, and cues to action. Attitudinal barriers, including concerns of stigma, shame, and embarrassment, were significant. The greatest structural barrier was not knowing where to go for help. Poor problem recognition was also evident through low perceived severity and susceptibility to the harms of alcohol.</p> <p><b>Key Words</b><br/>Help-seeking; alcohol; men's health</p> |
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## ABSTRACT

### Background

In Australia excessive alcohol consumption is still high amongst males, placing them at greater risk of alcohol-related harms and chronic disease later in life. Despite this, within primary care males have poor usage of health services and opportunistic prevention.

### Aims

This review aims to provide a critical summary of men's help-seeking behaviour to reduce their alcohol intake and to synthesise identified barriers and motivators to this action.

### Method

A literature search was conducted in three databases (CINAHL, Medline, and PsychInfo) using both MeSH and keywords covering key themes. Articles were analysed against inclusion and exclusion criteria leaving 18 articles included in the review. The Critical Appraisal Skills Programme Checklists were used to critically assess the studies. Findings were structured using the Health Belief Model. The population examined were adult males from Western countries who currently drink or previously drank alcohol.

### Conclusion

Barriers greatly outweighed motivating factors to reduce alcohol consumption. Identified barriers have strong recurring themes, centring on attitudinal barriers, with the most frequent findings being embarrassment, shame, and stigma. Poor problem recognition was also evident across the literature through low perceived severity and susceptibility to the harms of alcohol and risk of addiction. Finally, the predominant structural barrier reported was not knowing where to go for help.

Addressing the problem from a multidimensional approach is likely to have the greatest impact as complex and interrelated barriers prevent help seeking. Future research is needed to challenge identified barriers men experience to gain greater understanding of what can be done to increase engagement with health services. Findings suggest there remains a significant hindrance in men seeking help for alcohol reduction; however, there is value in screening for problematic alcohol use in those that do visit primary care and expanding the use of online materials to reduce barriers to attendance.

## BACKGROUND

In Australia alcohol has a complex role socially and culturally. While excessive alcohol consumption has been down trending over the past decade, a substantial proportion of men still consume alcohol at harmful levels.<sup>1</sup> According to the *National Health Survey, 2017–2018*, 1 in 4 adult males exceed the recommended limit of two standard drinks per day and more than 1 in 2 exceed four standard drinks on any one occasion, putting them at significantly greater risk of alcohol-related harms.<sup>1</sup> Alcohol-related harms are well documented and broadly include physical injuries, acute and chronic health problems, and psychological problems, all of which negatively impact the community.<sup>2</sup>

Across Australia, men have a greater share of the total disease burden in the population, larger proportion of premature death, and approximately 46 per cent of males are estimated to have one or more of the 10 most common chronic conditions.<sup>1</sup> Excessive alcohol intake contributes to many of these conditions or causes of injury.<sup>1</sup> Despite these facts, men have poor usage of health services and opportunistic prevention within a primary care setting.

This survey of the literature aims to provide a critical summary of men's help-seeking behaviour to reduce their alcohol intake and synthesise identified barriers and motivators to this action. This review provides a thorough analysis by uniformly addressing personal variables, individual beliefs and cues to action, as outlined by the Health Belief Model. Suggestions for practical application and areas of potential future research have been outlined to potentially improve engagement.

## METHOD

A systematic review was conducted in January 2020 through EBSCOhost across databases CINAHL, Medline, and PsychINFO. Results were limited between the years 2008 to 2020. The search strategy used MeSH (medical subject heading) terms and keywords covering key themes: alcohol, help seeking, treatment barriers, attitudes to health, and primary care (Table 1). The results were limited to those published in English resulting in 2,759 unique articles. For the first review, 2,759 articles were reduced to 93 after screening for relevance to the topic. We analysed 93 articles against the inclusion and exclusion criteria (Table 2) leaving 18 articles included in the review (Figure 1).

