2022

Person-Centered Substance use Treatment Program and Satisfaction of Care

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Master's thesis

April 29, 2022

Abstract

Person-centered care is an approach to substance use treatment that is responsive to the client's needs and values. It has been gaining popularity in recent years as there have been many negative connotations related to more traditional treatment methods that are directive and sometimes punitive. This research considered the use of the person-centered care approach to treatment and its effect on the clients' perception of the care they are receiving. A cross sectional survey study was conducted at the Town of Babylon Beacon Family Wellness Center. This facility is an outpatient level substance use treatment facility that utilizes the person-centered care treatment method. A simple linear regression and two Independent Samples *t* Tests were conducted. The results of the linear regression showed that time in treatment was positively associated with satisfaction of care. Independent Samples *t* Tests showed that there was no significant difference in mean satisfaction scores between non-mandated and mandated clients, nor was there a difference between mean scores for African American clients and all other races. Recommendations for future research and practice were considered.

Acknowledgments

I would like to express my sincere gratitude to my thesis advisor, Dr. Maria L. Taylor PhD., MSSW, for her guidance, support, and encouragement. Dr. Taylor helped me at every step of the way. She not only made the completion of the project possible, but interesting and yes, fun. Dr. Taylor's patience and generosity of her time is greatly appreciated. I would also like to thank Delores Bocklet LCSW-R, CASAC. As the director of the Town of Babylon, Beacon Family Wellness Center, Delores hired me for my first job as a CASAC-T in 2015. Since then, she has been my mentor, guiding me and challenging me to always do more. Delores encouraged me to continue my education and has been instrumental in me getting to where I am now.

I would like to thank my mother, Patricia VanTassell. Mom has always been there for me, supporting and encouraging me. No matter what the circumstances, Mom was willing to sacrifice her time, be inconvenienced, and set aside her needs to help me improve my quality of life. During the nine plus years I have been attending school and working full time, she has spent countless hours, filling the gaps when I was unable to, attending to my son's needs. As if that wasn't enough, she spent even more of her time painstakingly proofreading my papers with impeccable detail. Mom helped me in so many ways, her name should appear as a contributor to this project.

I would like to thank my father, Ronald VanTassell, who was the example I hope I am for my son. He and Mom, both went back to school as adults with 3 children. The example they both provided was one of sacrifice for others and determination for self-improvement. My father, who passed in 2016, was always an

example of honor and integrity. His support and inspiration have been an integral part of my achieving the goal of being a social worker. To people like my parents, the concepts in the NASW code of ethics come naturally.

I would like to thank my son, Douglas VanTassell. From the day he was born has been a bright spot in all our lives. His joy of living has helped me on days when the end seemed impossible. His sense of humor and warm personality inspire me and remind me that every day is to be relished and appreciated. During the long hours needed to accomplish my schoolwork over the years, and especially this thesis, he has always been respectful and considerate. Even as a teen, he makes each day easier and more enjoyable.

Finally, I'd like to thank Long Island University. From the day I walked in, just to see if the program would work for me, the entire staff went out of their way to make it possible. From the personnel in the office to the professors in the classroom, I never imagined such a concerted effort to provide this great experience for me. As I look back, I can see their helping hands, inspiration, and guidance making this impossible dream come true.

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Chapter 1: Introduction

Person-Centered Treatment and Client Satisfaction of Care

Many people with substance use disorder attend outpatient treatment programs to make changes in their lives. Not everyone who enters treatment has the same motivation and/or goals. Some are mandated and have no desire to change. Others are pressured by friends, family, and/or employers to address their difficulties with addiction. Still others may be self-motivated and enter treatment with a desire to make changes in their lives. Regardless of the initial reason for entering treatment, the motivation may change as time passes. The mandated clients may start out with no desire to change. This client is only attending treatment because he/she is forced to by the justice system. The mandated clients must comply with the requirements imposed on them by the court, probation or parole office or face consequences such as being incarcerated. The completion of treatment as a goal may only be due to these imposed requirements. The client may in reality, have no desire to reduce or abstain from using drugs and/or alcohol. However, after spending time in treatment, these clients often report that they have come to recognize the negative affect that substance use has had on achieving goals in their lives. This change in perspective can result in a new motivation that is independent of the mandate. The client that is mandated by family, friends, and/or employers may feel that they are required to attend treatment initially, but the forced abstinence can open the door to alternative approaches. After just a few short weeks of abstinence, they can convince those who insisted that they attend treatment that they are doing fine, and time spent attending treatment can be better spent working more hours at their jobs and spending more time at home being of service to the family. As for the person who comes to the

decision to apply for treatment on his own, the self-referral, this individual often feels helpless at the initial phase of treatment. The client being desperate to maintain abstinence often starts out eager to attend treatment sessions. But it does not take long for them to report that they may have been too hasty in their approach to recovery. Much like the client who is family pressured, this client often will disengage from treatment reporting that they feel that the time they are spending attending treatment sessions would be better spent working more hours at their jobs, exercising, or addressing problems at home that were neglected while they were engaged in active addiction. Regardless of the reason, early drop out can result in relapse. Therefore, it is important to keep all clients, whether mandated or not, engaged in the treatment program for as long as possible. As clients spend more time in treatment, they increase their likelihood of completion and thus reduce the rate of relapse. (Hohman, 2000) reported that clients involved in treatment longer than 180 days had an increased chance of completing treatment, stating that while the type of program was not significantly related to successful completion, the length of stay was.

One impact on retention levels is the perception of care. If a client feels that he/she is benefiting from the treatment, it is likely that he/she would be less inclined to drop out before completion. In addition, if the client has a positive perception of the care he/she is receiving, this too will likely decrease the rate of dropout before completion. Person-centered care, also known as patient-centered care, is an approach to care that is respectful of and responsive to individual client's preferences, needs, and values (Davis et al., 2019). An agency that considers itself person-centered functions with these principles at the core of its program design. Since the goal of any treatment program is

positive outcomes, it is beneficial to ascertain whether or not the person-centered approach has a positive impact on the client's perception of care. Therefore, treatment programs utilizing a person-centered approach periodically gather information from the clients regarding how they feel about care they are receiving from the providers. One method of obtaining this important information is by perception of care survey. The perception of care survey was designed by the New York State Office of Addiction Services and Supports, OASAS. The survey is designed to inform the agency how the clients feel about the service they are receiving. The program analyzes the data and can determine if the approach used is having a positive effect. Having a positive effect on clients may be the key to increased retention rates. Part of the demographic data collected is the respondent's time in treatment, which can be used to gauge the success the treatment facility is having on keeping the clients engaged for longer periods of time.

