Need to know and wish to know

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Need to know and wish to know: What individuals find important to know about treatment for alcohol problems in order to be able to decide whether to enter or not

ANETTE SOGAARD NIELSEN & ANNETTE ELKJÆR ELLERMANN

ABSTRACT
BACKGROUND – Over the years, several studies have tried to identify barriers to seeking treatment for alcohol problems. Lack of information about treatment availability has been identified as a barrier, but what kind of information do individuals in treatment for alcohol problems find should be available before treatment start and what information can wait until later? MATERIAL & METHOD – 25 treatment institutions participated in a survey among their treatment users. The questionnaire consisted of 30 items, of which 19 were questions about specific aspects of treatment, asking the participants how important it was to know about this aspect before treatment start. A total of 704 treatment users participated. RESULTS – By far the most participants rated information about the content of treatment as a priority. Information about how to contact the treatment institutions (via mail, phone or face-to-face) was given priority by about a fourth of the participants, closely followed by information about the influence the individuals themselves have on the treatment content, and information about treatment being free of charge. CONCLUSION – Individuals seeking and entering treatment for alcohol problems require information about the treatment itself and what it contains before they start treatment. This is in stark contrast to the kind of information that treatment seekers currently find, such as the opening hours of the treatment centre and similar practicalities.
KEYWORDS – patient information needs, treatment for alcohol problems, barriers for seeking treatment

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Introduction
When as researchers and treatment providers we design webpages or write brochures containing information about treatment options, we take it for granted that we know what potential users are interested in. But what does the prospective treatment user really want to know about treatment in order to be able to decide whether to seek it? As professionals, we may go over this repeatedly, discussing it and coming up with a range of hypotheses. But instead of guessing, why not ask the experts – the treatment users – themselves?

Acknowledgements
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Background
In the context of the detailed planning of a randomised controlled trial (Nielsen et al., 2015) on the significance of allowing the individual to choose among several treatment options for alcohol problems, we needed to know what type of information about treatment the treatment users find it important to have in order to be able to make decisions about whether or not to choose a particular treatment option. We searched the literature but, somewhat surprisingly, found no studies on treatment user information needs in alcohol-related care.

Having drawn a blank on this search, we looked instead for literature on barriers to treatment seeking. We expected that studies on barriers might include findings on what information about treatment people need before treatment entry. Barriers to treatment seeking have been studied extensively, as it has been known for decades that the time interval between the emergence of an alcohol problem and an individual’s seeking formal treatment is long, generally 10 years or longer (Kessler et al., 2001).

Several studies have addressed the issue of why it takes so long for persons suffering from alcohol use disorders to decide to seek treatment, and many have wondered if it is possible to remove some of the barriers to treatment. Most of the studies have been based on questionnaire and quantitative data, but the issue has also been explored using qualitative methods.

In the 1990s, seeking to understand the role of barriers in the process of treatment seeking, Saunders, Zygowitzc and D’Angelo developed a model that proposes a sequence of steps in the treatment-seeking process, and which posits that the barriers differ depending on where you are in the process (presented in Saunders et al., 2006) (Figure 1).

The process of treatment seeking is complex and multifaceted. In the Saunders model, the initial steps are thought to revolve around recognising that one has a drinking problem. These steps are therefore primarily cognitive and emotional in nature, related to the persons themselves and their social networks. Once the person with an alcohol problem recognises the problem, the next step in the process is about deciding whether change is necessary. Person-related barriers in the first two steps may include lack of problem recognition and doubt about the need for treatment, fear of stigma, with self-stigma (damage to self-esteem) distinguished from public stigma (based on fear of others’ reactions). Hence, the initial steps in the model may involve a lot of ambivalence towards both the need to cut down on drinking and the need for help in cutting down. If treatment is to be sought, the person in question needs to acknowledge at least to some extent 1) that he or she needs to stop drinking or cut down, and 2) that he or she cannot resolve the problem by him- or herself or with peer support alone.

However, the model presented by Saunders and colleagues also describes how potential barriers later in the treatment-seeking process may be not only person-related (i.e. stigma, fear of others’ reactions, doubting the need for treatment, ongoing self-change efforts) but also treatment-related. The model describes how the decision to seek professional help may lead to making and keeping an appointment at
a treatment facility, but may also end in problem resolution without professional help if the person in question encounters insurmountable barriers such as waiting lists or other practical obstacles related to the treatment or the treatment facility.