The Critical Appraisal Skills Programme (CASP) Checklists for cohort studies and qualitative research were used to assess the studies. Of the studies included 6 used qualitative methodologies (i.e., semi-structured interviews and focus groups), while 12 used quantitative methodologies (i.e., questionnaires, large national surveys). Countries covered in order of frequency were United States, Australia, United Kingdom, Sweden, Italy, Germany, Hungary, Latvia, Poland, and Spain. Various ethnicities within each country were included; however, most males were Caucasian.

The Health Belief Model has been used to structure the findings as a narrative (Figure 2). This framework focused attention on demographic and psychological factors, health motivators, perceived barriers, benefits, severity and susceptibility, and cues to action leading to help seeking for alcohol reduction.<sup>3</sup> Help seeking in all the studies was operationalised to men engaging with a healthcare professional regarding alcohol consumption. Particular attention has been given to the perceived barriers, which have been broken down to attitudinal and structural barriers, consistent with the literature and main findings.

## RESULTS

### Demographics

The literature paints a clear picture of the men seeking help for alcohol use. The most recurring factor for greater likelihood of treatment is older age (45 years or older).<sup>4,5</sup> Men who drank more alcohol per day and had a higher proportion of heavy consumption (>100g daily) were more likely to be receiving treatment.<sup>6</sup> Following this, men experiencing health complications from alcohol use, including dependence symptoms, liver complications, anxiety disorders, or otherwise rated their overall health as poor, had greater involvement with treatment.<sup>4,5,6</sup> Other factors associated with receiving treatment included low income or education and people who spoke English.<sup>4,5</sup> Being married or in a committed partnership also increased use of services, potentially from external pressure being applied as social pressure was also found to increase help seeking.<sup>5,7</sup>

### Psychological Factors

Psychological factors can have a motivating or hindering effect on a person's willingness to seek help. A positive belief in one's personal capability was found to be a promoting factor.<sup>8</sup> Men described this belief by stating they considered having a temporary problem that was amenable to treatment. Similarly, men experienced increased self-efficacy after stopping drinking for even a short period of time.<sup>9</sup> Those who looked to the future also expressed more motivation towards seeking help.<sup>8</sup>

Alternatively, psychological factors that negatively impacted help-seeking behaviours surrounded peer pressure. An awareness of social norms and wanting to fit in was shown to prevent the consumption of non-alcoholic drinks in social situations. Men described the need to covertly drink non-alcoholic drinks and an inability to outwardly make choices based on health in group settings.<sup>9</sup> Participants who identified the negative influence of peer pressure tended to be younger, 30 to 35 years.<sup>9</sup> Secretive behaviour and poor social supports create an isolating environment for people trying to change.

### Health Motivators

The onset of a health problem was a key motivating factor in reducing alcohol consumption when people were asked to identify reasons for reducing alcohol. In one Australian study a third of men stated they needed a health scare before they were willing to change their drinking habits.<sup>10</sup> This was reiterated in additional studies where disturbance to health was a key motivating factor; however, the reasons for seeking help was to resolve this disturbance, rather than to stop drinking.<sup>8,11</sup> The onset of health problems tended to be with men over the age of 60, which supports findings in demographics of older populations more likely to seek help.

Not all health problems trigger a reduction in alcohol consumption or move towards healthier behaviours. While some health problems lead to an appropriate reduction in alcohol consumption, others do not, and may increase the propensity for heavy use.<sup>12</sup> Understanding the likely change in alcohol consumption depending on the specific health problem is important for

understanding the potential for intervention. A positive reduction in drinking is found following the onset of heart or coronary problems and diabetes.<sup>12</sup> However, hypertension and serious injury do not appear to influence heavy drinking. Cancer was linked to an increase in heavy drinking, particularly for Caucasians.<sup>12</sup> This raises the question of whether the link between hypertension or cancer and alcohol consumption is routinely discussed in consultations.