Statistics on the Population

In 2014, a report by Substance Abuse and Mental Health Services Administration (SAMHSA) indicated that approximately 20.2 million people over 18 years of age had a substance use disorder in the past year (Lipari & Van Horn, 2017). Of the 20.2 million people, 16.3 million had alcohol use disorder and 6.2 million had an illicit drug use disorder, with a reported 2.3 million adults experiencing both alcohol and illicit drug use disorders. With such a high rate of SUD in the United States, comes the risk of medical complications and death. In 2017, 3,690 of new HIV diagnoses were attributed to intravenous drug use; 86.6% of new Hepatitis C cases indicated intravenous drug use prior to onset of symptoms, and in 2018, there were 67,367 drug overdose deaths reported in the United States (National Institute on Drug Abuse [NIDA], 2020). Many of

the people diagnosed with SUD attend treatment facilities that are geared specifically toward addressing this issue. In 2014, 2.5 million adults received substance use treatment which represented 1% of the total population that year (Lipari & Van Horn, 2017). With so many people being admitted to substance use treatment each year, it is imperative to provide the best practice methods to insure the maximum level of successful completion of treatment for this population.

Importance of the Study

The impact of substance use disorder (SUD) goes beyond those who are diagnosed. If the clients entering a treatment program cannot maintain abstinence, the people who are dependent on these individuals can be negatively affected for years. The family's friends, employers and coworkers of the client at the treatment center are all potential victims as the result of the void that is left when the client relapses. Receiving the brunt of the impact are the families whose lives are in a constant cycle of unpredictable behavior. The person with substance use disorder is often unable to live up to his/her responsibilities leaving the burden to fall on those around him/her. The most innocent victim in the cycle of madness is the child. To be the child of a person with substance use disorder can be extremely traumatic. The unpredictability of life with the substance user or alcoholic often results in a lack in proper supervision or parental support. Substance use is often associated with domestic violence against the spouse, children, or parents of the person with the SUD potentially affecting the whole family (Zilberman & Blume, 2005). In addition, the effect on the community as a whole can be devastating. The afflicted individuals are likely to experience medical problems, lost time at work and school as well as the hardship caused as the result of criminal activity related

to SUD. Whether it be addicted persons committing crimes to obtain funding for their drug habit, or injuries and deaths caused as the result of driving while under the influence of drugs/alcohol, there is scarcely any area of life that is not affected by this disease. Treatment facilities that address SUD play an important role in helping the people afflicted with this disease to regain control of their lives and be productive members of society. It would seem that, while entering treatment is a good first step, the key is how to achieve success in treatment and thus increase the chances of long-term recovery. Considering Zhang et al. (2008) reported that clients who are happy with the care they are given have better treatment outcomes, it is essential to consider what program modalities result in a positive perception of care. This study considers the person-centered treatment method and its impact on perception of care. If it can be found that person-centered treatment does in fact have a positive effect on perception of the care given, then treatment facilities can begin to implement this approach with the goal of increasing their rate of successful completion of treatment. The long term effect of this positive change will effect countless lives and businesses in the community they serve.

Chapter 2: Literature Review

There is sparse data regarding person-centered treatment and its effects on the perception of care. There is, however, some evidence that when people feel cared for, they tend to have a better perception of the treatment they are given and thus have improved performance and outcomes. Moreover, positive treatment is found to have an effect on the mood of the clients reducing depression scores. In this chapter, literature is considered that relates to positive care and its effect on treatment outcomes. In addition, the benefits of clients having an active role in decision regarding treatment will be discussed as well as the possible outcome effect of clients remaining in treatment for longer periods of time. Finally, the effect of role stressors on the treatment providers and consequently the clients and their rates of success will be considered.

Perception of Care Appears to Be Relevant

When it comes to healthcare, the patient's perception of whether or not they are being cared for can impact the ability of the treatment provided to be effective. In a study of patient experiences with hospital care, Isaac et al. (2010) studied hospital cleanliness as well as the staff responsiveness, patient experience, and their effect on treatment. The study found that much like the hospitals in the top 25% regarding cleanliness, the hospitals in the top 25% regarding staff responsiveness and positive patient perception of care, had fewer decubitus ulcers than those at the bottom 25%. This study is particularly significant because, unlike other similar studies, it considered the patient's perception of care and experience. The study reported that better patient experiences in areas such as a quiet environment and positive staff communication and responsiveness were associated with fewer infection rates. This perception of care appears to be significant in increasing

positive outcomes. Unfortunately, while patient satisfaction with health care began to be considered an important part of healthcare research in the 21st century, it was limited in the field of substance use-specific treatment. One study in 2008 did consider treatment satisfaction, or perception of care, by considering data from the National Treatment Improvement Evaluation Study administered to 4939 clients from 68 community-based treatment providers in 17 states between 1993 and 1995. The study measured patient satisfaction as the clients perceived the overall helpfulness of the treatment as recorded at discharge. A follow-up interview 11 months after discharge considered behavior during that period to assess long-term success regarding abstinence. Zhang et al. (2008) found that there was a positive effect of patient satisfaction of treatment on drug use outcomes in the one-year period considered. The study noted that in the interim, there had been an increase in mandated clients in treatment that may have an effect on current results. In addition, the study noted that the sample had a high proportion of African Americans and patients admitted to long-term residential treatment programs. In a more recent report Ramirez (2018) studied patients at a substance use treatment program that incorporated the client's family into the treatment plan. The study looked at how family support and treatment helpfulness affected motivation to engage in treatment and maintain abstinence. The use of the PHQ-9 depression scale and a treatment helpfulness questionnaire as part of the study enabled the author to assess the effect that support has on motivation to engage in the treatment process. Ramirez (2018) found that depressive symptoms were negatively correlated with a commitment to sobriety. Moreover, higher rates of treatment helpfulness were a predictor of lower depression scores, concluding that clients who report higher levels of treatment helpfulness are predicted to have a greater commitment

to sobriety. While the overall data is limited, there does appear to be a connection between treatment providers being perceived by the clients as helpful and interested in meeting their needs and a positive treatment outcome.

