

User-involvement/oriented Care Models and Substance Use Disorder Care: Review of the Literature

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Abstract

A review of the most current substance use disorder (SUD) treatment/care literature best practices, suggests implementation of user-involvement/oriented models of care results in successful care outcomes. User-involvement models of care are (1) person-centred, (2) demonstrate a patient/person participation approach, (3) apply shared decision-making, and (4) include a recovery model approach to care and client-provider interaction. Current studies that have examined the implementation of user-involvement models of care in SUD treatment are limited, and furthermore, represent a great degree of overlap without identifying care outcomes that are specific to each model. There appears to be no empirical study that examines SUD care outcomes based on a synthesis of the four models and this may be an indication of further research.

Keywords: Patient/Person participation; Person-centred; Recovery model; Shared decision-making; Substance use disorders (SUD); Therapeutic relationship; User-involvement/oriented models of care

Background

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), Behavioural Health Barometer: United States Annual Report in 2014, "In the United States, 6.6% of persons aged 12 or older (an estimated 17.3 million individuals) in 2013 were dependent on or abused alcohols within the year prior to being surveyed" (SAMHSA) [1]. The report also indicates "In the United States, 2.6% of individuals aged 12 or older (an estimated 6.9 million individuals) in 2013 were dependent on or abused illicit drugs within the year prior to being surveyed" (SAMHSA). Thus, in 2013 over 24 million individuals over the age of 12 were experiencing a SUD as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 (Substance Related and Addictive Disorders) [2].

That same year (2013), "In a single-day count, 1.25 million persons in the United States were enrolled in substance use treatment-an increase from 1.18 million persons in 2009" (SAMHSA). The Treatment Episode Data Sets [TEDS] reported, "For 2012, a total of 1,749,767 substance abuse treatment admissions aged 12 and older were reported to TEDS by 47 states, the District of Columbia, and Puerto Rico" (Centre for Behavioural Health Statistics and Quality, SAMHSA)[3]. Of those admissions, approximately 297,460 or 16.7% were residential treatment stays (SAMHSA) [3]. "Residential treatment" is defined as "short-term, 30 days or fewer of non-acute care; long-term, 30 days or more; hospital residential in a 24 hour medical care facility, excluding detoxification" (SAMHSA) [3].

These data reflect a high number of admissions for SUD care annually and the cost can be exorbitant. Specialized SUD care centres represent a significant component of the healthcare industry and in 2006, the gross estimated expenditure on SUD care was over \$20 billion [4,5]. Almost all insurances allow one residential SUD care stay per year, with a pre-determined number of stays per lifetime. However,

"the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires health insurers and group health plans to provide the same level of benefits for mental and/or substance use treatment and services that they do for medical/surgical care" (SAMHSA, 2015) [6]. Therefore, opportunities to participate in more than one episode of care have increased, and are expected to expand with the Affordable Care Act. For those currently uninsured, the state may absorb some or all of the cost of care. Expanded opportunities for care resulting from the implementation of the Affordable Care Act, may lead to cost-shares between 20-40% for SUD care ("Premiums may be low" p. 1). In addition to access to care through cost share, we may begin to see an increase in utilization because of recent Federal legislation, which allows for equal reimbursement for SUD care [7], and further expanded SUD care coverage in Federal healthcare reform [8]. In 2011, it was projected the Affordable Care Act (ACA) would cover 32 million uninsured Americans, 6 to 10 million of whom were believed to have a SUD and/or mental health disorder (Congressional Budget Office) [9]. As of 2014, the Office of National Drug Control Policy reported, "The ACA includes substance use disorders as one of the ten elements of essential health benefits" [10].

Regardless of cost, these data show that effective care is worth the money spent, as SUDs result in greater expense than treatment and services. According to the National Institute of Health [NIH], "Substance abuse costs our Nation over \$600 billion annually and treatment can help reduce these costs. Drug addiction treatment has been shown to reduce associated health and social costs by far more than the cost of the treatment itself" [11].

SUDs are pervasive and expensive, and accessing care can be a challenge. Although we understand the process of recovery from SUDs may include lapse and/or relapse, an individual's personal circumstances, insurance, access to care, time off from work, etc., may affect their opportunity to participate in or receive residential care over the course of one's lifetime. Beyond the importance of providing ethical care, the interventions must be efficient and demonstratively effective, given the access to care issues and limitations.

Methods

A robust and comprehensive review of SUD care literature using EBSCO host (University of Pennsylvania), Google Scholar, and PubMed, resulted in a review of approximately 230 articles, narrowed to those included in this paper. The aim of this review was to explore the presence of research of user-involvement models of care in SUD care, treatment, and services. While reviewing all related literature, the author maintained a specific interest in exploring the presence of these models in residential SUD care, as the length of stay might improve the opportunity for the implementation and evaluation of these models. However, the author considered all studies for this review based on their relevance to the application of user-involvement/oriented models of care and SUDs, regardless of SUD type, level of care, or the characteristics considered as successful care outcomes by the researchers.