In their study of person-related and treatment-related barriers to alcohol treatment, Saunders and colleagues sought, in particular, to investigate barriers at the latter end of the treatment-seeking process as it is conceptualised in the model in Figure 1. In order to do so, Saunders and colleagues devised a list of obstacles encountered by treatment-seeking and non-treatment-seeking participants. In addition to the person-related barriers, Saunders and colleagues found that not believing in the effectiveness of the treatment available appeared to be the most salient treatment-related barrier among treatment seekers, followed by cost and time barriers (Saunders et al., 2006).

Rapp and colleagues (2006) also studied barriers to treatment seeking. In their study, the views of 312 substance abusers at an intake unit were assessed with the aim of identifying barriers to treat-
ment. The factorial structure of the barrier concepts was then examined, with a seven-factor model proving to be the most appropriate. The model covered the following person-related categories: absence of problem, negative social support, fear of treatment and privacy concerns. The treatment-related categories were time conflict, poor treatment availability and admission difficulty (Rapp et al., 2006). Similarly, in a study by Tucker, Vuchinich, and Rippens (2004), treatment-related barriers were shown to include poor or inadequate availability of services, format of treatment and financial aspects of treatment. Clearly, the barriers are many and various. Treatment barriers may, however, also include lack of information about the form of the treatment itself.

Barriers to treatment seeking may be addressed in many ways. In Denmark, a reduction in barriers to treatment seeking is currently the goal of a public media campaign carried out by the non-profit organisation Alcohol & Society and funded by Trygfonden. The approach espoused in this particular campaign targets person-related barriers. A key slogan is “Regain respect”. Using advertisements and videos, the campaign focuses on how problem drinkers in fact gain, rather than lose, respect from peers and family if they address their alcohol problems by seeking treatment. So the thrust of the campaign is to diminish the stigma attached to treatment seeking.

Treatment-related barriers are also to some extent addressed in the national campaign, because it is pointed out that treatment is free in Denmark, and that problem drinkers have the right to remain anonymous during treatment if they so wish. However, the campaign does not inform about the treatment as such, what it entails and consists of and how the individual may influence its course.

Having failed to find studies on treatment user information needs in the alcohol treatment field, we searched the literature on mental health. A substantial body of research is available on various aspects of patient perspectives, preferences and expectations regarding mental health care (Barbato et al., 2014; Noble, Douglas, & Newman, 2001), with studies illustrating the strong need patients have for information on a wide range of topics (Tlach et al., 2014). However, here again, information needs in relation to the treatment itself were barely investigated. For instance, Barbato and colleagues only investigated patients’ perceived need for information about their illness and about drugs. They found that although patients were, in general, fairly satisfied with the quality of the mental health service in question, low positive ratings were recorded for information about drugs and illness, and negative opinions peaked in that area, too.

Noble et al. searched the literature to find out what patients expect of psychiatric services. Three studies devising interventions to improve the accuracy of patient expectations of the process of care were identified, namely the studies by Hagan, Beck, Kunce, and Heisler (1983), by Webster (1992) and by Douglas, Noble, and Newman (1999). Hagan and colleagues used a video to prepare patients for the transition from inpatient to outpatient care, and found that this led to higher attendance (Hagan et al., 1983). Another study tested the impact of written information prior to attendance and found
that information led to increased satisfaction compared with a control group (Webster, 1992). Similarly, Douglas and colleagues informed mental health patients about treatment by showing a video prior to treatment start but found no difference in relation to satisfaction (Douglas et al., 1999).

A study on patients’ and relatives’ satisfaction with psychiatric services found that consumers wanted to have more treatment-related information but the study did not go into very detail (Gigantesco et al., 2002). Providers have been found to believe that information materials ought primarily to include practical information, information on support groups and universal access issues (Williams-Piehota et al., 2010).

In order to increase our knowledge about treatment information needs in the alcohol treatment field, the present study investigates what types of information individuals feel should be available prior to treatment in order to be able to decide whether or not to seek the treatment. The study was conducted as a survey among treatment-seeking individuals in public outpatient treatment centres in Denmark.