Treatment Methods Effect on the Perception of Care

Various approaches can be utilized when working with clients in a substance use treatment facility. With the evidence suggesting that positive perception of treatment given increases the client's chance of success, then it would be helpful to consider treatment methods that result in this client's positive perception of care. Lindhiem et al. (2014) found that while the results were modest, they showed a statistically significant effect on outcome attributed to the client's involvement in decision making or receiving their preferred treatment. The effect was a higher treatment satisfaction, increased completion rates, and better outcomes than clients who were not afforded an active role in treatment decisions and/or receiving their preferred treatment options (Lindhiem et al., 2014). Marchand et al. (2019) reported that person-centered care has a positive effect on substance use treatment noting that shared decision making is one of the key components of his approach to treatment. Patient-centered care refers to treatment where patients are known as persons in the context of their own social worlds; they are listened to, informed, respected, and involved in their care. With patient-centered care, the patient's wishes are honored (but not mindlessly enacted) during their health care journey (Epstein & Street, 2011). The question is whether this approach has a positive effect on the perception of care or treatment outcomes. Davis et al. (2019) stated that treatment centers that were perceived by the clients to be person-centered had a statistically significant relationship between patient-centered care and improved outcomes and that there was a

relationship between satisfaction of treatment and positive outcomes. The present study will analyze data retrieved from a quantitative survey completed by patients being treated for substance use disorders in an outpatient setting. The goal will be to determine if the person-centered treatment received by these clients is perceived increasingly positive the longer length of time that they spend in treatment. Hohman (2000) reported that length of stay in treatment was significantly related to successful completion of treatment. If person-centered treatment is perceived increasingly positive as time in treatment passes, it would be reasonable to predict that this would result in higher successful completion rates by these clients.

Role Ambiguity in Person-Centered Approach Treatment

Working in a substance use treatment agency requires the treatment provider to be a counselor who is generally perceived by the client as someone who knows how to approach substance use treatment. This role as the one with the knowledge sets up a hierarchy where the clinician is in many respects looked up to by the patient. Most counselors are trained in providing treatment by utilizing the information gathered at assessment. The counselor then draws on training and experience to devise a treatment plan and ways to implement it. In the person-centered approach, however, the counselor's role is to educate and support the clients and help them make decisions and participate in their own care (Davis et al., 2019). This combined role of a person of authority now coupled with a collaboration role where the client makes decisions in their own treatment has the possibility of creating role ambiguity. At certain times the counselor will be in a collaboration mindset and at others in a role of authority where decisions are best made for the client. It would be likely that the roles, at times, will overlap which may be

confusing to both the counselor and the client. Celik (2013) studied the effect of role ambiguity on vice principals who are administrators and educators at the same time. The study confirmed that role ambiguity created uncertainty in decision-making and a decrease in performance.

On the other hand, Onyemah (2008) reported that moderate levels of role stressors (role ambiguity or conflict) are associated with higher performance in sales personnel, while low and high levels of role stressors resulted in reduced performance. The increased performance found at the moderate role stress level may be due to excess stimulus requiring increased focus. The low level may result in complacency, while the higher levels may cause over taxing of cognitive functions and thus both of these levels resulted in reduced performance according to Onyemah (2008). Since job performance is a factor in quality of care, it would be reasonable to consider the level of role stressors person-centered care has on substance use counselors and how it affects treatment quality. The present study does not consider any data that would expose role ambiguity if it does exist. Future studies at this agency may be beneficial to account for any effect role ambiguity may have on treatment quality and perception of care.

Research Question and Hypotheses

This research study will consider the question "Are clients in a person-centered substance use outpatient treatment program satisfied with the care they have received?" The following hypotheses were considered:

- H1: The predicted Hypothesis was that Clients who spend more time in person centered substance use treatment at an outpatient facility will be more satisfied with the care they have received.

- H2: Mandated clients who are attending a person-centered outpatient treatment program are less satisfied with services than non-mandated clients.
- H3: Black and/or African American clients who are attending a person-centered outpatient treatment program are less satisfied with the care they have been given than non-black/African American clients.

Contributions in conducting this study will help substance use treatment facilities make informed decisions about how to design their agency when considering the client's perception of care. The present study will contribute data that will either encourage or discourage agencies from pursuing person-centered care as their approach to treatment.

Chapter 3: Methodology

The research design for this study was a cross-sectional survey. This design is appropriate for this study as it is a part of a larger survey that has been completed by the majority of clients at various stages throughout the treatment process at The Town of Babylon Beacon Family Wellness Center, TOB. As time was limited and the goal is to increase understanding of outcomes, data previously collected by a sample population at a single point in time will achieve this goal. The survey has quantitative data that is readily available and easily accessed for analysis.

Population and Sampling

The theoretical population for this study was clients attending outpatient treatment at the Town of Babylon Beacon Family Wellness Center. A nonprobability sampling strategy, purposive sampling, was utilized for this study. Case records, which include Perception of Care surveys were collected from clients quarterly. The sample population was chosen from the entire caseload at The Town of Babylon Beacon Family Wellness Center in June of 2019. Clients were offered the opportunity to complete the survey while attending group sessions. There were 109 clients attending group sessions at the time of the survey. Considering clients not in attendance and clients opting out, the sample size was n=90. The clients were assured that the surveys are confidential, and that participation is voluntary. The clients were free to opt-out of participation in the survey at any time with no effect on their progress in treatment.

Data Collection

The surveys were distributed at the start of each group session held in June of 2019 until all groups scheduled had received the survey on one occasion. The surveys

were completed anonymously by the clients while attending the group counseling sessions. The surveys, whether completed or not, were placed in an unmarked envelope and one client who is picked by the group members was tasked with delivering the sealed envelope to the clerical staff at the agency. The clients in one-on-one sessions were given an envelope and were instructed to give the survey to the clerical staff upon exiting the treatment facility. The researcher was granted access to the paper studies by the Program Director. The studies were kept in a locked storage room on site.