Discussion

The search for successful SUD care outcomes

The current literature review did not reveal a concrete definition of a successful SUD care outcome. However, in most care settings it is agreed an unsuccessful outcome is when individuals dropout of care prior to an agreed upon discharge date. According to TEDS data (2011) "Of the 1,742,114 discharges aged 12 and older 26 per-cent of the discharges dropped out of treatment" (Centre for Behavioural Health Statistics and Quality, SAMHSA) [10]. TEDS data for 2010 reports care termination in the following ways: Incarceration, termination, other, dropped out, transferred, and completed. In 2010, only 44 per-cent of participants completed treatment (Centre for Behavioural Health Statistics and Quality, SAMHSA) [12].

Given the frequency in which persons dropout of SUD care, researchers seek to identify correlates to successful SUD care outcomes. A study conducted by Dawson et al. [13] identified factors associated with recovery including "female gender and being married" (p. 132).

Moos and Moos [14-16] identified protective factors that promoted abstinence and recovery including self-efficacy, health status, financial status, participation in Alcoholics Anonymous, and support from family, friends, and work. Characteristics including treatment/care length, female gender, age (older adult), supportive friends, and positive life transitions, predicted abstinence from alcohol and remission from five to nine years following initial treatment stay [17]. There are several other studies that identified characteristics that predicted low-risk drinking including gender/female, higher income, more years of education, persons whom are married, and those with greater social/psychological resources [13,18,19]. Identifying individual characteristics and protective factors that improve care outcomes is important; however, they may not represent all persons engaging in SUD care. Furthermore, abstinence may not be a care outcome or goal selected by the individual receiving care. The characteristics that define recovery are unique to each individual.

Interventions, modalities and outcomes

In the 1990's, the large-scale research of Project MATCH (Matching Alcoholism Treatments to Client Heterogeneity) [20] attempted to demonstrate successful SUD care outcomes could be achieved by matching individuals to specific types of interventions. The results of

the study concluded clinicians could not match clients to treatments or interventions in order to ensure a successful outcome ("Matching alcoholism," 1997.) In addition to the findings of Project MATCH, there is no research to support any one protocol or evidence-based practice is more successful than another [21]. There is also variation in client responses to care, regardless of programming or interventions [22]. More recently, a meta-analysis tested whether there were significant differences in effectiveness among interventions. Findings indicated no significant differences in approaches to care for alcohol use disorders [23].

Some studies explored whether long intervention duration resulted in improved care outcomes. Several studies identified longer treatment duration was predictive of successful care outcomes [24-27]. Perhaps, the longer a person remains in a controlled environment, such as rehabilitation, the longer he/she adapts to life without use, although remaining in care for a long period may not be possible for some participants.

To complicate matters, the presence of co-existing SUDs and mental illness (MI), presents even more challenges to achieving a successful SUD care outcome. Most of the research suggests at least half of those persons with a SUD, are also experiencing mental illness vulnerabilities [28]. Because of the severity and chronicity of these illnesses combined, much of the research reports the importance of an integrated approach to co-existing SUDs and MI. For example, Burnam and Watkins [28] recommend fragmented programs and funding sources integrate care in accordance with a person-centred model of care to increase the likelihood of successful care outcomes.

Although co-existing SUDs and MI are common, and often associated with poor care outcomes, the research is limited with respect to outcomes of integrated SUD/MI care [29]. To address the challenges of integrating care, SAMHSA published a toolkit representing evidence-based practices for co-occurring disorders to assist care programs with standardizing care using best practices (Substance Abuse and Mental Health Services Administration [SAMHSA]) [30]. In addition, practitioners can find a comprehensive listing of best evidence-based practices for SUDs on the SAMHSA website [31]. Despite the access to best practice resources, providers can develop a narrow view of what is important in SUD care, the person. Therefore, providers are cautioned "not to be so self-conscious over fidelity to a model that it dilutes any natural and effective style that engages clients in an effective working alliance" [32].

Within the SUD care literature, there have been studies conducted to identify individual characteristics and protective factors, which lead to specific outcomes. Yet, if not representative of a specific client demographic, these data may not be useful. The literature supports the integration of care, as demonstrated by the publication of best practices by leaders in SUD care and given the prevalence of co-existing illness. Nevertheless, the field of SUD care remains challenged to find strategies that encourage engagement, adherence, retention, completion, and ultimately, a successful outcome of SUD care by persons experiencing SUDs and co-existing MI vulnerabilities.

Clinical alliance and the therapeutic relationship

Many years of research in SUD care reinforce the importance of the alliance between client and care provider. The best predictor of outcome, even over the modality, appears to be the therapeutic relationship [32]. Ilgen et al. hypothesized the therapeutic alliance would positively affect drinking outcomes in clients treated for AUD

[33]. Findings of this study indicated clients could overcome low motivation with the support of a strong relationship between client and provider.

There is enough empirical evidence to show the importance of providers developing a strong, positive, relationship with clients, even more powerful than the modality one chooses to implement in SUD care. The early working alliance consistently predicts both client engagement and post-care substance use [34-37]. The solicitation of feedback regarding the course of care, including collaboration on care goals, improves the alliance between provider and client. Still, many times, providers develop care goals for clients and not with them, which is not consistent with person-centred care.