Material and method

The treatment offers at publicly funded treatment centres vary, as does the size of the treatment centres between the municipalities. However, typically the treatment centres offer motivational interviewing, cognitive behavioural therapy and family therapy. Most treatment centres also offer acute treatment for withdrawal symptoms and other kinds of pharmacological treatment. If a treatment centre is small and does not employ health care staff, pharmacological treatment is typically given in collaboration with the individual’s general practitioner.

All publicly funded outpatients treatment centres for alcohol dependence in Denmark were asked to participate in the survey. The centres were informed that they would not be compensated for the extra work this incurred. A total of 25 treatment institutions agreed to participate, which is about 45% of the public outpatient treatment centres in Denmark. Eight treatment centres expressed regret that they were unable to participate due to other scheduled activities taking place during the designated week. The participating centres, which were both large and small, were spread out across the country.

No validated questionnaire on information needs was found in the literature. Hence, a questionnaire was developed and pilot-tested at one of the major treatment centres. The questionnaire consisted of 30 questions, prefaced by an introduction that explained the purpose of the study and how the questionnaire should be completed. Nineteen of the 30 items were questions about specific aspects of treatment, asking the respondent how important it was to know about each particular aspect before treatment start – or whether
the information could wait till later. The respondents were asked to measure each topic on a Likert Scale ranging from 1 (very important to know beforehand) to 5 (should wait till later). One question asked the respondents to describe additional important information – not covered by the previous items – that should be available before a person decided whether or not to seek and start treatment. Finally, the respondents were asked to rank the topics and choose the three most important topics that treatment users should receive information about before starting treatment. The remaining questions collected the most basic information about the participants (sex, age, etc.). It was made very clear in the introduction that we were seeking treatment user input in order to make information about alcohol treatment more relevant and helpful to future treatment users. In particular, we needed help to prioritise the information about treatment that was most valuable to have before entering treatment, as opposed to information that could wait till later.

After pilot testing, the questionnaires were printed and distributed to the treatment centres, which were asked to hand them out to all individuals who showed up for an appointment during a specific week with the request that they fill out the questionnaire and leave it in the box provided. The questionnaires were filled out anonymously. The following week, the smaller centres posted the questionnaires to the Research Unit in pre-stamped envelopes. Staff from the Research Unit picked up the boxes with questionnaires from the larger centres.

A total of 704 questionnaires were returned to the Research Unit. The participating centres estimated that about 90% of the individuals who showed up for appointments during the week in question had completed at least part of the questionnaire. In about 10% of the cases the staff forgot to give the individual a questionnaire, or he or she did not have time to fill it out or was unwilling to participate. A total of 675 (96%) of the questionnaires received by the Research Unit contained complete data. No data are available on the individuals who had an appointment at one of the participating treatment facilities and did not fill out a questionnaire.

In the analyses, Student’s t-test was used for comparing the mean values and Chi2 test was employed for bivariate data. P<0.05 was chosen as the significant level. All analyses were conducted by means of SPSS V22 for Windows.

Results
Basic information on the respondents participating in the survey can be seen in Table 1. In general, the participants had a long history of problematic drinking. The males reported excessive drinking for more than 16 years (mean) and the women for more than 11 years (mean). For almost half of the participants, the current treatment course was their first time in treatment. Overall, the mean treatment course had lasted for a year or more (16.5 months for men, 11.6 months for women (means)). The median treatment course was 6 months, and 10% of the participants had received treatment for more than 36 months. A total of 15.4% of the participants were only three months or less into their first treatment course and were thus relatively new to the treatment system (17% females versus to 14.7% males, NS).
Table 1. Basic information on individuals in treatment at public outpatient treatment institutions participating in the survey.

<table>
<thead>
<tr>
<th></th>
<th>Men (n=483)</th>
<th>Women (n=200)</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean</td>
<td>50.5 (SD 12.2)</td>
<td>51.1 (SD 10.9)</td>
<td>NS</td>
</tr>
<tr>
<td>Married or living with partner</td>
<td>41.7%</td>
<td>44.4%</td>
<td>NS</td>
</tr>
<tr>
<td>Living with children</td>
<td>18.8%</td>
<td>30.5%</td>
<td>P&lt;0.01</td>
</tr>
<tr>
<td>Working</td>
<td>34.4%</td>
<td>34.8%</td>
<td>NS</td>
</tr>
<tr>
<td>First time in treatment</td>
<td>41%</td>
<td>48.7%</td>
<td>P&lt;0.05</td>
</tr>
<tr>
<td>Months in treatment, mean (current treatment course)</td>
<td>14.3 (SD 20.1)</td>
<td>11.44 (SD 17.4)</td>
<td>NS</td>
</tr>
<tr>
<td>First time in treatment AND been in treatment ≤ 3 months</td>
<td>14.7%</td>
<td>17.0%</td>
<td>NS</td>
</tr>
<tr>
<td>Years of problem drinking (self-reported, mean)</td>
<td>16.5 (SD 11.1)</td>
<td>11.6 (SD 10.1)</td>
<td>P&lt;0.001</td>
</tr>
</tbody>
</table>