Measures

The Perception of Care is a 13-item Office of Addiction Services and Supports (OASAS) constructed survey taken from a larger survey. The two variables that will be measured are person-centered care (Independent Variable) and level of satisfaction (Dependent Variable).

Dependent Variable

The dependent variable, level of satisfaction, was measured by utilizing 15 questions, relevant to satisfaction of care, that were part of a 24-item survey constructed by the New York State OASAS. This variable was operationalized by utilizing the client's response to question 13 found in part III of the survey which was titled, “What do you think about the services you received?” Question 13 directed the respondents to “check only one box in each row” to 24 items labeled a-x. Each row contained a 4-point Likert scale (1=disagree, 2=Somewhat Agree, 3=Agree, 4=Strongly Agree). Fifteen of the 24 items were utilized in this study; items, 13a to13m,w, and x. These items consisted of questions such as, “When I needed services right away, I was able to see someone as soon as I wanted,” and, “I helped to develop my service/treatment goals” which were

relevant to the dependent variable, level of satisfaction (see appendix A). Items were summed and then a mean score was computed given that 13m and 13l offered the respondent the option to leave the question blank. Mean scores can range from 1.00 to 4.00 with higher scores indicating a higher level of satisfaction with care.

The survey was constructed by the New York State Office of Addiction Services and Supports. All attempts by the researcher to confirm that the survey was derived from a standardized scale were unsuccessful, so that reliability and validity of this scale is unknown. However, reliability analysis was conducted on this sample indicating strorng reliability with a Crombach's alpha of .95.

Independent Variable

The independent variable, person-centered care, was measured by time in treatment. The independent variable is operationalized by question 1 on the survey: "About how long have you been in treatment?" The level of measurement is ordinal with 12 categories (1= One week, 2= Two weeks, 3= Three weeks, 4= Less than 1 month, 5= 1 month (4-7 weeks), 6= 2-3 months, 7= 4-5 months, 8= 6-8 months, 9= 9-11 months, 10= 1 year, 11= 1 ½ year, 12= 2 or more years).

Covariates

There were two control variables that were included in the analysis: "mandated to treatment" and the "race of the client." The covariate "mandated to treatment" was measured by question 8 of the survey which asks the respondent to answer, "Did you enter this program because a court judge, probation officer, or parole officer required or told you to?" The level of measurement is dichotomous nominal, with no scored 1 and yes scored 2. The covariate "race" was measured by question 5 in the survey, "What is

your race?" There were 6 choices with respondents directed to choose only one(1= American Indian/Alaskan Native, 2= Native Hawaiian or Other Pacific Islander, 3= Asian, 4= White, 5= Black or African American, and 6= other. The level of measurement is nominal).

Data Analysis

For the purposes of this study, a quantitative deductive analysis will be conducted on both univariate and bivariate variables using the SPSS statistical software (IBM corp., 2020).

Ethical Assurances

The research study was approved by the Institutional Review Board at Long Island University. The surveys were completed anonymously by the clients while attending the group counseling sessions. The clients were made aware that they were under no obligation to participate in the filling out of the surveys. The purpose of the surveys was explained in detail and the clients were asked if they had any questions, concerns, or objections to participating in the survey. They clients were assured that if they did not want to participate, they had the option to leave the group session during the taking of the survey, remaining in the session, but not be given a survey, or receive a survey and decide for themselves whether or not they would like to answer the questions or leave some or all blank. The clients were assured that participating or not participating would have no affect on their treatment or success in the program. The researcher was granted access to the paper studies by the Program Director. The studies were kept in a locked storage room on site.

Chapter 4: Findings

Clients that were attending person centered outpatient treatment were offered a survey regarding their perception of care that they were receiving. Ninety surveys were collected and scrutinized for missing data. Descriptive statistics were run for the two covariates, race and age to analyze the demographics of the respondents. Univariate statistics were run on the independent variable, time in treatment, and the dependent variable, level of satisfaction. The data from the surveys was then utilized to test the validity of 3 hypotheses. A simple linear regression was run for hypothesis #1. For hypotheses #'s 2 and 3, Independent Samples t-tests were run. The results were reviewed and implications for the hypotheses were considered.

Missing Data

Of the 90 completed surveys, *N*=90, 13 were deemed to have missing data from the dependent variable which was denoted in SSPS by the number 99. Missing data was defined as either having been left blank, or having been completed in such a way that the intended box to be checked could not be determined in all items with the exception of items l and m from question 13 on the survey, "What do you think about the services you receive?" For items l and m, the option to leave them blank was offered and is denoted in SSPS by the number 98 (not applicable). Of the 13 items with missing data, eight were missing one item, three were missing two items and two were missing three items. The researcher opted to set the cutoff for allowable missing data at three items per survey. This decision was based on the use of mean scoring rather than a summed score for the dependent variable. The use of mean scoring was used due to the option to leave items l and m blank. (Total *N*=90)

Descriptive Data

As shown in Table 1, the demographic characteristics indicate more than half of the respondents were white (65.5%), with Black or African American representing just under one fifth of the respondents (19.5%). None of the respondents identified as being Native Hawaiian or other Pacific Islander. Nor did any of the respondents report being American Indian/Alaska Native. Only one respondent identified as Asian and the rest of the respondents (13.8%) selected "other" for question 5, "What is your race?" There was no option to identify as Hispanic or Latino/a in question 5.

Table 1. Demographics of Respondents

Variables		*n* (*N*=90)	%
Race	American Indian/Alaska Native	0	0.0%
	Native Hawaiian or Other Pacific Islander	0	0.0%
	Asian	1	1.1%
	White	57	65.5%
	Black or African-American	17	19.5%
	Other	12	13.8%
Age	17 or younger	0	0.0%
	18-20	2	2.2%
	21-24	5	5.6%
	25-34	34	37.8%
	35-44	19	21.1%
	45-54	14	15.6%
	55 or Older	16	17.8%

Table 1 also shows that the majority of the respondents are between the ages of 25-34 (37.8%) with the 35–44-year-old respondents making up the second most common age group at 21.1%. Younger clients are less represented with 7.8% of the respondents

being under 25 years of age, and no clients in this survey reported being under 18 years old. The overwhelming majority of clients who responded to this survey are at least 25 years old (92.3%).