Patient/Person participation

In a broad context, patient/person participation includes involving service users in agency decisions, hosting forums, community meetings, and other opportunities for clients to provide input and share in the vision or development of the agency. In the context of service delivery, it advocates for more than simply explaining services and seeking a person's consent for care. First, consent for care goes beyond signing a consent form, and includes shared decision-making (SDM), where providers and clients explore options together. Often in mental health care, the professional is in charge, and makes all care recommendations with clients having minimal say throughout the care continuum. It is a paternalistic "I know what is best for you," approach to intervention, becoming more paternalistic with severity of illness.

As early as 1979, Bordin reported agreement between provider and client on care goals was one of the core components of a therapeutic alliance [38]. Zhang et al. showed improved care outcomes with agreement and adherence to care plans [39]. Yet, the study uses the words "agreed/adhered" as interchangeable terms. In some instances, clients may not agree to care plans, but will adhere especially if motivated by certain circumstances, such as legal mandates. Nevertheless, it appears considering the goals, needs, and preferences of the client positively affects outcome.

Rapp et al. discussed a strengths-based approach to SUD care, which outlined the importance of clients setting their own goals, and the provider/case manager acting as a consultant in the client's care [40]. While the authors discussed this approach in the context of care management, the concepts are congruent with recovery model care, discussed later in this paper.

Also within the literature evaluating SUD care outcomes, many researchers cite abstinence as the most important goal [32]. Not all persons who seek SUD care desire or are ready for abstinence. When programs accept the client may be more interested in reducing high-risk use, they are in a greater position to affect and promote change [41]. Regardless of what outcome a client seeks, allowing and encouraging the client to name his/her goals, and choose interventions which support achievement of those goals, is the operationalization of a person-centred approach to care.

Person-centred care

Maisto et al. propose three research directions, which could help improve SUD care protocols, including "real time data collection" or ongoing feedback [19]. The recommendation the authors make is congruent with research findings that illustrate waiting until care has ended to obtain feedback is too late. Furthermore, obtaining formal

feedback at each session not only promotes an early identification of a need to change modality, but also the trajectory of outcome. According to the literature, the solicitation of client feedback also helps to develop a strong alliance between provider and client [32]. Also recommended in Maisto is "adaptive treatment designs," and "more person-centred treatment options" [19]. Litt et al. further discuss the personalizing of SUD interventions through the development of individually specific coping skills [42].

Within the literature, describing best practices for mental illness is the frequently cited phrase "person-centred." Carl Rogers developed a theoretical framework for delivering therapy that placed the client at the centre of care. He believed, "Each person has the capacity and desire for personal growth and change" [43]. His philosophies were strengths based, hopeful, person-driven, and holistic, congruent with the guiding principles of today's recovery model care, as identified by SAMHSA [3].

A recent article published by the National Institute of Health, in the *Journal of the American Medical Association*, outlines the characteristics, which are essential to best clinical practices, and includes person-centred care [44]. Care planning with clients provides an opportunity for applying person-centred care, whereby the client names his/her goal(s). The interventions are collaboratively selected and agreed upon through the process of SDM, and reflect the needs and preferences of the client. McLoughlin and Geller, provide a framework for care planning best practices, using a person-centred approach [45]. They discuss the pitfalls of manualised care plans, templates used by a variety of disciplines, to provide input on what each believes the client should be doing. Care plan templates may be a time-saver, but they may not reflect what the client wants, or the ways each discipline will support the client with meeting his/her needs. The article also speaks to the potential for incongruence between what the client wants, and what the staff wants for the client. The client will be less likely to engage a plan he/she has not developed in accordance with their needs.

There is a long history of literature, which supports person-centred care for SUDs and matching care approaches to individual needs and preferences, and not diagnoses [46-49]. Yet, despite the support in the literature, and grounding in Rogerian theory, person-centred approaches appear to be lacking in the field of SUD care. Tondora discussed a number of concerns raised by providers regarding the implementation of person-centred care [50]. Those concerns include the risk of liability with allowing clients to make their own choices, and the time it would take to engage care planning based on choices (pp. 11-13). There may be risks involved in encouraging clients to think for themselves and fostering an environment of choices. It is also less time consuming to offer a template care plan and ask a client to sign it. Still, it appears to be a necessary adjustment, and a risk worth taking, to ensure the best outcomes of care.

Finally, a meta-analysis exploring the impact of preferences on care outcomes concluded there is some positive affect on care outcomes when clients choose care in accordance with preferences [51]. However, research in this area is limited and does not reflect the degree to which choice and preferences affect care, especially SUD care.