*) missing data about sex: 21 individuals. Hence only data on 683 individuals are shown in the table.

Table 2 shows to what extent the participants regarded each particular topic as important to have information on before treatment start. We carried out gender-specific analysis, and overall, men and women gave priority to the same topics. However, significantly more female participants than male gave high priority to information about ways of contacting the treatment centre (59.0% female versus 49.0% male, p<0.05), whether treatment was group-based or took the form of individual sessions (61.5% female versus 48.0% male, p<0.01) and whether there were waiting times before treatment could be started (61.5% female versus 54.2%, male p<0.05).

Table 2 indicates which topics the participants felt could wait to be addressed until after treatment start. Again, an overall agreement between the sexes was seen with a few exceptions. Significantly more female participants considered that information about how long the course of treatment could be expected to last could wait till after treatment entry (30.0% female versus 18.8% male, p<0.01). Significantly more female participants also considered that information about the goal of treatment (whether the goal is abstinence or controlled drinking) could wait till after treatment start (18.5% female versus 10.4% male p<0.01). Slightly more women than men also considered that information about whether or not the staff had the most updated knowledge about treatment could wait (13.0% female versus 8.3% male p<0.05), as against information about the staff's professional background, which slightly fewer female than male participants considered could wait till after treatment start (7.0% female versus 11.6% male p<0.05).

Overall, almost all categories of information were considered fairly important by the majority of the participants when assessed topic by topic. Figure 2 shows which topics were considered the most important to be informed about before treatment start, if the participants were to prioritise the three most important topics on the list. Information about the content of treatment was given priority by far the most respondents, regardless of gender.
Table 2: Treatment users’ assessments of the value of prior information in shaping their decision for or against treatment entry

