A qualitative study exploring the benefits and challenges of implementing client centered care in a substance dependence rehabilitation service

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Abstract

Background Client centered care is strongly advocated as key to improving the quality of health care. However, there is a notable absence of research about the acceptability and feasibility of a client centered approach in substance dependence treatment settings. The aim of this study was to explore client and staff perspectives of a new client centered model of care implemented at Kedesh Rehabilitation Services, a residential substance dependence treatment service.

Methods Participants were client and staff at Kedesh between April 2018 and April 2019. Clients were invited to take part in a focus group and staff in individual interviews. Questions elicited client and staff experience of client centered care at Kedesh, including advantages and disadvantages. Staff were also asked to describe how they would define the client centered model. Thematic analysis was conducted on transcriptions of audio recordings.

Results Four focus groups were conducted amongst 18 clients and 8 individual interviews amongst staff. Staff identified the defining features of client centered care as that which is flexible, comprehensive, open-minded and inclusive. Clients and staff shared predominantly positive views on the client centered model, with an emphasis on the satisfaction in providing and receiving what felt like more authentic and comprehensive care. Shared themes emerged for clients and staff on the challenge of striking a balance between flexibility and structure, and managing comprehensive and individualized care within existing knowledge, skills and resources.

Conclusions Client centered care encourages health care organisations and providers to strive for a more holistic and empowering standard of care. Results support the acceptability of client centered care in residential substance dependence treatment settings for both clients and staff. Future research is needed to develop knowledge in interpreting, implementing, and assessing client centered care in the treatment of substance dependence.

Background

Client centered care is defined as an approach to care that is respectful of and responsive to individual client preferences, needs, and values (1). It requires that clients have the education and support they need to make decisions and participate in their own care and that the role of carers in a client's healthcare is respected and accommodated (2, 3). Similar terms are patient centered, person centered, personalized, and individualized.

The Picker Institute has outlined eight principles of client centered care (4): i) respect for patient preferences, values, and expressed needs; ii) information, education, and communication; iii) coordination and integration of care and services; iv) emotional support; v) physical comfort; vi) involvement of family and close others; vii) continuity and transition from hospital to home; viii) access to care and services. The Institute of Medicine (1) adopted these dimensions in its landmark report *Crossing the Quality Chasm* and asserted that client centered care is key to improving the quality and safety of health care.

The release of the report spurred a reorientation of healthcare delivery systems across the world emphasising that the *way* that care is delivered is as equal to the care itself (5, 6). Thus, alongside health status, health-related quality of life, and physical and psychological symptoms (1), attention is focused on interpersonal aspects of care, such as patients' concerns and expectations, their sense of dignity, and their participation in decision making (1).

Reviews have concluded that there are demonstrable relationships between client experience, quality of care, and healthcare outcomes (6–8). Yet even in the absence of impact on outcomes, it is emphasised that client centered care is important on ethical grounds alone (8). Client centered care fosters ongoing respect and inclusion between healthcare organisations, healthcare providers, clients and their carers (9) and encourages healthcare organisations and providers to strive for a more holistic and empowering standard of care (7–9).

Client centered care in the treatment of substance dependence

The significant stigma and discrimination experienced by people accessing treatment for substance dependence and the profound impact this has on their lives is well established (10). It has been identified that negative attitudes of health professionals towards individuals with substance use disorders are common and result in suboptimal care (11). Negative attitudes are observed to be based in perceptions of substance users being dangerous, irresponsible, manipulative and poorly motivated (11, 12) and to have a dehumanizing effect among health professionals (12), which is consistent with the paternalistic and authoritarian leanings identified in historical legislation and treatment for substance dependence (13–15).

It is recognised that clients with substance use disorders should be offered choice in treatment options for recovery and be actively involved in decision making about the best options for them (16). Involving clients as partners in their care and giving them 'a voice' could 're-humanize' stigmatised perceptions of clients among health professionals (12, 17). Thus, client centered care is recommended as an appropriate model to improve quality of care in treatment for substance dependence.

Current research

There has been a call for greater client centered evaluation of substance dependence treatment (18). This paper will describe and explore the staff and client experience of a new client centered care model that has been implemented in a residential substance dependence treatment service. Specifically, this paper will report on staff perceptions of the defining features of the model, and staff and client perspectives on the benefits and challenges of implementing this approach. Over the past 3 years Kedesh Rehabilitation Services has transitioned toward a client centered model of care that strongly emphasises flexibility and responsivity in their overall approach and modifications of the program content to better meet individual client needs. This change has occurred through all aspects of Kedesh treatment – from the time participants first make contact, their experience on the waitlist to aftercare. This provides the opportunity

to present a case study to better understand implementation of client centered care in substance dependence treatment.