Shared decision-making (SDM)

SDM is a way of collaborating in care, sharing decisions about care and interventions, and implementing a team approach to care, between provider(s) and client. A recent literature review published by

Friedrichs et al. discusses the concept of SDM as it relates to SUD treatment [52]. The article describes SDM based on its roots in medicine, and illustrates its applicability to SUD care, given the success of this model in medicine. The outcome of their comprehensive literature review included a broad scope of findings with some limitations. Only two studies identified by the authors indicated patients wanted to be involved in decisions about SUD care. The authors of this article conclude that studies examining SDM in SUD care are limited. Despite the limited presence of studies examining SDM in SUD care, the literature shows there is efficacy with the application of SDM in the context of recovery model care [53]. Nonetheless, empirical data on the effectiveness of recovery approaches, which include SDM, when intervening with mental illness of any type are also limited [54].

Joosten et al. examined the effect of SDM on the therapeutic alliance in SUD care [55]. With their implementation of a SDM intervention (SDMI), findings resulted in perceived favorable alliances between provider and clients. Another study conducted by Joosten et al. examined the effect of SDM on drug use and psychiatric severity in SUD patients [56]. The research produced mixed results. A SDMI resulted in positive effects on illness severity, but had a limited effect on abstinence from substances. Again, these researchers attempted to translate the concept of SDM to SUD practice; however, these types of studies are under-represented in the literature.

A review of the mental health literature demonstrates while the degree of participation may vary, persons with mental illness vulnerabilities want to be included in decisions about their care and likely, have had fewer opportunities to participate in decision-making than they would prefer [57-59].

A statement in an article by Drake et al. summarizes the most important aspect of SDM. "Shared decision-making is an alternative to the wounding practice of medical paternalism, because it honors and values the voices of people with diagnoses" [60].

The "wounding of paternalism" led to SAMHSA's publication of "Shared Decision-Making in Mental Health Care: Practice, Research, and Future Directions" (SAMHSA) [7,61]. The SAMHSA publication accurately reflects the integration of recovery model care with SDM and provides a framework for intervening with clients in ways that are effective and congruent with social work practice.

Recovery model

SAMHSA has developed a working definition of recovery, which is, "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA) [3]. Recovery is "the primary goal for Behavioural healthcare" (SAMHSA) [3], and within that definition are ten guiding principles. The principles described are "Hope, Relational, Person-Driven, Culture, Many Pathways, Addresses Trauma, Holistic, Strengths/Responsibility, Peer Support, and Respect" (SAMHSA). These principles overlap with topics discussed earlier in this paper, including person-centred care, and are congruent with the principles of social work practice.

SAMHSA also published Treatment Improvement Protocol (TIP 42) [62], which references "The Six Guiding Principles in Treating Clients with Co-occurring Disorders (COD)," which includes "employing a recovery perspective" ("SAMHSA TIP 42,)[63]. The specific focus on SUD care, with respect to a recovery model approach, provides a

foundation for studies, which have explored the utility of recovery based interventions in SUD care.

In a recent article, the researchers make the statement, "As the SUD treatment system undergoes its most important transformation in at least 40 years, recovery research and the lived experience of recovery from addiction should be central to reform" [63]. Within this article, the authors discuss recovery in the same holistic terminology used by SAMHSA, which speaks to the core of what persons in recovery from any illness desire from life, to be the best version of themselves that they can be. Laudet and Humphreys offer an excellent summary of what has occurred in SUD care, and where the field is going. Historically, SUD care has not been recovery oriented. Instead, it has been symptom focused using a medical model for intervention [32,64]. Although Laudet and Humphreys discuss recovery in the context of support services as part of a comprehensive, person-centred approach to SUD care, they advocate for all care to be recovery-oriented, which began with Duncan, Miller and colleagues.

The literature also represents other recovery model proponents, those who support the patient-centredness of recovery model approaches for all mental illnesses including SUDs, primarily for its comprehensiveness and view of supporting the whole person [64-67]. Clossey and Mehnert make recommendations for agencies to use to overcome barriers to implementation of recovery model care [63]. They explored the use of appreciative inquiry (AI), an approach that fosters growth and development of persons or organizations. The authors used this approach, to help staff develop a positive attitude about helping persons with serious mental illness recognizing that change in this direction must begin at the agency level.

As with patient-centred care, there are also those who discuss the risks of applying a recovery model approach [50,66,68]. Some risks identified include risk of liability, the burden on resources, and "it's an irresponsible fad" [69]. Despite the opposition, and including those who believe in the viability of the model and yet, are unfamiliar with ways to implement it, of the concerns expressed in the literature, there is some validity to the challenges of this complete culture shift. Applying such revolutionary change to SUD care after decades of interventions resulting in poor care outcomes using an outdated medical model, would result in a great degree of growing pains.

In addition to recommendations for change in agencies, which provide services to those persons experiencing mental illness vulnerabilities, some researchers identified a need for recovery model education within disciplines, such as psychology and medicine [70]. In an article by Mabe, the researchers engaged an ambitious effort to transform a university's department of psychiatry into a completely recovery-oriented learning environment. It was the researchers' belief change begins in the educational institutions. The research endeavour resulted in several successes, including the inclusion of service users on advisory councils, in accordance with the concept of patient participation. In addition, the project made recovery-oriented principles routine in the education curriculum, thereby ensuring it is more common practice than phenomena. Within this project, the authors recommended for future directions, empirical studies to explore the degree to which academic settings promote recovery-oriented care.