<table>
<thead>
<tr>
<th>How important is it to receive information about … (item below) … before starting treatment?</th>
<th>Mean score (between one and five, five represents max: very important) (SD)</th>
<th>% participants who find information on the item very or somewhat important to have beforehand</th>
<th>P-value (difference between male and female participants)</th>
<th>% participants who find that information on the item should or can wait till later in treatment</th>
<th>P-value (difference between male and female participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to get in contact with the treatment centre</td>
<td>4.3 (1.0)</td>
<td>52.6%</td>
<td>49.9%</td>
<td>59.0%</td>
<td>P&lt;0.05</td>
</tr>
<tr>
<td>What the content of treatment is</td>
<td>4.5 (0.8)</td>
<td>62.7%</td>
<td>62.3%</td>
<td>63.5%</td>
<td>NS</td>
</tr>
<tr>
<td>Whether I have influence on the treatment</td>
<td>4.3 (0.9)</td>
<td>53.9%</td>
<td>52.8%</td>
<td>56.5%</td>
<td>NS</td>
</tr>
<tr>
<td>What the duration of treatment is</td>
<td>3.5 (1.1)</td>
<td>23.0%</td>
<td>23.2%</td>
<td>22.5%</td>
<td>NS</td>
</tr>
<tr>
<td>Whether treatment is individual or group-based</td>
<td>4.3 (0.9)</td>
<td>52.0%</td>
<td>48%</td>
<td>61.5%</td>
<td>P&lt;0.01</td>
</tr>
<tr>
<td>Whether antabuse is part of treatment</td>
<td>4.1 (1.1)</td>
<td>49.3%</td>
<td>49.1%</td>
<td>50.0%</td>
<td>NS</td>
</tr>
<tr>
<td>Whether SSOs get involved</td>
<td>3.8 (1.1)</td>
<td>30.0%</td>
<td>29.2%</td>
<td>32.0%</td>
<td>NS</td>
</tr>
<tr>
<td>When the treatment takes place (time of day)</td>
<td>4.4 (0.9)</td>
<td>57.7%</td>
<td>57.3%</td>
<td>58.5%</td>
<td>NS</td>
</tr>
<tr>
<td>How often treatment takes place</td>
<td>4.3 (0.9)</td>
<td>50.4%</td>
<td>50.1%</td>
<td>51.0%</td>
<td>NS</td>
</tr>
<tr>
<td>What the goal of treatment is (abstinence/controlled drinking)</td>
<td>4.1 (1.1)</td>
<td>51.0%</td>
<td>52.2%</td>
<td>48.0%</td>
<td>NS</td>
</tr>
<tr>
<td>Whether I can decide the treatment goal</td>
<td>4.2 (1.0)</td>
<td>49.0%</td>
<td>49.5%</td>
<td>48.0%</td>
<td>NS</td>
</tr>
<tr>
<td>What the effect of treatment is</td>
<td>4.1 (1.1)</td>
<td>48.6%</td>
<td>49.9%</td>
<td>45.5%</td>
<td>NS</td>
</tr>
<tr>
<td>That treatment is of free charge</td>
<td>4.5 (0.8)</td>
<td>67.2%</td>
<td>65.8%</td>
<td>70.5%</td>
<td>NS</td>
</tr>
<tr>
<td>Whether I can receive support for my children</td>
<td>4.0 (1.1)</td>
<td>44.9%</td>
<td>43.1%</td>
<td>49.5%</td>
<td>NS</td>
</tr>
<tr>
<td>Whether the staff are up-to-date in their expertise</td>
<td>4.1 (1.0)</td>
<td>44.4%</td>
<td>42.2%</td>
<td>49.5%</td>
<td>NS</td>
</tr>
<tr>
<td>What educational background the staff has</td>
<td>3.9 (1.0)</td>
<td>33.4%</td>
<td>32.3%</td>
<td>36.0%</td>
<td>NS</td>
</tr>
<tr>
<td>Whether there is a waiting time before treatment start?</td>
<td>4.4 (0.8)</td>
<td>56.4%</td>
<td>54.2%</td>
<td>61.5%</td>
<td>P&lt;0.05</td>
</tr>
<tr>
<td>Whether relapse during treatment is accepted</td>
<td>4.2 (1.0)</td>
<td>54.8%</td>
<td>54.5%</td>
<td>55.5%</td>
<td>NS</td>
</tr>
<tr>
<td>Whether there are side effects to the treatment</td>
<td>4.4 (0.9)</td>
<td>63.8%</td>
<td>62.9%</td>
<td>66.0%</td>
<td>NS</td>
</tr>
</tbody>
</table>

Figure 2: Percent male and female individuals in treatment for alcohol dependence stating the topic of information to be one of the three most important topics to have information on before treatment start (N=704. Missing information from 35 patients)

![Bar chart showing percent of male and female individuals in treatment for alcohol dependence stating the topic of information to be one of the three most important topics to have information on before treatment start.]

\* p < 0.05

(38.5% female versus 32.3% male, NS). Information about how to contact the treatment centres (via mail, phone or face-to-face) was given priority by about a quarter of the respondents, closely followed by information about the influence the participants themselves might have on the treatment content, and information about treatment being free of charge.

Finally, we investigated whether there were differences in the information that was considered the most important to have before treatment start among those participants in treatment for the first time and in the early phase of treatment compared with participants who had either received treatment several times or had been in treatment for more than three months. No differences were found, except that significantly more participants in the early phase of their first treatment course gave high priority to information about whether the treatment was group-based or individual (24.5% of the first-timers in the early phase of treatment compared with only 13.5% of the participants with a treatment history or at a later stage of their current treatment p<0.01).

Discussion

During the preparation of another study on the significance of being allowed to choose between various treatment options, we needed to know what type of information individuals want or would find helpful when considering entering and starting treatment. We decided to ask persons who had already entered treatment, as they now had experience of it. The most striking finding in our study is the high priority given to information about the content of the treatment. Both men and women...
found that information about the treatment itself was the most important piece of information to have before starting treatment. The respondents also gave relatively high priority to information about the degree of influence that the treatment user has on treatment, whether group-based or individual. They also rated fairly highly practical information such as how to get into contact with the therapists and the information that treatment is given free of charge.