Methods

Setting

Kedesh Rehabilitation Services is a community-based not for profit organisation that has provided residential drug and alcohol treatment since 1977 (19). It is located in a suburb of a regional city (population 200,000) in New South Wales, Australia. Participant recruitment occurred between April 2018 and April 2019.

See Fig. 1 for a description of the Kedesh treatment structure. Treatment commences as soon as clients connect with admission staff and the intensity and duration of support is collaboratively agreed upon between clients and staff.

The University of Wollongong Human Research Ethics Committee approved this study (2017/564).

[INSERT FIGURE 1 HERE. Figure 1. Treatment structure of Kedesh Rehabilitation Services.]

Treatment program. The Kedesh program provides participants with individual counselling, group therapy, and case management. Treatment programs are designed to address the psychosocial aspects of addiction as well as the physical components and consequences of addiction. The group content is primarily based in Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT) while also including other topics to promote healthy lifestyle behaviors and relapse prevention. Clients attend a variety of activities with the aim of promoting a healthy lifestyle and reintroducing clients to pastimes that do not involve substance use (e.g., bushwalking). Each client in the program is also allocated a daily job to encourage responsibility and cooperation. Residential clients are permitted to leave after the first week of the program and are entitled to increasing amounts of leave as they progress through the program.

Client centered care model. Kedesh espouses a strong culture of reflective practice and began the transition to a more enhanced client centered approach in January 2016. As an organisation they identified a disconnect in practice between organisational protocols and what clinicians believed may be better for an individual, and that rigid adherence to protocol maintained a distance from providing an authentically client centered service. The Chief Executive Officer opened a conversation with the board, staff, consumers and stakeholders around how the organisation as a residential substance dependence service could be more client centered. Discussion around potential modifications to the program and barriers continued over several months through regular scheduled staff and clinical meetings, client focus groups, and stakeholder surveys. The transition to a more client centered model of care has been iterative and progressive in nature and followed a process of generating ideas, implementing changes, and informally evaluating the changes amongst the team and via stakeholder surveys. Changes were made

across the treatment structure and program content and notably included the following: staff initiating check-in phone calls with clients on the waitlist; flexible and unlimited extension after program completion; permitting re-entry after lapsing; negotiable program length; negotiable leave entitlements; and the introduction of outpatient counselling.

Clients. Kedesh offers treatment for both men and women, aged 16 years and older. The criteria for entry into the Kedesh program is an alcohol or other drug problem that qualifies as a DSM-V substance use disorder. Clients are not excluded based on the diagnosis of a co-morbid mental health disorder unless the Kedesh assessment determines that the person's condition is not stable enough to effectively participate in the program. People using Methadone or Buprenorphine are not admitted to the service.

Staff. Kedesh staff comprise a multidisciplinary team of psychologists, intake workers and support workers. Registered psychologists or intern-psychologists are responsible for facilitating groups and delivering individual counselling. Intake assessment workers and residential support workers support the ongoing running of the residential facility.

Participants

Participants were residential clients and staff employed at Kedesh. Clients were excluded if Kedesh staff assessed cognitive impairment to be such that it adversely impacted comprehension of the study documents and decision-making capacity. Additional eligibility criteria for participants included age over 18 years and sufficient English comprehension and reading ability to understand and complete the study documents.

Materials

Client focus group and staff interview. Semi-structured questions were designed to draw out clients' and staff experience of client centered care. Staff were initially asked to describe how they would define the client centered care model. Clients and staff participants were then asked to consider the extent to which care at Kedesh was consistent with the Picker Institute principles and to comment on the advantages and disadvantages of the client centered approach, and suggestions for improvement.

Demographic questionnaire. Participants were asked to complete a brief demographic questionnaire to permit description of the sample. See Table 1 for participant descriptives.

Table 1
Client and staff participant demographics.

