DRUG & ALCOHOL FINDINGS Review analysis

This entry is our analysis of a review or synthesis of research findings considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original review was not published by Findings; click Title to order a copy. Free reprints may be available from the authors – click prepared e-mail. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text
The Summary conveys the findings and views expressed in the review. Below is a commentary from Drug and Alcohol Findings.

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▶ Patient preferences and shared decision-making in the treatment of substance use disorders: a systematic review of the literature.

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The first review to evaluate shared decision-making and patient preferences for substance use treatment finds evidence that greater patient involvement in decisions can improve outcomes and has no negative impacts.

SUMMARY Increasing attention is being paid to patient involvement in medical decision-making in substance use treatment, as reflected in these guidelines from the National Institute for Health and Care Excellence (NICE). There is not a huge body of research into patient participation and treatment preferences in substance use treatment. However, research into other health conditions does suggest that patients matched to their preferred treatments have a higher adherence to treatment, stay in their treatment for longer, and show improvements in their symptoms.

A policy or ethos of 'shared decision-making' can facilitate patient involvement by ensuring that responsibility for treatment decisions lies with both the clinician and the patient. It differs from the traditional paternalistic model of decision-making where the clinician decides on what is best for the patient, and also from the informed decision-making model where only the patient decides on their treatment. Shared decision-making is particularly appropriate in the treatment of chronic conditions, and in situations where two or more equivalent treatment options are available, or where the consequences of treatment will affect the patients' daily lives – as is often the case in substance use treatment.

During the shared decision-making process, clinicians contribute their evidence-based medical knowledge, experiences and attitudes while patients share their individual perspectives, expectations, goals, personal needs, values and daily routines.

Key points
From summary and commentary

This is the first review to evaluate shared decision-making and patient preferences in the context of substance use treatment.

Findings from 25 studies suggest that patients with substance use disorders should be involved in decisions about their treatment (as are patients with other health conditions), and a suitable approach for this is shared decision-making.

Further investigation is needed, with an emphasis on substance use and social outcomes.

This paper presents the findings of a systematic review of shared decision-making and patient preferences in the context of treatment for substance use disorders. It is the first review to evaluate this topic. Papers were included if they were published in English or German, if they related to adults with a substance use disorder, and if they were about either patient treatment preferences or shared decision-making.

Five key types of outcome were identified:
- Substance use: outcomes directly related to substance use, eg, reduction of consumption, severity of dependence, or abstinence.
- Mental health: outcomes about psychiatric or health status.
- Social: outcomes related to social functioning, eg, family, housing or legal problems.
- Shared decision-making: knowledge about treatment options or quality of decisions.
- Process: aspects like adherence, retention or satisfaction with the treatment.

The methodological quality of each study was also evaluated. However, "because of the comprehensive purpose of this review, no study was excluded owing to its methodological quality."

Main findings

Altogether 25 studies were included in the review: all conducted between 1986 and 2014; and involving 8,729 patients. The majority of studies (15) originated from the United States, three were conducted in the United Kingdom, two in Canada, two in the Netherlands, two in Germany, and one in New Zealand. The age of participants ranged from 26 to 51 years, and 57% of participants were male. In two studies, 89 clinicians were interviewed in addition to patients.

To what extent do patients with substance use disorders want to take part in making decisions about their treatment?

This question was evaluated by two studies – one investigating who the patient thinks should select treatment goals, and another investigating patients' desire for the autonomy to make medical decisions. Both found that patients with substance use disorders preferred to be actively involved in treatment decisions.

When asked about their general preferences for who decides treatment goals, 44% of participants in one study said they would prefer to decide themselves, 46% had a preference for shared responsibility, and 11% for the therapist to decide.

What sorts of treatment do patients prefer?

Preference for treatment setting was evaluated in eight trials, and preference for the mode of delivery was evaluated in 12 trials.

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Patients with alcohol use disorders preferred outpatient or day hospital settings to inpatient treatment in two studies, and similarly in three studies, the majority of opioid and cocaine dependent patients preferred outpatient to inpatient treatment.

After being given a description of treatment plans, cocaine and opioid dependent patients preferred individual counselling to group therapy in three studies. When given a simple description of motivational enhancement therapy (more therapist-directed) and non-directive reflective listening (less therapist-directed), patients with alcohol use disorders preferred motivational enhancement therapy over non-directive reflective listening. Comparing alternative treatments, like massages or yoga, versus Alcoholics Anonymous, more patients in one study preferred alternative treatments after reading information regarding treatment duration, philosophy, treatment goals and format. In a different study, 29% of worried drinkers preferred self-help support groups compared to online sessions or self-help booklets, and in another patients preferred receiving help from their physician rather than using internet programmes or attending Alcoholics Anonymous.