Dependent and Independent Variables

Univariate statistics were run on the independent variable, time in treatment and the dependent variable, level of Satisfaction (see table 2).

The level of satisfaction among the 90 respondents had a mean score of 3.08, a standard deviation of .55, and a range from 1.60 – 4.00. Since a score of 3.0 on the survey represents the respondents reporting that they agree with the statements regarding positive perception of care, a mean score of 3.08 would indicate a positive perception of care reported by most of the respondents in the survey.

Table 2. Descriptive Statistics for Time in Treatment and Level of Satisfaction

Variables		*n*	%	Mean	SD	Minimum	Maximum
Time in Treatment	One Week	4	4.4%				
	Two Weeks	3	3.3%				
	Three Weeks	1	1.1%				
	Less than 1 month	2	2.2%				
	1 month (4-7 weeks)	9	10.0%				
	2-3 months	19	21.1%				
	4-5 months	21	23.3%				
	6-8 months	11	12.2%				
	9-11 months	8	8.9%				
	1 year	9	10.0%				
	1 1/2 years	3	3.3%				
	2 or more years	0	0.0%				
	Total	90	100.0%				
Level of Satisfaction		90		3.08	.55	1.60	4.00

The survey allowed for clients to select one of 12 categories of time in treatment with the least amount of time being 1 week, and the greatest amount of time being 2 or more years. Table 2 shows that the greatest number of respondents indicated that they had been attending treatment for 4-5 months (23.3%). The vast majority of respondents reported being in treatment 1 month to 1 year (85.5%), with 11% of the clients reporting to be in treatment for less than 1 month, 13.3% being in treatment for a year or more, and no respondents reporting being in treatment for 2 or more years.

Research Question and Hypotheses

The research question for this study was, "Are clients in a person-centered substance use outpatient treatment program satisfied with the care they have received" along with three hypotheses. The results of these hypotheses are provided here

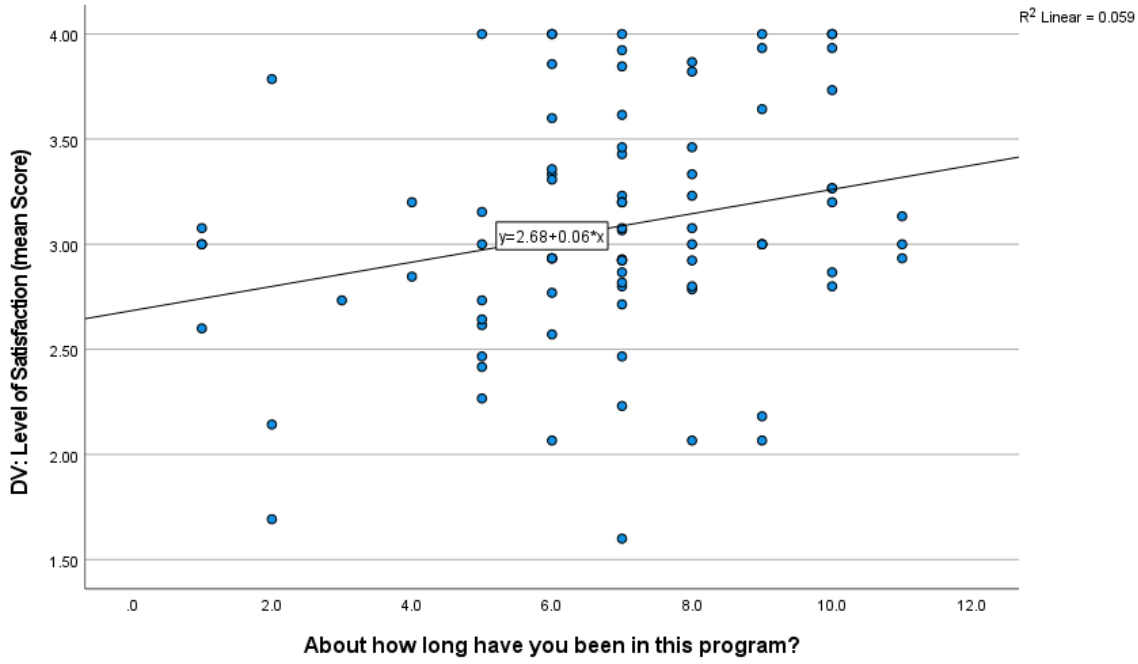
Hypothesis #1

A simple linear regression was run to examine if time spent in a person-centered substance use outpatient treatment facility predicted overall satisfaction with the care received. An analysis of standard residuals was carried out on the data to identify any outliers, which indicated that the data contained no outliers that needed removal. The data met assumptions of normality with normally distributed residuals. The scatterplot of standardized residuals showed that the data met the assumptions of homoscedasticity and linearity.

The results of the regression showed that weeks in a person-centered substance use outpatient treatment facility, explained only 5.9% of the variance in overall satisfaction with the care received, $R^2 = .059$, $F(1, 88) = 5.53$, $p = .021$. It was found that weeks in a person-centered substance use outpatient treatment facility was significantly

positively associated with overall satisfaction with care received (β = .243, p = .021). The estimated intercept of 2.68 is the average overall satisfaction score for client in a person-centered substance use outpatient treatment facility. The estimated slope indicated that for every additional week in treatment, overall satisfaction of the care received is increased by .058 points. Given the results of this regression, the null hypothesis was rejected, however the R^2 indicates the effect size is minimal with very little variance explained in the dependent variable by the independent variable. Figure 2 represents a scatterplot depicting the correlation of weeks spent in a person-centered substance use outpatient treatment facility and overall client satisfaction. A small positive increase in the slope is depicted in the scatterplot (see figure 1).