	Client	**Staff**
	N (%)	N (%)
Gender		
Male	9 (50)	2 (25)
Female	9 (50)	6 (75)
Age range (years)		
18–29	5 (28)	4 (50)
30–39	7 (39)	2 (25)
40–49	4 (22)	1 (13)
50–59	2 (11)	1 (13)
Country of birth		
Australia	16 (89)	6 (75)
Other	2 (11)	2 (25)
Education		
High school or less	15 (83)	1 (13)
Technical degree	2 (11)	0 (0)
Undergraduate	1 (6)	3 (38)
Postgraduate	0 (0)	4 (50)
Component	**Description**	**Recipients**
Community Access Centre	Screening, assessment and triage prior to commencing treatment, alongside case management and supportive counselling. The waiting list is capped and clients waiting for admission are provided with regular and ongoing contact and support.	All referrals

	Client	Staff
Residential	8 week group program plus case management and individual counselling. Clients can negotiate a shorter length of stay or extension with the clinical team. The team and client collaboratively develop a plan and determine the length of their program.	Intensity and duration discussed with team
Day program	8-week group program plus individual counselling and/or case management	Intensity and duration discussed with team
Outpatient	10 counselling or case management sessions	Clients in the community
Continued care and After care	10 counselling sessions as outpatient plus weekly group and individual counselling and/or case management.	Clients who have completed the program
Assertive after care	Two beds for 1 week stay. Clients may check-in with their counsellor and attend groups.	Past clients experiencing difficulty commuting to Kedesh after care is difficult or in crisis situation (e.g., homelessness). Includes rapid re-entry for clients that lapse within a 2-week period of leaving.

Procedure

Recruitment. Staff provided clients with information about the research and collected names of interested clients to pass onto the research team. A researcher then attended the service and gained written informed consent before conducting the focus group.

Staff were invited to take part in an interview through an email sent from the research team and staff were invited to express interest by replying to the email. The researcher then contacted staff members to arrange a time to attend Kedesh and provide further information about the study, gain informed consent and conduct the interview.

Data collection. Four client focus groups and eight staff individual interviews were conducted between April 2018 and April 2019. The client focus groups and staff interviews were facilitated by investigator ED who is trained and experienced in qualitative methods. The focus groups and interviews were held at Kedesh. Participants first completed the demographic questionnaire followed by answering the scripted questions. The focus groups ran for between approximately 45 and 80 minutes each and the interviews for 45 to 75 minutes, with both averaging approximately 65 minutes.

Data analysis

Demographic data is reported descriptively. Interview audio recordings were transcribed verbatim and analysed using QSR International's NVivo 11 Software. Participant codes and not pseudonyms replace names due to the small sample size. Thematic analysis was performed in six phases including:

familiarisation with data; generation of initial codes; searching for themes among codes; reviewing themes; defining and naming themes; and synthesising the final results (20). The researchers (ED and PK) met frequently throughout the data collection period to discuss progress and the point at which data saturation was achieved. Initial data coding was conducted by ED and discussed regularly with PK throughout significant points of the analysis. The coding was then verified by another researcher (TD) who coded 10% of transcripts to ensure inter-coder agreement. Discrepancies in coding were resolved through discussion between ED and TD until consensus was reached. Finally, the coding was discussed with the broader research team across different meetings to check accuracy of ideas and interpretation of the data.

Results

Participant demographics

Client (*n* = 18) and staff (*n* = 8) participant demographics are presented in Table 1. The most common substance of concern reported by client participants was alcohol (*n* = 9) followed by methamphetamine (*n* = 7), cocaine (*n* = 1) and heroin (*n* = 1). Participants reported an average of 14.94 years (*SD* = 9.43, range 4–45, median = 13.50) of problems with substance dependence. Half of participants (*n* = 9) were in the first three weeks of the Kedesh program (range 1–8, median = 3.50). Most had previously attended one or two rehabilitation services (*n* = 11), while the remainder had attended three or more services (*n* = 4) or no previous services (*n* = 3).

Staff participants came from a broad range of roles within the service, including community access coordinator (*n* = 2), psychologist/ counsellor (*n* = 2), case manager (*n* = 1), house coordinator (*n* = 1), quality improvement coordinator (*n* = 1), and service manager (*n* = 1). Staff had spent an average of 8.19 years (*SD* = 5.29, range 3–19, median = 7) in their current occupation and 4.94 years (*SD* = 4.39, range 1.50–15, median = 3) in their current role.

[INSERT Table 1 HERE]

Defining features of client centered care

Four overarching themes emerged from the staff interviews that captured the defining features of the client centered model: flexible, comprehensive, open-minded and inclusive. The themes are not mutually exclusive, but rather are complementary and interdependent.