#### **Perceived Barriers: Attitudinal Barriers**

Shame, embarrassment, and stigma were the most significant and pervasive barriers identified in the literature.<sup>11,13,14,15</sup> Feelings of shame were found to be particularly true for men who consumed high amounts of alcohol.<sup>13</sup> Men commonly expressed fears of being labelled an alcoholic as alcohol problems are thought to be synonymous with being an alcoholic, illustrating the stigma attached to alcohol addiction.<sup>14,15</sup> When asked about participating in treatment, many men stated they would be too embarrassed to discuss their problem with anyone.<sup>16,17</sup> The perceived stigma has a significant negative impact on the uptake of treatment,<sup>11, 18</sup> both from a reluctance to be associated with “alcoholics” and the perception that treatment only caters to people with a severe problem.<sup>13</sup> However, one individual recognised that feeling ashamed triggered him to acknowledge his alcohol problem.<sup>11</sup> This insight shows that acknowledgment of these feelings can lead to problem recognition; however, this was a minority.

Men also raised concerns that friends or family may find out about their drinking or they might be recognised at treatment.<sup>11,19</sup> Acts of hiding their drinking increased feelings of shame and guilt, which lead to an increase in drinking.<sup>11</sup> Concerns of stigmatisation understandably led to worries of privacy and confidentiality.<sup>20</sup> The anonymity provided by the Internet was highlighted as particularly useful in searching for help and preferred by people seeking anonymous support.<sup>14,18</sup>

Issues of shame and embarrassment were found to stem from a perceived sense of failure and sign of weakness from not being able to handle alcohol.<sup>8</sup> Men expressed the opinion that they should be strong enough to handle it alone and “drinking plenty of grog” was described as part of the Australian male tradition.<sup>12,16,17</sup> Concepts of masculinity have been seen to lead to delays in help seeking as sobriety in men has traditionally been regarded as un-masculine.<sup>8</sup>

#### **Perceived Barriers: Structural Barriers**

The most significant structural barrier highlighted was people not knowing where to go for help.<sup>5,15,17</sup> While this rang true for men across multiple groups, it was particularly felt by ethnic minorities and those who spoke languages other than English.<sup>5</sup> These men also experienced greater impact of other barriers, in particular, transportation.<sup>15</sup> Transportation barriers included loss of licence, insurance, and needing to travel long distances for services.<sup>15,19</sup> A lack of time also appeared as a barrier in a number of studies, followed by cost and admission hurdles.<sup>15, 17, 19, 20</sup>

An Australia study found most men did not attend for regular visits with a general practitioner (GP) and that harmful alcohol intake further decreased rates of attendance, compounding missed opportunities for detection and intervention.<sup>2</sup> However, a high proportion of men with dependence were offered advice about cutting down alcohol consumption when they visited their GP, and a similar proportion of men were referred to alcohol services or specialist help.<sup>18</sup> This suggests that people with dependence are regularly identified by a GP and offered advice, but poor attendance of at-risk people poses a greater barrier.

### Perceived Benefits

The perceived benefits of reducing alcohol intake was not widely investigated by the literature, owing largely to poor problem recognition as well as low perceived severity and susceptibility. While health improvements were the most significant benefit identified, other benefits were anticipated. Improvements sought included increased self-confidence, financial, lifestyle, returning to the workforce, and keeping their licence.<sup>8</sup> Younger men described not wanting to progress areas of their life such as starting a family until their drinking was better controlled.<sup>8</sup> Intention and motivation to reduce drinking was highest amongst those who perceived broader benefits. Similarities can be seen to those who are future focused and self-motivated to reduce problem drinking.<sup>8</sup> It was as common for men to worry about the loss of alcohol and the perceived benefits drinking brings including reduced inhibition, providing a basis for friendship and, substitute for other activities.<sup>8</sup>

### Perceived Severity and Susceptibility

Susceptibility describes the likelihood of being negatively affected or becoming addicted, whereas severity refers to the size of the risk or degree of impact drinking was having in a person's life. Men were found to often minimise both the perceived severity of the behaviour and their susceptibility. One-third of men believed their drinking problem would get better by itself.<sup>16,17</sup> In one study 22 per cent of men surveyed believed the problem was not serious enough to seek help.<sup>16</sup> Jakobsson et al.<sup>8</sup> investigated individuals who had sought treatment and found that prior to treatment men held the belief they could stop drinking if they chose, but once they tried they realised they needed help, discovering the problem was more severe than previously thought. Participants correlated severity with a disruption to their life, however, many relied on a point where they hit “rock bottom” as a trigger for treatment rather than intervening earlier.<sup>11</sup> This suggests that subtle disruptions are likely to be unappreciated by men. Further, it highlights the fact that low perceived severity and susceptibility cause additional delays seeking treatment. Difficulty determining socially acceptable levels of drinking from excessive use has been suggested to cause alienation from specific treatment such as Alcoholic Anonymous where the problem was not considered severe enough to warrant the programme.<sup>14</sup> Participants also continued to describe confusion about whether their behaviour falls outside these ranges.<sup>1</sup>