Figure 1. Scatterplot of Time in Treatment Predicted on Level of Satisfaction



Hypothesis #2

Non-mandated client will have higher levels of satisfaction in treatment than mandated clients. An Independent Samples t-test was run to find out if non-mandated

clients mean satisfaction scores were higher than mandated clients satisfaction scores. Test of normality were run and met levels of acceptability. According to the Independent Samples test there was no significant difference in mean satisfaction scores between non-mandated clients and mandated clients t= -104 (df = 87), p = .459. Accordingly, we fail to reject the null hypothesis. This indicated that there was no statistically significant mean difference in levels of satisfaction of treatment between these two groups of clients. However, there was a medium effect size as indicated by the Cohen's *d* (.54).

Hypothesis #3

Black and African American clients have a lower level of satisfaction in person centered outpatient treatment than all other clients. An Independent Samples t-test was run to find out if Black and African American client's mean satisfaction score was higher than all other clients satisfaction scores. Test of normality were run and met levels of acceptability. According to the independent sample t-test there was no significant difference in mean satisfaction scores between Black and African American clients and all other clients, t = -1.49 (85), p = .070. Accordingly, we fail to reject the null hypotheses. This indicated that there was no statistically significant mean difference in levels of satisfaction of treatment between these two groups of clients. Similarly to hypothesis #2, there was a medium effect size as indicated by the Cohen's *d* (.54).

Summary

Of the three hypotheses only hypothesis #1 was supported finding that more time in treatment resulted in a significantly significant increased satisfaction of care. Independent Samples t-test found that Hypothesis #2 was not supported as there was no significant difference in mean satisfaction scores between non-mandated and mandated

clients who responded to the survey. Similarly, an independent samples t-test found that there was no significant difference in mean satisfaction scores between clients who were Black/African and all other races of clients who responded to the survey.

Chapter 5: Discussion

This chapter is going to discuss the findings regarding the three hypotheses. The first hypothesis was supported by the data in that as clients spent more time in the outpatient treatment facility where the survey was distributed, they reported a higher level of satisfaction with the care they received. The second hypothesis was not supported as the data did not show that non mandated clients at the agency had a higher level of satisfaction with the care they received. Similarly, the third hypothesis was not supported by the results of the data analysis. This chapter will also discuss implications that the results of this study may have on policy and practice. Also, the strengths and weaknesses of this study will be considered. Finally, this chapter will discuss recommendations that can be made as the result of the outcome of this study.

Hypothesis #1

Hypothesis #1 predicted that clients who spend more time in person-centered substance use treatment at an outpatient facility would be more satisfied with the care they received. The results of this study did support this prediction. The clients that had just entered treatment reported satisfaction level of 2.68. According to the data, for each week a client had remained in treatment, the mean score for satisfaction of care increased .058 points. The most populated time in treatment was a client who had been in treatment for 4-5. These clients reported an average rating of satisfaction of care at 3.08 where 3 equals agree, and 4 equals strongly agree with the positive statements regarding care. There were no clients who reported being in treatment for the maximum of two years, but the data predicts that these clients would have a mean score of 3.38 regarding level of satisfaction. This increase in satisfaction is consistent with Lindhiem et al. (2014) who

found that clients who were allowed to share in the decision-making regarding treatment reported higher treatment satisfaction. It appears that as clients remain in treatment, they have more time to understand that they have a say in the kind of treatment they will receive and thus have a better appreciation for the services.

The data shows that there is a drop off in clients after five months with only 35% of clients remaining. The completion time for an outpatient treatment program is six months, provided that clients maintain abstinence and achieve most of the treatment goals. While the data does not show why there are less clients at longer lengths of treatment, the clients who remain, continue to report a higher level of satisfaction. It is likely that the drop off of clients in the longer times in treatment is due to successful completion, but there is no data to support this assumption.

While person-centered care does appear to increase the positive reporting of treatment as time elapses, there are likely to be other factors that contribute to this positive perception. As a client spends more time taking care of themselves and their life situation, they are likely to become less cynical. Moreover, their abstinence is likely to increase the positive feedback from family members and employers. The person-centered approach may be just the beginning of the treatment process, and as the client begins to heal, many other factors contribute to their positive attitude. Many of the clients may have previous experiences with substance use treatment that was not person centered. They may come to this treatment episode with preconceived ideas that may lead to an initial skepticism. Once the client realizes that it is a collaborative effort, and that they are given some freedom to choose the approach, their attitude may shift and contribute to a snowball effect that opens the other doors of positive experiences at home and work.

Thus, while it is true that the other factors may be more impactful on the client's perception, the initial change may come from those first weeks in treatment where the negative belief systems are challenged and a new way of thinking and approaching recovery begins.

Hypothesis #2

Hypothesis #2 predicted that mandated clients who are attending a person-centered outpatient treatment program are less satisfied with services than non-mandated clients. This was not supported as it was not found to be statistically significant, but with a medium effect (Cohen's $d = 0.54$), it is possible that a larger sample size would be statistically significant. There are many reasons that the mandated and non-mandated are reporting similar perceptions of the care they receive. It may be that regardless of the motivation to attend treatment, the response to person centered care is the same. In addition, as discussed earlier, the non-mandated client may come to treatment with a desire to change, but in short order, feels that the obligation to attend treatment sessions is interfering with their ability to improve other areas of life such as work and family. Conversely, the mandated client may have no desire to attend treatment, but with no choice but to attend, they may accept their circumstances and do what they can to successfully complete treatment. Moreover, the mandated client may be forced to attend treatment due to legal circumstances that have shed light on the seriousness of the addiction that the client previously denied was an issue.

Hypothesis #3

Hypothesis #3 predicted that black and African American clients who are attending a person-centered outpatient treatment program are less satisfied with services

than all other races. Much like the mandated clients, the difference between Black and African American client's vs all other client's mean scores was not statistically significant but had a medium effect (Cohen's d = 0.54). Person-centered treatment consists of care that is said to be respectful of and responsive to the individual patient's preferences, needs, and values (Davis et al., 2019). That is to say that all clients are treated with the same respect and responsiveness regardless of their race. So, while some Black/African American clients may enter treatment having had negative experiences, much like the mandated clients, they would immediately find that the person-centered treatment is different. The new experience being that all persons are treated with respect may be a factor in the similar mean scores regarding perception of care. Another aspect of this study is that the clients are all from the same community. They have been exposed to the same external experiences in this community and may all share similar values and assumptions. Their aligning as community members from similar socio-economic backgrounds rather than their race may result in their perceiving the care in a similar way. Moreover, as they spend more time in groups together, they share their feelings about the care they receive, and this too is reflected in the survey responses.