Flexible. All staff described care as being conscientiously tailored to the clients' individual needs – in other words "making all the decisions around, and always taking into consideration, the needs of the client and doing what's best for them" (S1). Staff explained that decision-making and treatment planning are directly shaped from client needs and adapted over time as necessary. S1 added:

It's not that one size fits all treatment, like what we traditionally thought about rehabbing in the past. It's from the get go, you know, these are all your options, what do you actually need out of treatment? Is it outpatient? Is it residential? If it's residential, what is it going to look like? How long do you need? And constantly assessing that as you go through the program with the client.

Providing flexible care was described as being dependent upon transparency between staff and clients and an open mindset. Most staff explained that they have needed to help clients adjust to the intensity of flexibility or tailoring offered at Kedesh by regularly questioning clients about their needs and reminding them of their options. As S5 observed, "I think there's a lot more discussions and involvement with the client in terms of what their time here looks like". Staff identified significant components of this flexibility as the adaptable treatment and program structure, unlimited extension, accessible re-entry, and graduated and negotiable leave.

Comprehensive. All staff emphasised the importance of looking at the holistic, individualized needs of a client and that in doing so the care naturally becomes more comprehensive and in-depth. For S2:

The way I describe it is that we look at the needs of the client so we try and look at the overall context of the client not just at Kedesh but their context in their life, we look at their context in relation to their mental and physical health and we try to work with them as much as possible with that in mind.

Staff described there being a greater spirit of authenticity to care by acknowledging the client from a whole person perspective with consideration to the family and community systems that they ultimately need to re-integrate into. Staff identified a vital part of this approach as negotiating leave with clients, in which clients typically take progressively more leave throughout the program and return to the service where they process any issues that arise. As S3 explained:

Clients weren't accessing things that they really needed to, that were important for their recovery and rehabilitating them back into their own life outside of rehab life wasn't working quite as well as where it may have in our client centered model that we're providing them a lot of time outside of here to integrate back into their normal life.

Open-minded. All staff described the need to hold a curious and open-minded attitude to the possibilities in care. This appeared to take the form of setting aside ideas of a standard protocol (e.g. treatment program, service rules) and instead routinely questioning, challenging and discussing the best approach indicated for the client. S1 explained that adjusting to this mindset took time and teamwork:

When we first started moving towards it, it was a bit like, "Can we do this?" Like, "What are we allowed to do?". We were still in that old rehab model around being allowed to do certain things, being not allowed to do certain things. But now it's kind of more of a conversation of, "Why or why not?" Rather than, like a, "Yes or no you can or can't do it." So, I think it's created a lot more discussion.

Inclusive. Client centered care was experienced as a more compassionate approach by all staff participants. This meant actively acknowledging the autonomy of clients in managing their care and

making room for client mistakes in order to provide the care that they need. S1 said:

We're actually considering the client, rather than just being very clinical and going through the procedures and ticking boxes and you know, making these huge decisions that really affect peoples' lives without really considering the impact that's going to have on them and just going based on the procedure.

In order to show more leniency and flexibility around rules staff frequently identified, "using our clinical judgment a lot more" (S3). Most staff explained that a natural consequence of this approach is that the needs of the client are prioritised over the needs of the house.

Benefits and challenges of client centered care

There was significant overlap between client and staff participants regarding the benefits and challenges they identified in the client centered care model at Kedesh. The benefits and challenges could be grouped as subthemes within each of the identified overarching themes of flexible, comprehensive, open-minded and inclusive. The exception was the inability to capture a client identified challenge for flexibility, which did not emerge from the data.

Staff perceived benefits and challenges.

Flexible. Staff identified the benefit of *individualized care* and the challenge of *consistency*. All staff reported that there is a great deal of room for flexibility and creativity in tailoring the program to individual clients. S6 observed that, "There's no set, "this is what we provide". It's always essentially what they need and the amount of support required". Consequently, staff described nurturing reciprocity and collaboration between staff and clients and reported the belief that this directly promotes client autonomy. As S4 explained:

Often when they've come from addiction where there's been a lack of boundaries, sometimes I think for them there can be safety in very strict boundaries. But then yeah, the strict boundaries doesn't necessarily foster for them what we or they would hope to get out of it.