### Cues to Action

Cues to action encompass any trigger that prompts action towards help-seeking. While many cues may be imperceptible, from the literature cues have been identified as those that have been recognised by participants as contributing to help-seeking. External pressures identified as a prompt towards treatment included access to children, loss of licence, or legal consequences.<sup>5,11</sup> These areas identified have strict controls in place where it is harder to avoid addressing problematic drinking. Partner and relationship problems also appeared as prompting help seeking.<sup>8,11</sup> Men emphasised, while this initial prompt helped triggered them to action, it still required their own willingness to seek help.<sup>8</sup> Poor problem recognition is also evident in the findings with men identifying the reason they sought help was for another reason such as preventing their marriage breakdown, not because they recognised they had an alcohol problem.<sup>11</sup>

## DISCUSSION

### Key Findings

The literature demonstrated the complexity surrounding help seeking and multiple factors surrounding accessing treatment for alcohol reduction. Overwhelmingly, attitudinal barriers, including concerns of stigma, shame, and embarrassment were pervasive through the review. These factors act as major barriers to accessing treatment through not wanting to be associated

with “alcoholics” or fear friends and family may find out.<sup>14</sup> The greatest structural barrier was not knowing where to go for help. Poor problem recognition was also evident across the literature through low perceived severity and susceptibility to the harms of alcohol. Waiting for significant disruptions to health or “hitting rock bottom” and low reported benefits to reducing alcohol intake, demonstrate poor problem recognition.<sup>11</sup> Low engagement with GPs means lost opportunities to intervene early and prevent health complications later in life, which is ultimately what commonly prompts treatment. The demographics of help-seekers supports these findings as those who do engage are older, with greater health problems and higher alcohol consumption. Self-efficacy and looking to the future also motivated change, particularly in younger men, wanting to make improvements in their lives.

### Comparison to Literature

Parallels can be drawn between problem drinkers in the community and people receiving treatment. The Australian Institute of Health and Welfare found that risk of injury on a single occasion of drinking daily, was highest among males aged 50 to 69.<sup>21</sup> Older men drink significantly more frequently than younger men, however, they consumed fewer drinks per event.<sup>10</sup> However, older men who do drink at risky levels were more likely to drink daily.<sup>21</sup>

Comparing the help-seeking behaviours of men for broader medical treatments presents similar results and strengthens the findings in this review. Demographic factors associated with lower likelihood of help seeking for medical treatment included younger age, non-English speaking background, and being unmarried.<sup>22</sup> Furthermore, the lack of knowledge about treatment options, as well as time and cost restraints, were found to be recurring structural barriers to medical care.<sup>23</sup> This suggests barriers are not solely due to alcohol consumption or demographics of people with problematic alcohol use and are present for men engaging with health services in general. Similarly, viewing health symptoms as minor, hoping they would go away or stating they would need to be very ill before seeking help demonstrates the parallels to men minimising the susceptibility and severity.<sup>24,25</sup> Men enduring symptoms for longer before seeking help, especially if symptoms are not physically restrictive also supports the findings.<sup>23</sup> High levels of embarrassment from medical interactions were reported by men and found to be the strongest predictor of not seeking help.<sup>23</sup> This echoes the major finding in the literature where shame and embarrassment posed the significant barrier to help seeking. Embarrassment, problem admission, and lack of control have been raised as all going against self-concepts of masculinity, which is a key factor in delaying help seeking.<sup>23</sup> Instead of avoiding interactions, regular contact with a medical professional can help normalise medical consultations, reduce embarrassment, and build trust so men are more likely to seek help when issues arise.<sup>2</sup>

### Strengths and Limitations

This review included quantitative and qualitative data to capture the attitudes of the male population examined. Quantitative data in the form of national surveys allowed for the sentiments of large proportions of the population to be captured. Smaller sample sizes using qualitative methods provided valuable insights on the individual level and detailed exploration of key issues, although were not generalisable.