User-involvement/oriented care models (Person-centred, Patient participation, Shared decision-making, Recovery model)—A synthesis

Although the research is limited, user-involvement models of care appear to have a positive impact on SUD care outcomes, when applied with some demonstration of overlap. Absent in the literature are empirical studies examining the impact of a synthesis of these models on SUD care outcomes. Miller [32], and colleagues have been most successful in identifying the importance of synthesizing user-involvement models of care in SUD intervention, although they do not define these principles specifically as “user-involvement care models.” The meta-analyses conducted by Miller and his colleagues, references these concepts individually stressing the importance of their comprehensive inclusion as best practices in SUD care, treatment, and services [32].

Miller and his colleagues propose advances in SUD care, which they believe would significantly improve care outcomes. Recommendations include person-centred care plans, early and frequent opportunities to obtain feedback from service users regarding their perception of care, alliance between provider and clinician, and use of client feedback to shape on-going care [32]. These authors consider the care plan a living document, collaborative, including shared decisions about how to proceed with care. In Heart and Soul of Change, they discuss a common practice in SUD care, which is the treatment/care track [32]. Tracking care based on pathology is in opposition with patient participation, where the client makes informed decisions about his/her care based on needs and preferences. Tracking by pathology results in the practitioner deciding when the client moves forward in accordance with compliance with care and the provider’s determination of progress. Also incongruent with recovery model care, this approach focuses on pathology or illness and not strengths and abilities. Duncan et al. advocate for ensuring the client, with the support and consultation of the provider, guides his/her care and outcome trajectory [32]. Recovery-oriented care requires a shift in service delivery; a requirement for staff to be flexible and open to the desires of clients, and assist with the development of collaborative, person-centred care plans, which include the stated goals of the individuals served. All of the concepts discussed by Duncan et al. represent a synthesis of user-involvement models of care [32].

An article published by Storm and Edwards, appears to be the first identified publication to advocate for the implementation of user-involvement care models (person-centred, patient participation, shared decision-making, and recovery model) in a synthesized manner. Duncan et al. discussed these concepts without the use of overarching terminology, and Storm and Edwards developed a nomenclature synthesizing these concepts as “user-involvement models” [32,71]. The use of nomenclature is critical for the development of further studies, especially given the overlap and common features of these concepts and the potential for describing one without mention of the others. For example, a person-centred approach encourages the individual’s participation in the form of voice and representation. It includes opportunities for SDM as a forum for implementation of these approaches. Ensuring care participants are leading their care encourages the development of goals that will move him/her towards a life of their choosing, hence recovery model.

In Storm and Edwards, the authors use the words “user-involvement” as an overarching term, which emphasizes the importance of a balanced approach to implementation of these

concepts in a mental health care setting. From a psychiatric nursing perspective, the authors advocate for the application of all of the models, and discuss the challenges for implementing them in an inpatient mental health setting. Although this article does not speak specifically to SUD care, and further explores these concepts individually using over-arching terminology, the article represents an important effort toward creating a framework for models of care that would likely maximize outcomes when applied in a synthesized manner. The question becomes, if the literature demonstrates improved care outcomes with the application of each model applied separately, would a synthesized approach lead to greater improvement in care outcomes.

A review of the SUD intervention literature reflects advocacy for each individual user-involvement/oriented care model, and effective outcomes of care with the implementation of each; however, not found were empirical studies that discussed care outcomes in settings using all models, or the effectiveness of all models implemented in a synthesized manner. Finnell and Lee endorse a person-centred approach to SUD care and the inclusion of clients in the development of care plans [72]. They include SDM as important for a person-centred approach, where clients have choices from several options of care. In this study, the researchers attempted to establish a psychometric measure to assess patient decision-making. While the study’s aim was towards person-centred care, there appeared to be several limitations. It seems the authors were attempting to develop a tool for weighing the pros and cons of care options. Perhaps a tool is not as effective as having a conversation about options, through the process of establishing rapport, or client provider alliance. It may be more prudent to explore the outcome of providing clients with a range of choices of interventions. In other words, applying a holistic approach to care, offering a variety of interventions from support services to evidence-based care, and then evaluating the impact of such choices on outcome, may provide more information about SUD care outcomes in general.

In a study conducted at the University of New South Wales [73], the researchers found that drug treatment participants had positive outcomes when participating in their care. This is an important study for identifying positive outcomes based on the overlap of patient/person participation and SDM. The researchers use the overarching term “consumer participation,” which as described in the study, encompasses positive outcomes experienced with the client’s opportunity to be included in care planning, thus SDM. In addition, this terminology describes the concept of person-patient/participation, whereby, clients have knowledge of their rights. Although different from the terminology identified in studies conducted in the United States, it is important to focus on the positive outcome of care described by the study.