However, all staff noted that metering flexibility on a case-by-case basis inevitably leads to some inconsistency in approaches and confusion about what to do. S5 stated:

It's sometimes difficult to make a decision because you don't know what the boundaries and limitations actually are and what framework or what sort of expectation are you working with. So again, one person might think this is a really good idea because of this, but then this person might think, well actually, no because what about these things as well.

Hence, the majority reported that finding a middle ground where all staff can agree about a particular action can be challenging.

On other occasions staff noted that clients may observe inconsistency in an approach that in fact arose from a considered rationale. For example, staff may provide different treatment to individual clients

because circumstances indicated a different approach was needed at the time. S8 commented that clients approach staff with complaints of “I want what this bloke got” and “You let him stay because he had a slip, why aren’t you letting *him* stay because *he’s* had a slip?”. Staff explained the need to adroitly communicate their decision-making to clients.

Comprehensive. Staff identified the benefit of *holistic* care and the challenge of *logistical complexity*. All staff reported a focus on thoroughly considering clients’ needs beyond drug and alcohol issues. S5 explained:

Because we’re dual diagnosis, we look at more than just drug and alcohol, we look at all the other things that are going in their life, mental health and we look at creating a treatment plan that doesn’t just fit being in rehab, but more so, what their problems are in general, what they want to work on.

This holistic standpoint was viewed by all staff as instrumental to the successful reintegration of clients into their family and community systems and thus sustained change. As S3 identified:

A couple of weeks in a program feels great, but when you’re on the outside of Kedesh, it could really hit home. So I think we’re addressing things now that probably weren’t addressed before and I feel like it’s a quite important part of recovery for these clients.

At the same time, all staff explained that providing this depth of care complicates decision-making and therefore more logistical work. They noted challenges of communication and coordination between staff in individualising treatment as opposed to one-size-fits-all. S7 commented that, “because it is client-centered and we’re changing the way we’re doing things all the time – we talk about it, but I don’t know how well that often translates to the whole team.”

Staff also noted the difficulty in determining their capacity to provide individualized support in the residential environment. S3 commented that, “it is difficult to manage a bigger group of clients when you’re trying to focus on their individual needs” and S4 explained that while they may want to endorse timely re-entry of a discharged client, “it can get a bit tricky sometimes because it depends on the needs of the people on the waitlist as well”.

Staff also identified a notable logistical difficulty in providing support to family and friends of clients and opportunities and treatment for reconciliation. They noted the key issues within this particular domain as feeling underskilled in family liaison, the broad catchment area of their service, and varied levels of willingness of clients and their families to be involved. So, while meeting individual needs was a strength, a challenge was having the requisite skills or resources to meet diverse needs.

Open-minded. Staff identified the benefit of being *enterprising* and the challenge of *resource intensive* service. All staff described the client centered model as highly collaborative and supportive. As S1 explained, “it’s never one person making these decisions. It’s constant discussion and questioning and you share the load as a team”. All staff consistently reported a questioning as opposed to conclusive undercurrent to their decision-making.

Inherent within this approach is a respect that “everyone’s opinions are valid” (S3). This inclusivity was described as for the benefit of the client because “when you have a team of people that are giving input and saying, “How about we try this or how about we do that?” it actually is for the advantage to the client because you’ve got all of that different input coming in” (S2). As a consequence, staff described becoming closer and more respectful as a team.

However, the majority of staff also noted that delivering this model inevitably involves much more time and effort spent in discussions and critically thinking about courses of action. As S3 expressed:

If we worked by a book, it’d be very easy to make decisions. That person used, they get discharged, there’s nothing to talk about. As opposed to, “This person used, okay. What was the situation? How did they respond when they came back? Were they honest about it?” All that turns into an hour-long conversation, which is time consuming.

Staff reported that this issue can be significantly exacerbated by staffing availability.

Inclusive. Staff identified the benefit of *satisfying* work and the challenge of *anxiety provoking* responsibility. Staff were highly positive about client centered care being more satisfying to deliver. They reported showing a more compassionate approach to care in which, “staff get that genuine sense of doing what’s best for the individual … that sense of we’re doing what we can” (S6). They described feeling more like critically thinking clinicians and coming to have greater confidence in their skills and one another’s. S4 found that, “when we started the client centered care it boosted my confidence so much because it was kind of that, okay, it might be scary doing this new approach, but I do have good judgment”. S2 summarised the benefits of being *inclusive* for staff as:

… autonomy and variety and creativity and learning to respect each other’s professionalism but also having their professionalism respected, feeling that they are making a difference and that they’re an active participant in this as well, seeing some pretty cool ideas come to fruition with a client and seeing the impact that that has on the client.