Due to the nature of this review only the author assessed each article, limiting the reliability of the results, with potential selection bias. Similarly, conducting a review of all available current literature meant only three included studies specifically focused on Australia. While Australia is a vastly multicultural country, studies were included from other countries and results may not be representative of Australian males and cannot be generalised. A methodological limitation of

many included studies is the reliance on self-reported data, which is subject to recall bias and limited by the awareness people have towards their motivations.

Patient outcomes were not assessed as part of this review, nor did it separate those who have and have not received treatment in the past. This is suggested in a few papers as impacting the attitudinal and structural barriers concerning treatment.

### Clinical Implications and Future Direction

Future research is needed to challenge identified barriers men experience to gain greater understanding of what can be done to overcome them and increase engagement with health services. Findings suggest improving and expanding the use of online materials may improve help-seeking. Providing anonymous, informative support online could play a key role in reducing attitudinal barriers of stigma and shame as well as structural barriers, including cost and transportation. A potential direction for research could look to evaluate online content, accessibility, and effectiveness to reduce alcohol intake or prompt help-seeking.

There is evidence that on presentation to their GP, men with problematic use are regularly identified. As a common structural barrier identified was not knowing where to find help, GPs are able to help reduce this barrier by addressing alcohol consumption. Similarly, opening up conversations and reducing the stigma and shame felt may yield the greatest impact to men's health. Lastly, ensuring clear links are made between alcohol and health outcomes either in consultation or via online platforms may enhance health motivation towards alcohol reduction, generating realistic perceived susceptibility and severity.

### CONCLUSION

The Health Belief Model provided a valuable framework for highlighting the important and recurrent aspects in the literature. This review adds to the current body of literature by highlighting areas of significance regarding help-seeking. While there remains a significant hindrance in men attending the GP or alike for alcohol reduction, there is substantial value in screening those that do attend. Findings from the review suggest future research should focus on addressing specific barriers and the most effective ways to overcome them.

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#### ACKNOWLEDGEMENTS

None

#### PEER REVIEW

Not commissioned. Externally peer reviewed.

#### CONFLICTS OF INTEREST

The authors declare that they have no competing interests.

#### FUNDING

None

#### ETHICS COMMITTEE APPROVAL

This report complies with the NHMRC National Statement on Ethical Conduct in Human Research. Information used in the completion of the report consisted entirely of previously published information.

Table 1: Search strategy terms

| Themes              | Search Terms   |
|---------------------|--|
| Alcohol             | (MH "Drinking") OR (MH "Drinking Behavior") OR (MH "Binge Drinking") OR (MH "Alcohol Drinking") OR (MH "Alcoholism") OR ("alcohol*") OR (drinking AND (behavio#r*)) OR (MH "Alcohol Rehabilitation Programs") OR (MH "Alcohol-Related Disorders") OR (MH "Alcohol Abuse") OR (DE "Alcohol Drinking Attitudes") OR (DE "Alcohol Drinking Patterns") OR (DE "Drinking Behavior") OR (DE "Alcohol Abuse") OR (DE "Alcoholism") OR (DE "Binge Drinking") OR (DE "Alcohol Rehabilitation") OR (DE "Alcohol Use Disorder") |
| Help-seeking        | (MH "Help-Seeking Behavior") OR (MH "Information Seeking Behavior") OR (MH "Patient Acceptance of Health Care+") OR (("help" OR "health" OR "treatment" OR "information") AND ("seek*")) OR ("acceptance" AND "health care") OR (DE "Help Seeking Behavior") OR (DE "Health Care Seeking Behavior") OR (DE "Health Care Utilization") OR (MH "Motivation") OR (DE "Motivation") OR (MH "Health Behavior") OR (DE "Health Behavior")  |
| Treatment barriers  | (DE "Treatment Barriers") OR (DE "Treatment Planning") OR (("treatment") N2 ("barriers"))  |
| Attitudes to health | (MH "Attitude to Health") OR (("attitude") N2 ("health")) OR (("attitude") N2 ("alcohol")) OR (("patient") N2 ("attitude")) OR (MH "Patient Attitudes") OR (DE "Health Personnel Attitudes") OR (DE "Health Attitudes") OR (DE "Client Attitudes") OR (("client") N2 ("attitude")) OR (MH "Attitude to change")  |
| Primary Care        | (MH "Primary Health Care") OR (("primary") N2 ("care")) OR (DE "Primary Health Care") OR (MH "Family Practice") OR (MH "General Practice+")  |