Evaluating whether SUD care participants want to make choices regarding care may be premature with a population historically made to believe they are too sick to make their own choices. Again, it may be more advantageous to offer choices, support clients as they explore their options, and evaluate outcomes based on a synthesis of user-involvement models of care. Nevertheless, care and intervention choices are person-centred, and apply an individualized approach to care planning.

Conclusion

SUDs affect the lives of millions of persons every day as indicated by the statistics reported in this paper. Changes in healthcare legislation point to the likelihood more persons will seek help, and ideally, those persons would be able to expect the most advanced and comprehensive care possible. The exploration of the current literature revealed the importance of applying user-involvement models of care (person-centred, patient participation, shared decision-making, and recovery model) in SUD care, treatment, and services. Nonetheless, there appears to be limited empirical research, which demonstrates successful SUD care outcomes when each model is applied. There further appears to be no empirical research of care outcomes resulting from a synthesis of these markedly promising approaches.

On the surface, simply applying these approaches in a synthesized manner might be a step in the right direction. Yet, with the mere diagnosis of SUD, care participants have faced discrimination with respect to the clinical course of the illness, and the field is only recently beginning to recognize the importance of removing the barrier of stigma for persons seeking help. Consistently held accountable for aspects of their illness, persons with SUDs have had limited control over the course of their care, resulting in a paternalistic approach to care, including shame and blame. Before immersing this population in the freedom of self-determination in the context of user-involvement models of care, it may be important to explore the experiences of SUD care participants on a deeper level, specifically, those whom have engaged in residential SUD care where the practice of these models are likely to be represented given the length of care.

Areas for further research include an exploration of user-involvement models of care and SUD care, treatment, and services. However, a potential challenge in conducting this research would be the difficulty of separating these models and studying each, given the overlap identified in the studies identified in this review. Therefore, the author proposes further studies that would facilitate the development of user-involvement model nomenclature, and outcome evaluation based on a synthesis of these models.

Limitation

This literature review was conducted by a Doctoral Candidate in Clinical Social Work at the University of Pennsylvania, Philadelphia, School of Social Policy and Practice. The Doctoral Candidate has been practicing clinical social work in excess of sixteen years, working predominantly with Military Members, Veterans, and families who receive SUD care in the United States or on military bases abroad. The basis of this review incorporates the practice frame of reference for this Doctoral Candidate and is not representative of the global or international understanding of SUD care captured by international practice literature.

As an overview of user-involvement models of care, this review does not explore the variation across SUD types, specific evidence-based practices with user-involvement models of care as an overlay, or a comparison of specific care provided for co-existing illnesses. The focus of this literature review was to examine best practices for SUD care, specifically, user-involvement/oriented care models as applied in any SUD care setting. This review recognizes the literature that suggests longer care stays improve outcomes, and does not engage in in-depth discussion of outcomes based upon length of stay.

References

1. Substance Abuse and Mental Health Services Administration (2014) Behavioral health barometer.
2. (2013) Substance Related and Addictive Disorders.
3. Centre for Behavioural Health Statistics and Quality, SAMHSA (2012) Treatment Episode Data Sets (TEDS).
4. Kimberly JR, McLellan AT (2006) The business of addiction treatment: A research agenda. *J Subst Abuse Treat* 31: 213-219.
5. Mark TL, Levit KR, Vandivort-Warren R, Coffey RM, Buck JA; SAMHSA Spending Estimates Team (2007) Trends in spending for substance abuse treatment, 1986-2003. *Health Aff (Millwood)* 26: 1118-1128.
6. Substance Abuse and Mental Health Services Administration (2015) Implementation of the mental health parity and addiction equality act (MHPAEA).
7. Barry CL, Huskamp HA, Goldman HH (2010) A political history of federal mental health and addiction insurance parity. *Milbank Q* 88: 404-433.
8. Buck JA (2011) The looming expansion and transformation of public substance abuse treatment under the Affordable Care Act. *Health Aff (Millwood)* 30: 1402-1410.
9. (2011) Selected CBO publications related to health care legislation, 2009-2010.
10. (2014) The White House, Office of National Drug Control Policy.
11. (2012) National Institute on Drug Abuse website.
12. Centre for Behavioural Health Statistics and Quality, SAMHSA (2011) Treatment Episode Data Sets (TEDS).
13. Dawson DA, Grant BE, Stinson FS, Chou PS, Huang B, et al. (2005) Recovery from DSM-IV alcohol dependence. *Addiction* 100: 281-292.
14. Ilgen MA, Wilbourne PL, Moos BS, Moos RH (2008) Problem-free drinking over 16 years among individuals with alcohol use disorders. *Drug Alcohol Depend* 92: 116-122.
15. Moos RH, Moos BS (2005) Sixteen-year changes and stable remission among treated and untreated individuals with alcohol use disorders. *Drug Alcohol Depend* 80: 337-347.
16. Moos RH, Moos BS (2006) Rates and predictors of relapse after natural and treated remission from alcohol use disorders. *Addiction* 101: 212-222.
17. Moos RH, Moos BS (2007) Treated and untreated alcohol-use disorders: course and predictors of remission and relapse. *Eval Rev* 31: 564-584.
18. Satre DD, Chi FW, Mertens JR, Weisner CM (2012) Effects of age and life transitions on alcohol and drug treatment outcome over nine years. *J Stud Alcohol Drugs* 73: 459-468.
19. Maisto SA, Kirouac M, Witkiewitz K (2014) Alcohol use disorder clinical course research: informing clinicians' treatment planning now and in the future. *J Stud Alcohol Drugs* 75: 799-807.
20. (1997) Matching Alcoholism Treatments to Client Heterogeneity: Project MATCH posttreatment drinking outcomes. *J Stud Alcohol* 58: 7-29.
21. Berglund M, Thelander S, Jonsson E (2003) Treating alcohol and drug abuse-An evidence based review. Weinheim, Germany: Wiley-VCH.
22. Duncan BL, Miller SD, Sparks JA (2004) The heroic client: Principles of client-directed, outcome-informed therapy. San Francisco: Jossey-Bass.
23. Imel ZE, Wampold BE, Miller SD, Fleming RR (2008) Distinctions without a difference: direct comparisons of psychotherapies for alcohol use disorders. *Psychol Addict Behav* 22: 533-543.
24. McClellan AT, McKay JR (1998) The treatment of addiction: What can research offer practice? In Lamb S, Greenlick MR, McCarty D (eds.) Bridging the gap between practice and research. Washington, DC: National Academy Press.
25. Mertens JR, Weisner CM, Ray GT (2005) Readmission among chemical dependency patients in private, outpatient treatment: Patterns, correlates and role in long-term outcome. *Journal of Studies on Alcohol* 66: 842-847.