Strengths and Weaknesses

This present study was conducted using data that was collected in June of 2019. The surveys were distributed with the assurance of anonymity and no ramifications for answers given or refusing to participate. Nevertheless, having been distributed during the counseling sessions and by the client's counselor, it is possible that concerns of completing the survey may have biased the client's answers. In addition, studies that evaluate the effectiveness of an intervention using a retrospective design are subject to

several threats to validity, which limit the interpretation and generalizability of the results (Tofthagen, 2012). This study used purposive sampling that did not allow for random selection of the respondents. All who were attending treatment at that time were offered the survey. As this was a non-experimental study, there was only one group, specifically all the clients in the agency at that time who were present and willing to participate. There was no control group to compare the results to and no follow up to consider the long-term effects of person-centered care.

While the data may have been subject to bias due to counselor being present, some of the distribution and collection methods were intentionally designed to ensure anonymity and reduce the fear of repercussions due to negative responses. The clients filled out the surveys anonymously and the counselor never handled the completed survey. In addition, the sample size, n = 90, was sufficient and the dependent variable, satisfaction of treatment, met assumptions of normality. In addition, while the cross sectional study is not as robust as an experimental design, the survey method is cost effective, easy to distribute, and easy to collect.

Recommendations

There are many areas where person centered care may be useful in addition to substance use treatment. Medical treatment for both physical and mental health, as well as agencies that care for those who cannot care for themselves may benefit from this treatment approach. The results of this study can also be used to advocate for policy changes regarding funding for programs as well as incentives for insurance agencies to cover substance use treatment. Finally, we will consider some areas of research that can build on the result obtained in the present study.

Recommendations for Practice

The present study showed that person centered care has a positive effect on how clients view the treatment they are receiving over time. This is encouraging since Hohman (2000) found that regardless of the type of treatment, length of stay in a program had a positive effect on treatment outcomes. If person centered care increases positive perception of care, then the implementation of this approach would be beneficial to societies that wish to reduce the negative impact of substance use disorders on their communities. Many states have oversight on the agencies which are providing substance use treatment. In New York State, where this agency provides treatment, OASAS is the licensing entity that has some influence on the type of treatment the providers utilize. OASAS provides guidelines for best practices requirements in NY State. The treatment provider must document the methods used in their program. For example, the harm reduction model is part of the OASAS guidelines. The agencies licensed by OASAS must show how they are complying with the guidelines under the harm reduction model. Similarly, OASAS can require the agencies they license to implement the person-centered approach. This Statewide use of this model can help to increase positive perception of care in all communities. The use of this approach across the board may over time reduce some of the stigma and negative perceptions regarding substance use treatment agencies that is reported by past clients.

The person-centered approach may reduce the stress of working with oppositional clients. Many of the people who are applying for services at substance use treatment agencies are not ready to make changes in their lives to support recovery. The pushback is likely to cause conflict with the treatment provider who has set goals that must be

achieved in a certain time frame. The use of person-centered treatment allows for the practitioner to meet the client where they are and design a plan of action that the client has helped design. This reduced stress would have a positive impact on the client as well as the practitioner.

One of the major obstacles to people with substance use disorder seeking treatment is the cost of services. Many of the people in need of treatment are without adequate medical insurance. While Medicaid does cover substance use treatment, many potential clients have private insurance that does not cover substance use treatment or does cover the treatment but has extremely high co-payments. As more research is done showing the benefits of person-centered care on treatment outcomes, insurance agencies may be able to justify covering the treatment under basic plans. Moreover, interest groups may utilize the data to show the increase in positive outcomes and the relationship to reduced cost to the community. This ancillary effect may be the key that opens the door to legislation and funding that will increase access to treatment for underserved populations.

Substance use treatment may be just the tip of the iceberg for the use of person-centered care. Other areas such as mental health, medical treatment, nursing homes, assisted living agencies, and more may one day be implementing the principles of person-centered care. Hospitals, with their layers of administration and over worked providers, can sometimes felt like they are lacking in the personal touch. They too can be shown just how beneficial person-centered care can be on the patient's perception of care received and hopefully reduce some of the stress and strain on relationships between provider and patient.

Recommendations for Future Research

While retrospective designs may risk threats to internal validity, they can provide preliminary data useful for developing future studies (Tofthagen, 2012). This purposive cross-sectional study revealed that for the point in time, June, 2019, men in one specific treatment facility had an increase in positive perception to the person-centered care the longer they remained in treatment. Future studies using an experimental design with a comparative group could strengthen the results. By using two groups where one group is a comparison group and does not receive person centered care, but another treatment modality, the researchers in future studies may increase the internal validity of the study. In addition, future studies can increase internal validity by having the participants selected randomly where they have an equal chance of being placed in either group. However, ethical concerns in random assignments should always be considered first and foremost.

Another possible avenue of research would be regarding role stress. The use of person-centered care may have an effect on the relationship between the client and the provider. Studies showing the effect on the therapeutic alliance may encourage agencies to adopt this practice and reduce negative effects of role stressors such as counselor burnout. Lastly, if person-centered treatment has a positive effect on people with substance use disorder diagnosis, it may be reasonable to study if similar effects result when utilized in the treatment of other diagnoses. Many mental health facilities address

various diagnoses that may also benefit from this mode of care. In addition, these professionals may benefit from reduced role stress and potential staff burnout.