Three study groups evaluated the preference for treatment goals of patients with alcohol-related problems. Nearly half of the patients preferred a reduction of alcohol consumption to a non-problematic amount, whereas 15% preferred to be completely abstinent. In contrast to this, two studies found that the majority of patients preferred abstinence to moderate drinking. Evaluating preferences for medication with opioid dependent patients, methadone was the preferred choice, followed by buprenorphine – with the former perceived as having a greater impact on mental health and the latter on heroin use.

Is treatment more effective when it matches patient preferences?

When patients with alcohol use disorders in one study were matched to their preferred treatments, no differences were found for number of drinking days and number of days intoxicated. However, in another study patients matched drank less over time than unmatched patients. In several studies, patients using illicit drugs tended to have better drug-related outcomes (eg, use in previous 90 days or primary drug use) when they were matched to their preferences. In two studies, cocaine using patients showed no significant effects on drug-related outcomes regardless of whether they were matched to preferences or not.

In two studies, patients using illicit drugs didn't show any improvement in mental health symptoms when matched to their preferences. In another study patients matched to preferred vocational, housing, family or medical services stayed longer in therapy.

How shared decision-making was implemented in one study

Clinicians received training on how to follow a shared decision-making protocol, and to use motivational interviewing techniques to explore and compare treatment goals, and reach final agreement with their patient.

The intervention (1,2,3,4) itself lasted five sessions. It began with an exercise involving cards. The clinician and patient individually sorted cards representing different treatment goals according to their own personal level of importance and priority. They used these cards to compare and discuss treatment goals and expectations. And based on this, drew up a mutually agreed "treatment contract".

After a mid-way evaluation, the goals and expectations for treatment were again explored and discussed, enabling patient and clinician to adjust the treatment as necessary.

Which shared decision-making aids are available in the treatment of substance use disorders?

Several different types of intervention to support patient decision-making were evaluated. This included a shared decision-making intervention, aided by clinician training in motivational interviewing and the use of a protocol; a six session, 18-hour team-building curriculum to help with group discussions, which resulted in the establishment of joint patient-staff governance committees; and a computerised feedback tool containing personalised descriptions of the patients' current drinking status compared to safe drinking norms, and advice about the need to develop goals for behavioural change and possible strategies for doing so.

The authors' conclusions

Patients with substance use disorders should be involved in treatment decisions, as are patients with other health conditions. A suitable approach is shared decision-making, emphasising the patients' preferences. Due to the diversity in methodologies and outcomes of the studies included in this review, further research is needed regarding shared decision-making interventions in substance use populations (with an emphasis on substance use and social outcomes), and the development of decision aids, which could support patients to consider their treatment goals (eg, moderation, abstinence) and treatment services (eg, detoxification, counselling, peer group support).

FINDINGS COMMENTARY An inherent limitation of any systematic review is the methodological quality of the studies it reports on. The authors of this paper made the decision not to exclude any papers on the basis of their (lack of) methodological quality. As the first review to evaluate research into shared decision-making and patient preferences in substance use treatment, and met with a small pool of research, this was arguably a necessary decision.

The focus of this paper was *patient involvement* in treatment decision-making, contrasted against historic expectations for the patient to defer to the clinician's professional (medical) knowledge. Perhaps unintentionally, this framed clinician decision-making as the norm, ie, clinicians as the typical 'owners' of treatment, and patients as the 'recipients' – something made all the more apparent if we consider other ways the research could have been described, for example, 'clinician involvement in patient's treatment decisions', or 'the relative contributions of patients and clinicians to treatment decisions'. If shared decision-making is truly about "the conversation that happens between a patient and their health professional to reach a healthcare choice together", it may be appropriate to think more in terms of the relative contributions of patients and clinicians.

Another implication of the paper was that treatment is what takes place in a clinical setting between clinician and patient, overlooking what recovery work patients *do* outside of the clinical setting, and what contribution this can make to the recovery process, for example the impact of one's choice of friends, use of leisure time, approach to employment, and plans with family. As analysis of the UK Alcohol Treatment Trial revealed, catalysts for change (such as revelations in how patients saw their drinking) often preceded treatment entry, and patients saw themselves as responsible for the changes they made using subsequent treatments.