Conversely, all staff spoke about there being greater room for uncertainty and doubt when leniency and flexibility are introduced. They explained that there is safety in hard and fast rules and procedures while in client centered care it is the team’s decision-making under the spotlight. As S5 explained:

We also sometimes feel there’s a lot of pressure to make the right decision and before sometimes it was like decisions were made for us, but now it’s like, well do we, don’t we. If we do, this is what’s going to happen, if we don’t this is what’s going to happen. So, for me personally, there is that, sort of, ongoing pressure in that you’re always having to make a decision and you’re not always going to know if that’s going to be the best or the right decision at that time.

Client benefits and challenges.

Flexible. Clients identified the benefit of *individualized* care. A corresponding challenge did not emerge from the data. The majority of clients identified that staff showed an open-minded and adaptable consideration of their unique needs and how best to "customise certain things to what we need" (P3, Group 1). Clients expressed appreciation for being provided with options and choice in their treatment planning and the sense that staff were being thoughtful of their needs. For example, P5 in Group 1 commented:

My counsellor's given me time through the week to give me the iPad so I can go in a room by myself and do some mindfulness. So she's taken out – she's organised some time for my illness, I guess, and, like, actually considered it, which I haven't gotten from any other residential rehab before.

Comprehensive. Clients identified the benefit of *holistic* care and the challenge of *confronting* personal work. Most clients reported that staff developed an in-depth and sophisticated formulation of their presentation that took into consideration the context of the whole person. P1 of Group 1 explained, "when you've got the case manager, the counsellor and all the other staff you're really forced to focus on yourself as an individual. So you can't just fit in with the herd and just fly under the radar …". P4 of Group 4 expressed appreciation for staff being able to "pinpoint" specific emotional struggles "because then I'm able to work on it". As a result, clients expressed the belief that "You get more help in the end" (P3, Group 1). P6 of Group 4 commented that "you can tell the times when they are doing the client-focused stuff because that feels totally more effective".

At the same time, some clients advised that this depth of care can be confronting or experienced as overwhelming. They described times of processing a lot of information and working through insights of intense personal significance. Nonetheless, clients frequently viewed this work as a necessary part to their recovery and reported being able to manage it with support and guidance from staff. As P5 of Group 1 explained:

I mean therapy is more challenging because I think we're getting more done. So it's not happening – I mean it's hard because I think they're getting down to the nitty-gritty and we're actually getting – it can get worse before it you get better but not in a bad way.

Open-minded. Clients identified the benefit of having *agency* and the challenge of *uncertainty* in taking ownership of their care. The majority of clients reported being invited into an open-ended consideration of their care and having a say in what they do. P4 of Group 2 stated that staff teach clients "accountability" and "responsibility" and "give you tools that allow you to learn for yourself". Thus most clients reported adopting a more reflective stance to how they approach decisions and life challenges. P1 of Group 1 commented:

I think staff can feel like we're making meaningful change because the change is coming from within, rather than just doing what is told and doing it just to exist and we're getting told in the house – because it's client based therefore a lot of decisions are coming from within us.

All clients endorsed the benefit of gaining “freedom” with the graduated leave so that “you can go out a bit more and more and you can test yourself” (P3, Group 4). Clients reported that this provided opportunities to review these experiences with staff upon their return from leave.

On the other hand, some clients also expressed anxiety and frustration with this independence due to feeling like they did not have the knowledge or skills to know what is best for them or how to go about it. This led to client concerns about the availability and willingness of staff to be able to see them through their care journey. P5 of Group 2 identified as having “a lot of self-responsibility with my care here” and that they were “the one that’s brought a lot of it out and said what my needs are”.

Clients discussed the need for a balance between being guided and challenged – a “two-way street” (P5, Group 2). P4 of Group 4 described the approach at Kedesh as “pushing you a little bit and letting you do it at your time”.

Inclusive. Clients identified the benefit of *compassionate* care and the challenge of times when treatment seemed *unfair*. All clients endorsed that staff provided authentic and empathic care. After leaving a rehabilitation service with “more of a group approach”, P2 of Group 4 explained “I went and had one counselling session and I already feel like I’m human again”. P2 of Group 3 identified authenticity in “funny” things like being able to have a bike on the premises because if it were denied you would feel like, “Oh God, I wish I had my bike”.