Table 2: Inclusion and exclusion criteria

| Inclusion Criteria  | Exclusion Criteria  |
|---|---|
| Adults over 18 years old  | Under 18 years old  |
| Data separated by gender or provided male specific data                 | Only women included in study or no gender differentiation in the data |
| Published in English  | Only available in languages other than English                        |
| Published from 2008 to 2020   | Published prior to 2008   |
| Publications describe help-seeking behaviours towards alcohol reduction | Unrelated to help seeking or reduction of alcohol intake              |

Figure 1: Study selection (the preferred reporting items for systematic reviews and meta-analyses)

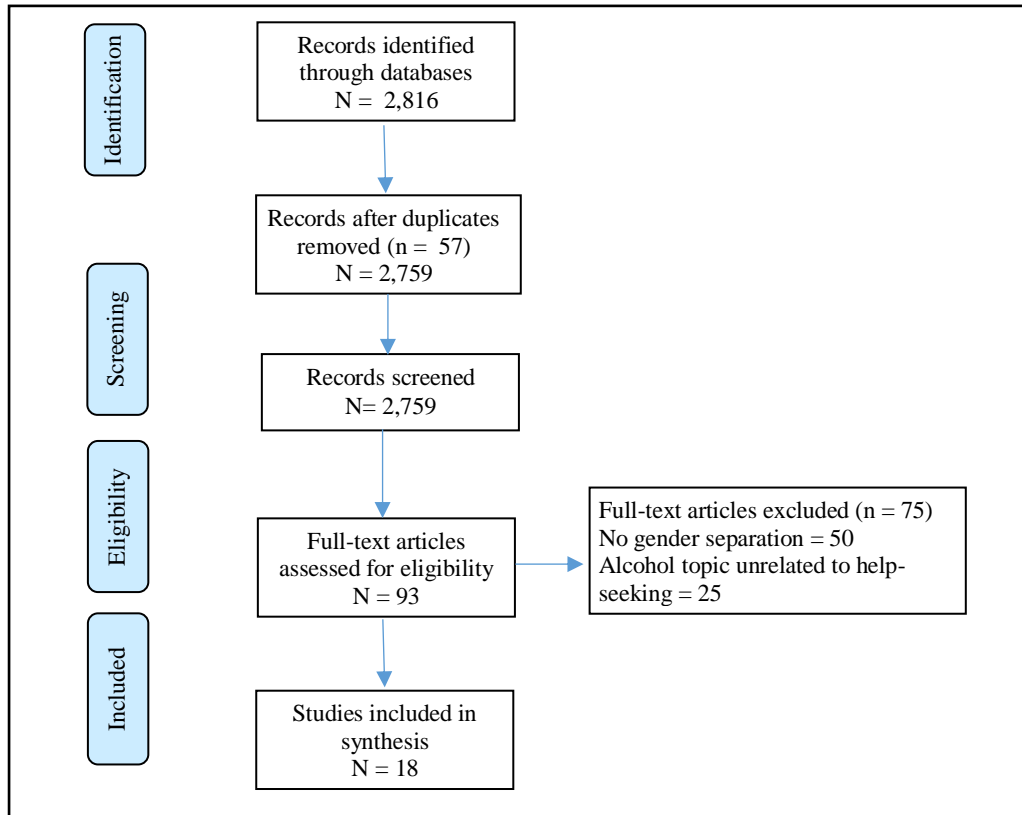


Figure 2: Health Belief Model

