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Featured Finding

Research Identifies Opportunities to Improve Person-Centered Care for Substance Use Disorder

The Question:

How can specialty substance use disorder treatment facilities operationalize person-centered care across eight dimensions?

Person-centered care (PCC) is an ethical and health service imperative, but it has been inconsistently conceptualized and poorly operationalized. To date most PCC operationalization research has occurred outside of substance use disorder (SUD) treatment. Studies examining PCC in SUD treatment have overwhelmingly focused on one dimension: respect for client treatment preferences, such as through a shared decision-making process. This dimension is very important, but treatment facilities need to know that other dimensions of PCC exist and how to operationalize these dimensions in daily practice. Therefore, researchers from the University of Central Florida, Indiana University-Indianapolis, and Georgia State University sought to identify how SUD treatment facilities can operationalize each of eight PCC dimensions (based on those defined by the Picker Institute) using the experiences and perspectives of treatment providers, administrators, and clients.

With input from an advisory board of stakeholders, Barbara ("Basia") Andraka-Christou, J.D., Ph.D., and colleagues developed an interview instrument to examine research participants' perceptions of how SUD facilities could implement PCC across eight dimensions: 1) respect for client preferences, values, and culture; 2) information provision; 3) coordination and integration of care, 4) emotional support; 5) physical comfort; 6) family integration into treatment; 7) continuity and transition into the community; and 8) access to evidence-based practices. We recruited 37 participants from SUD treatment facilities in South Florida, including outpatient and residential settings, for in-depth, semi-structured telephone interviews. Recruitment and data analysis occurred iteratively until thematic saturation was reached. Using qualitative thematic data analysis, we identified patterns of operationalization practices for each dimension and across dimensions. We also created a list of specific practices for each dimension.

Key Findings

- The eight dimensions of person-centered care are inter-related, such that operationalizing one dimension may help operationalize another.

- All staff, clinical and non-clinical, are critical for operationalizing person-centered care.

- Operationalization of each dimension is important; merely operationalizing respect for patient preferences in treatment (the dimension with the most attention in scholarly work to date) is insufficient.

The Implications:

The researchers had three broad findings: participants believe all dimensions are critical; the dimensions are synergistic; and operationalization requires a range of staff.

1. Participants believed each PCC dimension must be operationalized, not just a subset. For example, participants would not consider a residential facility that operationalizes one dimension (e.g. by allowing choice in goals) but not another dimension (e.g. by forbidding phone calls to family) as person-centered.

2. The dimensions interact in synergistic ways, such that operationalizing one dimension may contribute to operationalization of another. For example, operationalizing physical comfort through recreational spaces or gardens may contribute to family integration by providing a comfortable location for family to visit and relax.

3. Successful PCC operationalization depends on a range of staff roles. For example, receptionists can operationalize emotional comfort by nonjudgmentally directing clients to appropriate clinical staff in times of crisis; food workers can operationalize physical comfort and respect for patient culture by modifying food options for individual dietary needs.

The team also created a list of dozens of specific practices that SUD treatment facilities can adopt to implement each PCC dimension. Examples of these recommendations include:

- provide a menu of treatment modalities instead of a preset program, with choices in medication, group therapy topics, and peer support group types (dimension 1);
- repeat information about the purpose of treatments throughout the treatment process instead of only at the beginning (dimension 2);
- include staff with lived experience, like behavioral health technicians and peer support staff; in client case conferences (dimension 3);
- provide routine access to peer support specialists (dimension 4);
- let clients decide whether they want a roommate in residential facilities (dimension 5);
- permit young children to room with parents in residential facilities (dimension 6);
- have peer support specialists do regular aftercare checks with clients after leaving residential facilities (dimension 7); and
- offer or refer for all forms of medications for opioid use disorder (dimension 8).

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You can also find research from the **Health Economics Program** on other health policy topics in Minnesota.