Clients reported that staff showed respect and responsiveness to their boundaries by regularly checking in and emphasising their availability for support while also allowing space for clients to move at their own pace. P2 of Group 3 reported:

If something has been a little bit close to home or triggered and I've got a bit teary or emotional about it towards the end of the group, "Are you okay?" So when the group finishes you've pretty much been asked if you want to speak about it, explore the feelings anymore, that sort of thing”.

However, some clients also noted the potential for clients to take advantage of the leniency and flexibility given by staff. P1 of Group 1 commented:

Because it’s not like a boot camp, a military school and it is meant to be that staff encourage feedback, there is an option if that power is given to the clients to be used. Because if somebody already comes in with a – the universe revolves around me, sort of, mentality, they could really come in from the door and be like, “All right, that means I can just whinge and complain about every little thing and staff are going to be at my beck and call”, sort of thing”.

Some clients expressed frustration when witnessing other clients “get away” with misdemeanours or not do their share of the house tasks, especially when they feel such clients are not genuinely and actively seeking recovery.

Discussion

This paper has provided valuable insight into the key features of a client centered model of care for the treatment of substance dependence. The defining features of flexible, comprehensive, open-minded and inclusive are highly consistent with the Picker Institute principles of client centered care (2) and capture the perspective that, the *way* care is delivered is equal to the care itself (5, 6). It was observed that the implementation of client centered principles in practice was facilitated by looking through the lens of being flexible, comprehensive, open-minded and inclusive. The findings also show consistency with implementation strategies that are identified as characteristic of leading client centered care organisations, including committed senior leadership; regular monitoring and discussion of client feedback; resourcing improvement to care delivery and environment; building staff capacity and a supportive work environment; supporting a learning organisation culture; and establishing accountability in performance (21). The Picker Institute principle and implementation strategy identified as notably difficult to address in the current study was engaging families in clients' care. This is reflective of a broader challenge within the substance dependence treatment sector in which there exist barriers related to organisational issues (e.g., lack of funding, time), family issues (e.g., diminished interest, limited networks), and clinical issues (e.g., confidentiality, professional self-efficacy, knowledge and skills; 22, 23). Overall, the findings from the present study are encouraging for demonstrating a respectful and considered approach to care that has the potential to ameliorate the stigma and disempowerment experienced amongst people accessing treatment for substance dependence (10, 11).

Staff and client participants indicated that a client centered approach was overall acceptable in a residential setting and even preferred to a standard approach when participants reflected on previous practice (staff) or experiences at other residential services (clients). Staff and client descriptions of working collaboratively and developing client agency is consistent with suggestions of how to 're-humanize' substance users among health providers and thereby combat stigmatised attitudes that have detrimental impacts on quality of care (12, 17). Indeed it is telling that one client commented on feeling "human again" (P2, Group 4). In addition, staff report of satisfaction in their work and a sense of fulfilment and making a difference is encouraging as these factors have been identified as negatively related to burnout amongst clinicians (24, 25).

Nonetheless, client centered care was also observed to pose challenges to staff and clients. Notably, these challenges seemed inseparably linked to the benefits; that is, a benefit generally did not exist without a corresponding challenge. Providing care that embodies flexibility, comprehensiveness, open-mindedness and inclusivity appears inherently dynamic and collaborative and thereby especially vulnerable to intra- and interpersonal difficulties amongst staff and clients. Staff and client participants seemed to want to convey the caring and satisfying potential of this deeply human approach while advising of the pragmatic constraints and potential pitfalls of too optimistic a view of human behavior. For example, staff expressed appreciation for having the flexibility to show leniency to clients who lapse while also questioning whether it was the "right thing" to do. At the same time, clients expressed an appreciation for what felt like a more compassionate approach to care while reporting concerns that this

may be taken advantage of by others. Staff and client participants consistently referred to the need to strike a balance between the benefits and challenges, and there was some uncertainty as to how to best manage these tensions. Staff identified the need for ongoing learning through experience and routine evaluation, as well as education and consultation of clients, as necessary steps to refining their approach. Even so, the nature of client centered care suggests that managing the balance between the benefits and challenges will be an inherent and ongoing requirement of its implementation.

Implications

The findings from this research suggest a number of clinical and research implications. It is noted that the generalisability of these findings is limited given the small sample size and that data arose from one service and their interpretation of delivering client centered care. Nonetheless, the consistency observed between the Kedesh client centered care model and Picker Institute principles suggests potential applicability for other services intending to make their care more client centered.