26. Mertens JR, Kline-Simon AH, Delucchi KL, Moore C, Weisner CM (2012) Ten-year stability of remission in private alcohol and drug outpatient treatment: Non-problem users versus abstainers. *Drug and Alcohol Dependence* 125: 67-74.
27. Simpson DD, Joe GW, Rowan-Szal GA, Greener JM (1997) Drug abuse treatment process components that improve retention. *Journal of Substance Abuse Treatment* 14: 565-572.
28. Burnam MA, Watkins KE (2006) Substance abuse with mental disorders: specialized public systems and integrated care. *Health Aff (Millwood)* 25: 648-658.
29. Brunette MF, Mueser KT, Drake RE (2004) A review of research on residential programs for people with severe mental illness and co-occurring substance use disorders. *Drug Alcohol Rev* 23: 471-481.
30. Substance Abuse and Mental Health Services Administration (2010) Integrated treatment for co-occurring disorders evidence-based practices (EBP) kit.
31. Evidence-based practices web guide website (2014).
32. Duncan BL, Miller SD, Wampold BE, Hubble MA (2010) *The heart and soul of change* (2nd Ed.). Washington, DC: American Psychological Association.
33. Ilgen MA, McKellar J, Moos R, Finney JW (2006) Therapeutic alliance and the relationship between motivation and treatment outcomes in patients with alcohol use disorder. *J Subst Abuse Treat* 31: 157-162.
34. Connors GJ, Carroll KM, DiClemente CC, Longabaugh R, Donovan DM (1997) The therapeutic alliance and its relationship to alcoholism treatment participation and outcome. *J Consult Clin Psychol* 65: 588-598.
35. Crits-Christoph P, Connolly MBG, Gallop R, Hamilton J, Ring-Kurtz S (2011) The dependability of alliance assessments: The alliance-outcome correlation is larger than you might think. *Journal of Consulting and Clinical Psychology* 79: 267-278.
36. Fiorentine R, Nakashima J, Anglin MD (1999) Client engagement in drug treatment. *J Subst Abuse Treat* 17: 199-206.
37. Meier PS, Barrowclough C, Donmall MC (2005) The role of the therapeutic alliance in the treatment of substance misuse: a critical review of the literature. *Addiction* 100: 304-316.
38. Bordin ES (1979) The generalizability of the psychoanalytic concept of working alliance. *Psychotherapy: Theory, Research, and Practice* 16: 252-260.
39. Zhang Z, Gerstein DR, Friedmann PD (2008) Patient satisfaction and sustained outcomes of drug abuse treatment. *J Health Psychol* 13: 388-400.
40. Rapp RC, Siegal HA, Fisher JH, Wagner JH, Kelliher CW, et al. (1993) A strengths-based approach to enhance treatment compliance. *Addiction and Recovery* 13: 22-25.
41. DiClemente CC, Nidecker M, Bellack AS (2008) Motivation and the stages of change among individuals with severe mental illness and substance abuse disorders. *J Subst Abuse Treat* 34: 25-35.
42. Litt MD, Kadden RM, Kabela-Cormier E (2009) Individualized assessment and treatment program for alcohol dependence: Results of an initial study to train coping skills. *Addiction* 104: 1837-1838.
43. (2014) PsychPedia, Good Therapy.
44. Bradley KA, Kivlahan DR (2014) Bringing patient-centered care to patients with alcohol use disorders. *JAMA* 311: 1861-1862.
45. McLoughlin KA, Geller JL (2010) Interdisciplinary treatment planning in inpatient settings: from myth to model. *Psychiatr Q* 81: 263-277.
46. Gotheil E, McLellan AT, Druley KA (1981) Matching patient need and treatment methods in alcoholism and drug abuse. Springfield, IL: Charles C Thomas.
47. McLellan AT, Woody GE, Luborsky L, O'Brien CP (1983) Increased effectiveness of substance abuse treatment: A prospective study of patient-treatment "matching." *Journal of Nervous and Mental Disease* 171: 597-605.
48. Mee-Lee D (1995) Matching in addictions treatment: How do we get there from here? *Alcoholism Treatment Quarterly* 12: 113-127.
49. Miller WR, Hester R (1986) *The effectiveness of alcoholism treatment: What research reveals*. New York: Plenum Press.