Across psychotherapy the client's contribution to their own improvement was the theme of the book, *How Clients Make Therapy Work: The Process of Active Self-healing*, published by the American Psychological Association. For therapists there was a clear, overriding message: "The single most important thing ... is clients' involvement and investment in the process. Involved clients will frequently be able to use whatever approach to therapy is being offered them. It follows

that the most important thing for the therapist to do is to facilitate, support, and help develop client involvement." The

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that the most important thing for the therapist to do is to facilitate, support, and help develop client involvement." The radical implication was that it was not the skills of the therapist or clinician which count, but how much they value and support the client's engagement and autonomy in the process of getting better.

This Effectiveness Bank hot topic focussed on gathering examples of the many different ways problem drug users and drinkers contribute to their own treatment and recovery and that of others, and among injectors in particular, help reduce substance-related harm. It emphasised that even when no specific steps are taken to 'involve' patients, treatment and harm reduction are in essence something the client or patient does rather than something done to them – that talking therapies, medications, needles and syringes (for example), are not things they just receive, but things they make use of.

Across psychotherapy, the evidence is strongly in favour of patients and therapists collaboratively agreeing goals and how they will go about reaching them, and underscores the centrality of incorporating patient preferences when making treatment decisions. Public Health England guidance describes how service users can, should, and have been involved in their own treatment and in the strategic development and commissioning of treatment services.

The NHS is seeking to embed shared decision-making through its Right Care Shared Decision Making Programme. Via a dedicated website, patients can access decision aids about 36 conditions (not including substance use), designed to help patients learn and make difficult decisions about their health-care. Decision aids were (briefly) mentioned in this study as a useful tool to aid patient involvement, and recommended by the researchers as an area for development in substance use treatment. A tool not mentioned was 'node-link mapping', recommended by the NHS National Treatment Agency for Substance Misuse to support communication, focus, producing ideas, and memory (four components of effective counselling sessions). Node-link mapping is a form of note-taking – key ideas are placed in boxes ('nodes') and connected to other nodes with lines ('links') representing different types of relationships. The boxes can be different shapes to indicate, for example, trigger items, positive items, and decision items. While to begin with the practitioner may need to take the lead in explaining the process, the patient and practitioner should co-create the map. "Observations of mapping-enhanced counselling sessions suggest that [node-link mapping] increases collaboration between client and therapist by taking the direct focus off the client and putting it onto a 'picture' of the therapeutic issues."

'What do the *patients* want?' was the question considered in this Effectiveness Bank hot topic. The answer was complex – research on patient perspectives is critical, but also sometimes contested. From the often-cited DORIS national treatment evaluation study was the finding that 57% of Scottish drug treatment clients selected abstinence as their sole goal for changing their drug use. What wasn't clear, however, was *what* the clients meant by abstinence. Did they mean free from all drugs, or just the one(s) causing them problems? Free now, or some time in the future? Was this an aspiration, rather than what even the patient would claim was a realistic goal? Findings from a major UK study support the argument that treatment programmes for dependent drinkers should not be predicated on either abstinence or controlled drinking goals, but offer both and facilitate an informed choice. In general it seems that (perhaps especially after a little time in treatment) patients gravitate towards what for them are feasible and suitable goals, without services having to risk alienating them by insisting on a currently unfavoured goal.

Ambivalence about taking medication is commonly observed in long-term prescribing. This can influence the treatment goals patients identify – not just for substance use issues, but for chronic physical and psychiatric conditions also. This ambivalence can be informed by the desire to be free from having to take medication regularly or concern over its side-effects and efficacy. For opiate users prescribed methadone or other substitutes, it may understandably be influenced by the unusual burdens the treatment can entail, such as supervised consumption and daily attendance, the stigma attached to regularly consuming opiate-type drugs (even legally prescribed), and the fact that the treatment marks the patient as an 'addict'. Clinicians on the other hand may fear that the perceived weight of these negative factors may lead their patients to decide not to take, or to prematurely cease or cut down medication, to the possible detriment of their health.

A change of policy at a US clinic offered the chance to evaluate what would happen if clinicians let methadone maintenance patients set their own doses. They found that average doses barely increased, and illicit opiate use became rarer than it had been before the change. Background notes on the study suggested that flexibility and individualised doses *can transform* 'failing' patients in to successes, but "whether the flexibility is nominally in the hands of staff or the patients is less important".

Thanks for their comments on this entry to David Skidmore based in England, former probation officer, addiction counsellor and regional manager with the National Treatment Agency for Substance Misuse. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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