The results pointed to the utility of developing a guidance document with an articulated framework of how to deliver client centered care in substance dependence treatment. Existing guidelines are available that define client centered care and provide recommendations for how to make healthcare organisations more client centered (21). While such guidelines are useful in establishing foundational ideas, they are broad and general and do not take into account the challenges associated with implementation within the substance dependence setting. A guidance document for service providers of treatment for substance dependence would help promote greater coherence in interpretation of client centered care for the sector and potentially improve consistency in delivery. This may help staff feel more supported in their decision-making and provide a common language to communicate more effectively amongst the team. This would also help in training new staff to the service and for other services wanting to enhance the care they provide.

The findings also suggest that implementing enhanced client centered care may require more staffing because of additional workload associated with individualising aspects of care and an expanded range of treatment components to meet client needs. This is a considerable challenge given that maintaining adequate staffing and managing budgetary constraints are common issues within the sector. It would therefore be beneficial for services and future research to include cost analyses to determine whether benefits to clients and staff may offset any increase in cost. Additionally, collaboration and exchange of knowledge and experience between services would also be of immense value and potentially go some way to ameliorating the increased logistical challenges associated with an enhanced client centered approach.

Finally, the findings suggest that the sustainability of implementing a more client centered approach to care is substantially dependent on the willingness of services to conduct ongoing evaluation to determine the acceptability, feasibility and effectiveness of the model within their service. Future research to develop a better understanding of the extent to which principles of client centered care feature throughout

treatment and how these impact outcomes and perceptions of overall quality of care would prove invaluable to refining intervention and service evaluation.

Conclusions

Providing enhanced client centered care in residential substance dependence treatment appears to be acceptable and feasible to staff and clients, although not without challenges. The findings suggest that striking a balance between the benefits and challenges is an ongoing and iterative process that is inherent to a client centered approach. Future research to promote more support for staff in interpreting client centered care in practice and clearly analyse the benefits and costs associated with client centered approaches is needed.

Declarations

Ethics approval and consent to participate

Ethics approval was granted for the conduct of this study by the University of Wollongong Human Research Ethics Committee (2017/564). All participants provided written informed consent.

Consent for publication

Not applicable

Availability of data and materials

The datasets generated and analysed during the current study are not publicly available, but may be available from the corresponding author on reasonable request and compliance with ethics protocols.

Competing interests

The authors declare that they have no competing interests in this section.

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Authors' contributions

All authors contributed to the design of the project. ED executed the project and analysed the data with support from PK and TD. ED drafted the initial manuscript and all authors revised the manuscript critically for important intellectual content. All authors read and approved the final manuscript.

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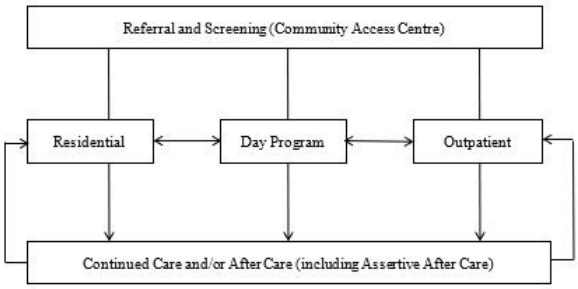
Figures



Component	Description	Recipients
Community Access Centre	Screening, assessment and triage prior to commencing treatment, alongside case management and supportive counselling. The waiting list is capped and clients waiting for admission are provided with regular and ongoing contact and support.	All referrals
Residential	8 week group program plus case management and individual counselling. Clients can negotiate a shorter length of stay or extension with the clinical team. The team and client collaboratively develop a plan and determine the length of their program.	Intensity and duration discussed with team
Day program	8-week group program plus individual counselling and/or case management	Intensity and duration discussed with team
Outpatient	10 counselling or case management sessions	Clients in the community
Continued care and After care	10 counselling sessions as outpatient plus weekly group and individual counselling and/or case management.	Clients who have completed the program
Assertive after care	Two beds for 1 week stay. Clients may check-in with their counsellor and attend groups.	Past clients experiencing difficulty commuting to Kedesh after care is difficult or in crisis situation (e.g., homelessness). Includes rapid re-entry for clients that lapse within a 2-week period of leaving.

Figure 1

Treatment structure of Kedesh Rehabilitation Services.