Conclusions

Person centered care is an approach to treatment that is respectful of the individual client's needs and values (Davis et al., 2019). This study considered the effect this approach had on clients who were receiving substance use treatment. The study found that there was a significant relationship between time in treatment and a positive perception of care. The implication is that by utilizing this approach, clients' feelings about the care they are receiving increases as time goes on. This improved perception of care is likely to reduce early dropout rates and increase the success rate of the agency. Moreover, the study found that neither race nor having been mandated to treatment had a negative effect on perception of care. The results indicate that regardless of who the client is or why he/she is in treatment, the equally supportive treatment results in a more positive experience and increases the likelihood the client will remain in treatment and successfully complete the program. Considering the over 67,000 drug overdose deaths reported in the United States in 2018 (NIDA, 2020), it is imperative that researchers study treatment approaches and their effect on treatment outcomes in an effort to reduce the impact of this nation-wide problem.

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Appendix A: Perception of Care Survey

PERCEPTION OF CARE SURVEY
What do you think about the services you receive?

Thank you for completing this voluntary survey. You can stop the survey at any time. Your services in this program will not be affected by whether or not you complete this survey. Your answers to this survey are confidential. They will not be linked to you or affect your participation in this program.
Please do not write your name on this form.
Your answers will be added with other client's answers to give program managers a picture of how the program is doing. Please note that the 3 open-ended questions at the end of the survey are for you to complete if there are other issues, things you see and/or concerns that you feel are not covered in the survey but want program managers to know about.

Participant Type: ☐ Treatment ☐ Recovery ☐ Access To Recovery/SOARS ☐ Mental Health ☐ Other

Please enter today's date: _____

1. **About how long have you been in this program?**
   - ☐ One week
   - ☐ Two weeks
   - ☐ Three weeks
   - ☐ Less than 1 month
   - ☐ 1 month (4-7 weeks)
   - ☐ 2-3 months
   - ☐ 4-5 months
   - ☐ 6-8 months
   - ☐ 9-11 months
   - ☐ 1 year
   - ☐ 1½ years
   - ☐ 2 or more years
2. **How old are you?**
   - ☐ 17oryomger
   - ☐ 18-20
   - D 21-24
   - ☐ 25-34
   - ☐ 35-44
   - ☐ 45-54
   - ☐ 55orolder
3. **Gender:**
   - ☐ Male
   - ☐ Female

Please turn over.**

4. **Are you Hispanic or Latino/a?**

- ☐ No
- ☐ Yes

5. **What is your race? (Please choose one.)**

- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ Other

Part II: What kind of services are you receiving?

6. **What is the primary reason you are receiving services?**

- ☐ Substanceuse
- ☐ Mental health
- ☐ Both

7. **Have you ever received services for this problem or a similar problem anywhere prior to coming here? (Check all that apply)**

- ☐ No
- ☐ Yes, Detox or crisis services
- ☐ Yes, Inpatient rehab or residential treatment
- ☐ Yes, Outpatient or day treatment
- ☐ Yes, Sober house or community residence
- ☐ Yes, Other.

8. **Did you enter this program because a court judge, probation officer or parole officer req ed or told you to?**

- ☐ No
- ☐ Yes

9. **Did someone from this program (your counselor, a doctor, nurse, or other therapist) discuss with you the use of medication(s) to assist in recovery? Which kind of medications? (Check all that apply.)**

- ☐ Yes, to help me stop smoking or craving cigarettes and other tobacco products
- ☐ Yes, to help me stop using or craving alcohol or drugs
- ☐ Yes, to help me treat my mental health or emotional problem
- ☐ No, none of the above

10. **When you came for services, were you given information about your rights as a client?**

- ☐ No
- ☐ Yes

11. **Have you been employed since you entered this program?**

- ☐ No, not since entering this program
- ☐ Yes, but not currently employed
- ☐ Yes, currently employed

12. Have you been enrolled in school since you entered this program?

- ☐ No, not since entering this program
- ☐ Yes, but not currently enrolled
- ☐ Yes, currently enrolled

PART III: What do you think about the services you receive?

13. Please check only one box in each row.	Disagree	Somewhat Agree	Agree	Strongly Agree
a) When I needed services right away, I was able to see someone as soon as I wanted.	☐	☐	☐	☐
b) This program helped me develop a plan for when I feel stressed, anxious, or unsafe	☐	☐	☐	☐
c) The people I receive services from spend enough time with me.	☐	☐	☐	☐
d) I helped to develop my service/treatment goals.	☐	☐	☐	☐
e) The people I receive services from are sensitive to my cultural background (race, religion, language, sexual orientation, etc.).	☐	☐	☐	☐
f) I was given information about different services that were available to me.	☐	☐	☐	☐
g) I was given enough information to effectively handle my problems.	☐	☐	☐	☐
h) *As a result of the program services I have received*, I am less bothered by my symptoms	☐	☐	☐	☐
i) *As a result of the program services I have received*, I am better able to cope when things go wrong.	☐	☐	☐	☐
j) *As a result of the program services I have received*, I am better able to accomplish the things I want to do.	☐	☐	☐	☐
k) *As a result of the program services I have received* I am not likely to use alcohol and/or other drugs.	☐	☐	☐	☐
l) *As a result of the program services I have received*, I am doing better at work/school. (If this does not apply to you, please leave it blank.)	☐	☐	☐	☐
m) *As a result of the program services I have received*, I get along with my teachers/boss. (If this does not apply to you, please leave it blank.)	☐	☐	☐	☐
n) There is someone who cares about whether I am doing better.	☐	☐	☐	☐
o) I have someone who will help when I have a problem.	☐	☐	☐	☐
p) I have people in my life who are a positive influence.	☐	☐	☐	☐
q) The people I care about are supportive of my recovery.	☐	☐	☐	☐
r) People count on me to help them when they have a problem.	☐	☐	☐	☐
s) I have friends who are clean and sober.	☐	☐	☐	☐
t) I have someone who will listen to me when I need to talk.	☐	☐	☐	☐

Please turn over...

Please check only one box in each row.	Disagree	Somewhat Agree	Agree	Strongly Agree
u) Using alcohol and/or drugs is a problem for me.	□	□	□	□
v) I need to work on my problems with alcohol and/or drugs.	□	□	□	□
w) I would return to this program if I need help in the future.	□	□	□	□
x) I would recommend this program to a friend or family member.	□	□	□	□

Please write in your answers…

14. What is this program doing right?

15. What could be done to improve this program?

16. Is there anything else about this program that you would like to say?

THANK YOU