It is thought-provoking, however, that respondents overall gave relatively little priority to information about the duration of treatment, how often it takes place, whether or not significant others may participate in the treatment course and the professional background of the staff. This is the type of information that tends to be most freely available. At the same time, this finding is somewhat in line with the study by Gigantesco et al. (2002), which found that consumers identify treatment-related information as topics about which they would like more information. Studies have shown that providers tend to focus on giving practical information in the information packs (Williams-Piehota et al., 2010), and a cursory perusal of the webpages of Danish alcohol treatment centres confirms this. However, our results indicate that information on the treatment as such should be more detailed and specific. Ordinary people may not have a clue about what happens during treatment, and our findings show that the individuals already in treatment say that knowledge about the treatment itself would make it easier to decide whether or not to seek and start it.

Half of the respondents participating in our survey had received treatment for more than six months (median). It should be noted that in Denmark, the duration of outpatient treatment tends to be relatively long. Just under half of the respondents said that their current course of treatment represented their first time in treatment, even if they had had a drinking problem for 10–15 years or more. The long gap between developing a drinking problem and seeking treatment is, however, more the rule than the exception (Kessler et al., 2001; Wang, Berglund, Olsson, & Kessler, 2004). As the participants in our study were treatment-seekers only, we expected there to be differences in what information was viewed to be important prior to treatment entry, depending on whether the respondent had a long experience of treatment or not. We found, however, hardly any differences between the two groups, and could therefore conclude that our findings may well be consistent.

Saunders and colleagues investigated barriers to treatment seeking and divided them into two groups: 1) person-related barriers and 2) treatment-related barriers (Saunders et al., 2006). They found that not believing in the effectiveness of the treatment available seemed to be the biggest treatment-related barrier among treatment seekers, followed by cost and time barriers (Saunders et al., 2006). These topics were, however, given scant priority by the participants in our study. This may be because Saunders and colleagues investigated barriers rather than information needs and because they therefore presented treatment-related barriers in terms of the personal experience of uncertainty about the practical aspects of treatment. In our study, we asked about what type of information the individuals regarded
as important prior to starting treatment. This may explain some of the differences between their findings and ours, and it means that our finding may even enrich the model by refining the barriers at step 4, as not knowing what treatment involves may constitute a further barrier over and above waiting lists, practical problems and doubts about the effectiveness of treatment.

Antabuse, a Danish discovery, has for many years played a fairly prominent part in outpatient alcohol treatment in Denmark (Nielsen et al., 2006). A recent qualitative study on treatment barriers found that pharmacological treatment was viewed negatively by alcohol-dependent non-treatment seekers (Finn, Bakstj, & Andreasson, 2014). Seen in this light, it is somewhat surprising that information about whether or not Antabuse plays any part in treatment is prioritised fairly lowly in our study. Perhaps Antabuse has for so long been taken to be a part of treatment for alcohol problems, as it still is, that Danish treatment users simply assume that it is an option. However, the opposite may also be the case: that the treatment users consider Antabuse to be nothing more than a minor adjunct in treatment, and therefore not worth mentioning before treatment start.

In the study by Rapp and colleagues, assessing the views of substance abusers led to the identification of absence of problem, negative social support, fear of treatment and privacy concerns, time conflict, poor treatment availability and admission difficulty as barriers to treatment seeking (Rapp et al., 2006). The treatment-related barriers in the study are consistent with the model proposed by Saunders and colleagues, and suggest that barriers may differ, depending on whether or not treatment availability is high. If hardly any treatment at all is available, this obviously poses a very difficult barrier. If treatment is freely available and even publicly funded and delivered free of charge, it follows that information about the content of treatment becomes more important. Given the legislation on health care provision in Denmark, treatment of alcohol problems is eminently available and individuals even have the right to receive treatment within two weeks following first contact. This information is disseminated by public information campaigns and may explain why information in this area is not prioritised by the individuals.

