Reviewer's report

Title: Attitudes towards 12-step groups and referral practices in a treatment culture unfamiliar to 12-step ideology; a survey study

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Reviewer: Thomasina TB Borkman

Reviewer's report:

1. Major Compulsory Revisions
1a/b Methods: a. Nothing was said about what language the questionnaires were in but the original ones were in English. Were they translated into Norwegian, and if so, what process was used to validate them? If English questionnaires were used, what assurances do readers have that the practitioners understood English well enough to understand the questionnaires?

b. The variable “referral practices” as defined is open to multiple interpretations that were not clearly discussed by the authors. “Referring to TSG” was defined as “actively motivating patients to participate in TSG.” This definition of referral could mean multiple things depending on the context and the structure and practices of the agency. Since my experience is in the US, I will provide a US example—the point being that the way referrals are structured within a treatment program need to be considered. In the US for example, many staff running groups in a treatment program often talk about TSGs and “actively motivate patients” to attend TSG meetings. A number of staff could be actively motivating patients to participate in TSG meetings every time they hold counseling sessions or whatever they term group meetings of patients. This form of motivation is quite different from formalized referral practices involved in discharge planning. In US treatment programs, there is often a discharge planning team that may obtain input from all staff who know a client but who are responsible for discharge planning which includes referrals after treatment—referrals that are more formalized than “actively motivating patients to participate in TSG” in a group meeting.

Limitations: As I reread the paper, I kept thinking of the fact that there were only 294 AA/NA meetings in the whole of the large geographic area of Norway. Self-efficacy scores of those who did not refer or referred little to TSG were very low (4.3 and 6.2) —could this be at all related to clinicians not knowing if there were any TRG meetings where patients lived. I think the authors need to address the issue that there is or is not a TSG meeting within 50 miles (or some reasonable distance) of the treatment unit (assuming that patients are recruited geographically from near the unit). From what we know, treatment units that encourage TSG help to generate TSG meetings near their units or near where their patients live.

2. a/b Title, Abstract and Wording: a. The use of the word “ideology” conveys a
bias that may not be intended. Ideology in American English has so many negative political connotations that it is a loaded word. Eliminate the word “ideology” throughout and substitute 12-step philosophy or 12-step groups as is used in other places in the manuscript.

b. I think the abstract needs to specifically say how many AA/NA meetings there are in the country (and # per 100,000 inhabitants) to make clear that this is not just an attitudinal issue of a “treatment culture unfamiliar with the 12-step philosophy” but a situation in which there are not many AA/NA meetings from which clinicians can learn about TSGs.

3. Other wording: P. 4-background—saying that TSG are “free of charge” is misleading. They do not charge fees but they ask for small donations. Clarify

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Minor Essential revisions which authors can be trusted to correct
1. Methods: There are actually two response rates (page 11)—the number of questionnaires returned (79.1%) and the number of usable questionnaires (lower response rate). I think it is more honest to use either both numbers or the usable questionnaire rate which was not done in the abstract or the text.

2. Discussions & conclusions: The data that attitudes toward TSG were moderately positive was well described and covered in the manuscript but the important corollary finding that the treatment professionals, regardless of referral practices, also thought that TSG were not harmful, that higher scores on TSG as harmless was not mentioned; that finding should be incorporated into the discussion, not left to the reader scanning Table 3.

3. Title & abstract: Why isn’t Norway in the title? I think it would be helpful to readers rather than going around the bush “in a treatment culture unfamiliar to 23-step groups.”

4. + Wording changes: a number of small wording changes need to be made.
   • P2, Results, correct response rate. 2nd sentence has wording problem at end—but referral to these groups among Norwegian addiction professionals was low, as “was” also the level of knowledge about TSG. Was is missing.
   • P2-3: higher self-efficacy to make a successful referral or or for making a successful referral
   • P. 7-Instrument: lst sentence: to explore the clinicians attitudes, not to explore of clinicians attitudes.
   • P. 9, 2nd full graph: last sentence—12-steps should be plural
   • P. 12, bottom of page: awkward sentence: “Clear between group differences with the same pattern also emerged in self-efficacy and knowledge.”
   • P. 13, top on geographic differences. Are these really geographic differences or networking differences related to proximity geographically? How many other treatment units were in the area with the one 12-step oriented one?
   • P. 14, bottom of page awkward sentence: “Except from those in the county with the 12-step ward, few participants reported integrating and using the 12-steps in
their daily counseling work and the overall knowledge score was only moderate.”

- P. 15, Ist full graph, awkward wording: I don’t think it is higher knowledge –higher scores = more or greater knowledge. Greater knowledge about TSGs and higher self-efficacy to make referrals were also predictive factors for referring patients to TSGs. TSG should be plural as TSGs in above and other places.
- P. 16 top—change “poor” knowledge to “less” knowledge of TSGs
- P. 17, bottom --you say TSG are only one source of mutual support. In US many churches provide support. Are there churches in Norway that help people with substance abuse problems?
- P. 18, middle of page: greater TSG knowledge level, not higher—again the score is higher but knowledge is greater.
- Table 1—I think title should include treatment clinicians to help reader. Also the labeling of education to a US audience is problematic. Why not primary/secondary, college graduate, graduate degree +

3. Discretionary revisions

My comments above about the dependent variable "referral practices" I recognize will not be noticeably changed because the research is already done but the issue could be discussed. My criticism is to the entire line of research illustrated here that engages in what I call the “psychological fallacy”—assumes that every treatment professional staff operate independently of any structure in a treatment agency. As if there are no discharge planning teams, or staff who do intake or others who conduct group meetings. As if there are no implicit policies or practices in a treatment program regarding TSGs. One item “Perceived openness to TSG at workplace” is the closest item that was measured that gets at the idea that the treatment agency probably has a policy or implicit set of practices positive, neutral or negative toward TSG somewhat. In Table 3, in each referral category, “personal attitude toward TSG” was more positive than “Perceived openness to TSG at workplace”—the differences were small but consistent.

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Needs some language corrections before being published

Statistical review: Yes, but I do not feel adequately qualified to assess the statistics.

Declaration of competing interests:

I declare that I have no competing interests.