

Literature Review of Client Participation/Input into Drug and Alcohol Services

The parameters of the literature search were journals/articles/books/newspapers in English from search dates 2000-2014 using EBSCO host. Data bases included Premedline and Medline, Psychinfo and Embase. No further relevant literature was found on the following databases, Cochrane, Nursing and Allied Health, Informit or Google scholar.

The following search terms were used in combination: client participation AND/OR input in drug treatment/ client AND/OR consumer AND/OR user participation AND/OR involvement in drug treatment/indicators AND/OR perceptions of stability in methadone maintenance AND/OR Opioid substitution/take-aways consumers AND/OR clients AND/OR drug user's perceptions.

The inclusion criterion was any study that identified with drug using client participation/input /perspective into service provision. Twenty five articles/journals contained elements that were applicable to my proposal but none fully addressed client involvement in the creation of assessment tools.

The literature states that in recent times Healthcare driven by the rise and acceptance of Evidence Based Practice (E.B.P) and its inclusion of the client perspective is embracing client participation in future service development. However with respect to the drug user accessing treatment it is evident that there is a paucity of client input/perspective on a global scale. Europe at present is actively addressing 'this lack' in a more aggressive manner than Australia (King, 2011; Patterson, Weaver, Crawford, & 2010; Schulte, Moring, Meire, & Barrowclough, 2007; Ti, Tzemis, & Buxton, 2012; Treloar, Fraser, & Valentine, 2007; Treloar, Rance, Madden, & Liebelt, 2011).

The reasons for this lack of research giving the clients perspective are multi-factorial and lie in the tangled web of history, culture, morality, the illicit profile of drugs and the paternalistic ideology of healthcare whether it be the institution or individuals. This background insidiously colours societies' and therefore healthcare's perspectives on the need and value of seeking out drug users ideas, opinions and viewpoints whilst at the same time reinforces the stigma and discrimination that marginalizes drug users into an acceptance that they have no right to have an input (Fischer & Neale, 2008).

The barriers to user involvement found by Fisher and Neale (2008) fall into five broad categories (1) the perceived characteristics, needs and expectations of drug users; (2) the attitudes of professionals; (3) the dynamics of treatment encounters; (4) treatment programme design; and (5) structural factors affecting service provision. These categories are predominantly “grounded in user-provider power differentials and stigma relating to drug dependency” (Van Hout & McElrath, 2012) other authors have similar themes of it not being the users place to take part and that they do not have the interest or skills to participate (Bryant et al., 2008).

Interestingly Treloar et al (2001) evaluation of the Treatment Services Users Project found that it was the service itself rather than the clients who were not stable enough for consumer participation. From this literature search research studies in the drug and alcohol field are not providing the evidence required for changes to occur and so the status-quo remains. One example of this would be clinic rules on the subject of take away medications, dosing times, bringing family members and friends to the clinic, providing urine drug screens and a variety of other matters that affect the daily lives of the clients. Resinger et al (2009) states that from the perspective of the client these matters play a key role in satisfaction and retention but have not been a subject of study.

Furthermore the literature supports the concept of shared decision making (SDM) in treatment decisions because it has a “significant add-on effect” in reducing drug taking by increased client autonomy and control behaviour. In drug and alcohol treatment the main modality of treatment is considered to be the therapeutic alliance. SDM has been shown to result in favourable changes in the clinicians perceptions of the therapeutic alliance which it could be argued is due to a shift in the power balance due to increased communication orientated to specific outcomes which empowers the client (E. Joosten, De Weert, Sensky, van der Staak, & de Jong, 2008; E. A. Joosten, De Jong, de Weert-van Oene, Sensky, & van de Staak, 2011; E. A. Joosten et al., 2009; Street Jr, Makoul, Arora, & Epstein, 2009). Empowerment through user involvement works by allowing clients greater control over their lives, helping them to build confidence, increasing their self-esteem, and initiating mutual-support mechanisms (Fischer & Neale, 2008)

The value and contribution of drug user’s perspectives on policy and practice was highlighted by Treloar et al (2007) as an area where research does not currently exist. She goes on to

suggest that without consumer perspective there are no safe guards to ensure that services are targeted to meet clients' needs not the service's and that service evaluation doesn't under or miss represent their value to clients. King (2011) also points out the ambiguity that exists between policy recommendations on service user involvement and actual practice within treatment services. This is despite the fact that in 2005 NSW Department of Health published A Guide to Consumer Participation in NSW Drug and Alcohol Services to facilitate consumer involvement.

This literature review highlights that there are few actual projects in Drug and Alcohol where user involvement was included as part of the research process. Some of the barriers mentioned apart from power differentials were that client participation took the form of clients being involved in committees and groups which involve a level of commitment most clients were unable or unwilling to give. However there are many aspects of treatment that clients can have input into if more direct 'in the now' methods are utilized.

The disconnect between current purported policies of consumer participation and what research concludes is the reality requires a better understanding and balance of user and provider needs (Schulte et al., 2007). Patterson et al (2009) suggest that understanding of the impact on outcomes of user involvement could be beneficial to sustaining the process of involving clients. In addition O'Reilly et al (2011) suggests that tokenistic user involvement implementation and/or maintenance of user involvement (UI) in Opioid Substitution Treatment (OST) is because the 'gold standard' reputation of methadone medication alone creates high rates of consumer satisfaction which are reflected onto the service provider but is not attributable to the quality of that service. This has allowed services to continue the 'status quo' of poor engagement with UI and perpetuated the attitude of 'if its not broke why fix it' (King , 2011).

This review raises the unpleasant thought that Drug and Alcohol services themselves are the barrier to client involvement. They are afraid of client empowerment through user involvement which works by allowing clients greater control over their lives, helps them to build confidence, increases their self-esteem, and initiation of mutual-support mechanisms might open Pandora's box and lead to emancipation like it has for many other previously marginalized sectors of society(Fischer & Neale, 2008).

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