We turned to literature on barriers after failing to identify studies on information needs. The most often used questionnaire in studies on barriers to treatment for alcohol problems is the Barriers Questionnaire (Miller & Tonnigan, 1995). This questionnaire lists 50 barriers to help-seeking that are commonly experienced by individuals with an alcohol use disorder. Each item is endorsed on a four-point Likert-type scale ranging from 0 (not at all important) to 3 (very important). The scale reflects the person-perceived difficulty posed by each barrier in the help-seeking process. The Barriers Questionnaire seeks to highlight the barriers facing the individual, concentrating exclusively on personal feelings and attitudes towards to each particular item. And so its focus is clearly not on whether the individual feels a need for insight into the content of treatment or for information about how treatment works and what to expect. Our study suggests that individuals do indeed require such information, but we still do not know, of course, to what extent the lack of such
information constitutes a barrier to treatment. Future studies on barriers should therefore also focus on the individuals’ information needs.

Our findings that the treatment users do not prioritise information about the professional background of staff converge with those of Tucker, Foushee, and Simpson (2009). Furthermore, Tucker and colleagues found that personal contact was much preferred by patients over more anonymous computerised and self-help options. Taken together, the findings indicate that the quality of personal contact matters, but that it may be considered less important whether it be a nurse, a social worker or a doctor that you meet. However, it should also be stressed that all staff in the Danish alcohol treatment centres are well trained – often as nurses, psychologists, social workers or doctors – and treatment users may take this for granted.

The gender differences in our study findings were few, but nevertheless indicated that men placed less value on immediate information about the how the treatment is performed and structured, i.e. whether it is group-based or individual, how to get in contact with the therapists and whether there is a waiting list. Women seemed to give even less priority than men to information about whether or not significant others can participate in treatment. Gender differences are hard to explain, but it may be that men are slightly more reluctant to involve family or spouse than women are, and therefore like to know beforehand if this is done. Women on the other hand have, in general, a stronger tendency to seek treatment for health problems and may therefore be more interested in knowing whether there is a waiting list.

Men are known to be slightly more reluctant to seek treatment in general than women, and may therefore be a little less concerned about whether or not they have to wait before treatment can be initiated. However, our data do not support these potential explanations.

In the Danish health care system in general, treatment users – patients and clients – are increasingly being regarded as active consumers, with more and more focus placed on ensuring the public’s access to relevant information about treatment and treatment methods. The success of the national website on health issues, www.sundhed.dk, is just one example of how patients’ needs are met in this regard and the priority that they are given. In general, one may expect links between expectations and compliance and treatment satisfaction. Identifying individuals’ expectations at the outset of treatment is particularly important in order to increase the likelihood of treatment users’ engaging with treatment and in order to clarify areas of disagreement. Interventions to inform and educate individuals about what to expect in treatment have a role in this process.

Our study shows how treatment users view their information needs prior to treatment for alcohol problems. It is a limitation of the study that this need is viewed retrospectively and is influenced by what the participants have learned during their treatment course. But by the same token, this is also strength of the study, as the participants may have become aware of information that they regretted not having before treatment start. The absence of differences between the treatment users, relative to whether or not the present treat-
ment course was their first time in treatment, indicates that the findings may be robust.

Our questionnaire was distributed by mail to the participating treatment centres together with a letter of instructions for staff on how to hand out and collect the questionnaires, along with a description of the purpose of the survey for the participating individuals. It may be considered a weakness of our study that we do not know in detail how the questionnaire form was presented to the participants, and, notwithstanding the pilot testing of the questionnaire in a functioning treatment facility, we cannot be sure that all questions were understood correctly.

Another limitation of the present study is the somewhat limited information that we have about the participants. Simplicity of design was, however, a key priority for us, in order to attract as many respondents as possible. The simplicity of the questionnaire had implications not only for the number of participants as such, but also for the number of participating treatment facilities. If the questionnaire had been more detailed and had required the involvement of a therapist to help participants fill it out, the number of participating treatment facilities would have been far smaller. The high number of participants in the study is a clear strength. It is, of course, a limitation that we do not know how representative the participants are of the totality of treatment-seeking individuals in the public outpatient treatment facilities in Denmark. However, as it is estimated that around 90% of the individuals who had an appointment in one of the participating treatment facilities filled out a questionnaire, we feel reasonably confident that our findings are fairly accurate.

Conclusion

Individuals seeking treatment for alcohol problems require information about the treatment itself and what it consists in before they seek treatment. They are interested in knowing more than just the opening hours of the treatment centre and other such practicalities. Although more information is needed on what the individuals are interested in knowing, we would recommend that webpages and brochures inform not only about practical issues but also about the content of the treatment on offer.

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