50. Tondora J (2010) Top 10 Concerns about Person-Centered Care Planning in Mental Health Systems.
51. Swift JK, Callahan JL (2009) The impact of client treatment preferences on outcome: a meta-analysis. *J Clin Psychol* 65: 368-381.
52. Friedrichs A, Spies M, Härter M, Buchholz A (2016) Patient Preferences and Shared Decision Making in the Treatment of Substance Use Disorders: A Systematic Review of the Literature. *PLoS One* 11: e0145817.
53. Rabenschlag F, Konrad A, Rueegg S, Jaeger M (2014) A recovery-oriented approach for an acute psychiatric ward: is it feasible and how does it affect staff satisfaction? *Psychiatr Q* 85: 225-239.
54. Storm M, Edwards A (2012) Models of user involvement in the mental health context: intentions and implementation challenges. *Psychiatr Q* 84: 313-327.
55. Joosten E, DeFuentes-Merillas L, DeWeert GH (2008) Systematic review of the effects of shared decision-making on patient satisfaction, treatment adherence, and health status. *Psychotherapy Psychosomatics* 77: 219-226.
56. Joosten E, DeJong C, Weert-van Oene G, Sensky T, Van der Staak C (2009) Shared decision-making reduces drug use and psychiatric severity in substance-dependent patients. *Psychotherapy Psychosomatics* 78: 245-253.
57. Curtis LC, Wells SM, Penney DJ, Ghose SS, Mistler LA, et al. (2010) Pushing the envelope: shared decision making in mental health. *Psychiatric Rehabilitation Journal* 34: 14-22.
58. Park SG, Derman M, Dixon LB, Brown CH, Klingaman EA, et al. (2014) Factors associated with shared decision-making preferences among veterans with serious mental illness. *Psychiatric Services* 65: 1409-1413.
59. Woltmann EM, Whitley R (2010) Shared decision-making in public mental health care: Perspectives from consumers living with severe mental illness. *Psychiatric Rehabilitation Journal* 34: 29-36.
60. Drake RE, Deegan PE, Rapp C (2010) The promise of shared decision making in mental health. *Psychiatr Rehabil J* 34: 7-13.
61. Substance Abuse and Mental Health Services Administration (2011) Shared decision-making in mental health care.
62. Substance abuse treatment for persons with co-occurring disorders (2009). In *A treatment improvement, protocol (TIP 42)*.
63. Laudet AB, Humphreys K (2013) Promoting recovery in an evolving policy context: what do we know and what do we need to know about recovery support services? *J Subst Abuse Treat* 45: 126-133.
64. Clossey L, Mehnert K, Silva S (2011) Using appreciative inquiry to facilitate implementation of the recovery model in mental health agencies. *Health Soc Work* 36: 259-266.
65. (2005) National Association of Social Workers.
66. Tanenbaum SJ (2008) Perspectives on evidence-based practice from consumers in the US public mental health system. *J Eval Clin Pract* 14: 699-706.
67. Webb L (2012) The recovery model and complex health needs: what health psychology can learn from mental health and substance misuse service provision. *J Health Psychol* 17: 731-741.
68. Davidson L, O'Connell M, Tondora J, Styron T, Kangas K (2006) The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services* 57: 640-645.
69. Hardiman E, Hodges J (2008) Professional differences in attitudes toward and utilization of psychiatric recovery. *Families in Society* 89: 220-227.
70. Mabe PA, Ahmed AO, Duncan GN, Fenley G, Buckley PF (2014) Project GREAT: Immersing physicians and doctorally trained psychologists in recovery-oriented care. *Professional Psychology Research and Practice* 45: 347-356.
71. Storm M, Edwards A. (2013). Models of user-involvement in the mental health context: Intentions and implementation challenges. *Psychiatric Quarterly*, 84, 313-327.

72. Finnell DS, Lee J (2011) Psychometric properties of the decisional balance for patient choice in substance abuse treatment. *Issues Ment Health Nurs* 32: 243-249.
73. Brener L, Resnick I, Ellard J, Treloar C, Bryant J (2009) Exploring the role of consumer participation in drug treatment. *Drug Alcohol Depend* 105: 172-175.