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Experiences of patient-centred care in alcohol and other drug treatment settings: A qualitative study to inform design of a patient-reported experience measure

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Abstract

Introduction and Aims: A growing body of literature supports the use of patient-reported experience measures (PREMs) to monitor the provision of patient-centred care to people accessing health services. However, there is an absence of research into PREMs in the alcohol and other drugs (AOD) field. The aim of this study was to explore patient experiences of AOD care and to develop a PREM for AOD treatment settings. **Design and Methods:** Five focus groups were conducted with people accessing AOD treatment services in New South Wales, Australia (N = 39). Data were analysed using iterative categorisation. A draft PREM was developed based on focus group findings and was modified following a subsequent review by consumers and service providers. **Results:** Participants emphasised the importance of timely access to integrated care delivered in a structured program by staff members who genuinely care. Furthermore, participants described positive experiences when services addressed the problems that maintain addiction, held them responsible for themselves and facilitated self-reflection. The PREM for Addiction Treatment (PREMAT) is a 33-item measure that captures what participants said regarding their experience of patient-centred care in AOD treatment. **Discussion and Conclusions:** The experiences of people accessing AOD treatment provided useful feedback that can be translated into service improvements and that informed the design of a PREM for AOD treatment settings. Future research is necessary to further investigate the validity of the PREMAT.

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Experiences of patient centred care in alcohol and other drug treatment settings: A qualitative study to inform design of a patient reported experience measure (PREM)

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Conflict of Interest: The research team have ongoing research consultancies or research projects being conducted with the services involved in the current study.

Abstract

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Design and Methods: Five focus groups were conducted with people accessing AOD treatment services in New South Wales, Australia ($N = 39$). Data was analysed using iterative categorisation. A draft PREM was developed based on focus group findings and was modified following a subsequent review by consumers and service providers.

Results: Participants emphasised the importance of timely access to integrated care delivered in a structured program by staff who genuinely care. Furthermore, participants described positive experiences when services addressed the problems that maintain addiction, held them responsible for themselves, and facilitated self-reflection. The *PREM for Addiction Treatment* (PREMAT) is a 33-item measure that captures what participants said about their experience of patient centred care in AOD treatment.

Discussion and Conclusions: The experiences of people accessing AOD treatment provided useful feedback that can be translated into service improvements and that informed the design of a PREM for AOD treatment settings. Future research is necessary to further investigate the validity of the PREMAT.

Key words: patient satisfaction, patient-centred care, substance-related disorders, patient reported outcome measures, patient experience, client experience.

Introduction

Patient centred care involves recognising the patient as an experiencing person rather than a diseased object (1). The Australian Commission on Safety and Quality in Health Care (2) have recommended that patient centred care be the guiding framework for improving the quality of health care across Australia due to clear benefits associated with quality, clinical outcomes, and the experience of care. The person-centred approach to care has emerged from the consumer movement in western health-care, that originated in the 1970s in response to human rights violations in health institutions (3). The movement rejected paternalistic care in favour of care where people are self-determined and can voice their needs and preferences (3). As the movement developed in Australia, mental health reform began to reflect the importance of involving people in all stages of their care and of holding services accountable for providing quality care (4). Patient-centred care is particularly important among vulenerable populations, including people with substance use disorders, for which communication and collaboration with health care providers can be difficult and disempowering (2).

Patient reported measures, such as patient satisfaction measures, support the provision of quality care by collecting feedback from consumers that can be used to inform service improvements (5). Patient satisfaction has been defined as people's positive evaluations of whether treatment has fulfilled their expectations or desires (6). However, the validity and usefulness of patient satisfaction measures for service improvement have been questioned because of their inability to fully capture patient experiences, including negative evaluations (7-10). This has led the Australian Commission on Safety and Quality in Health Care (2) to recommend that patient surveys go beyond measurement of patient satisfaction, to measure patient experiences within a patient centred care framework. Patient reported experience measures (PREMs) are questionnaires that people accessing health services complete to

convey their perception of what did or did not occur while accessing the service, rather than their perception of their health, quality of life, or functional status (11). In other words, PREMs are concerned with the process rather than the outcome of service delivery (11). Measures of patient experience provide opportunities to help improve health care service delivery by permitting benchmarking of services and permitting comparison between and within services (9, 12).

PREMs have been successfully developed for settings such as hospital (13), general health-care (14, 15), emergency care (16), and primary mental health-care (17). However, to date no study has conducted a comprehensive assessment of patient centred care in the AOD treatment setting and no PREM specific to the setting exists. Focus groups are an important initial step in the process of developing a PREM for the AOD treatment setting because they ensure that development of the measure proceeds from an understanding of patient experience from the perspective of people accessing AOD treatment (18). In this way, consumer involvement in PREM development provides not only the means to measure patient experience but also to empower consumers to have a say in their care (19). The Picker Institute's eight domains of patient centred care are recommended to guide focus groups investigating patient experiences (20). The Picker Institute domains represent the leading model of patient centred care (2) and comprise: respect for the patients' values, preferences, and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support and alleviation of fear and anxiety; involvement of family and friends; continuity and transition; and access to care (21). Previous research on patient experiences in AOD settings (e.g., 22, 23, 24) have focused on specific issues or aspects of the treatment experience and not the extent to which care overall was experienced as patient centred. Such research is vital to adequately capture what is

important to people accessing AOD treatment services and to provide a comprehensive and global assessment of the patient centred experience.

The first aim of this study was to explore patient experiences of AOD care using the patient centred care framework. To do this, the Picker Institute's principles of patient centred care were used to guide focus group discussions with people accessing five different AOD treatment programs. The second aim of this study was to develop a PREM for AOD treatment settings based on the themes of the focus group discussions. This involved constructing questionnaire items that were subsequently reviewed by consumers and service providers of AOD treatment services.

Method

Stages of Questionnaire Development

The development of the PREM for AOD treatment settings was guided by Rose and collegues (18) who described a process for developing measures from the perspective of people accessing services. This process involved developing a topic guide for focus groups, conducting focus groups, constructing a draft measure based on focus group analysis, and having an expert panel review the measure. Like other studies, this study focused on the initial stages of questionnaire development rather than on psychometric evaluation of the measure (25-27). This methodology permits greater transparency in reporting how people accessing AOD services were involved, and so ensures that these people have a voice in the development of the measure. The researchers were aware of the potential for the social distance between themselves as researchers (KH, PK) and a past service provider (PK) to impact participant willingness to talk openly about experiences. To address this, they explicitly emphasised the vital importance of understanding and learning from the authentic consumer experience.

Stage 1: Focus groups. Focus groups followed the NSW Agency for Clinical Innovation (20) guidelines that outline how to conduct focus groups to capture patient experiences. Staff at five AOD treatment facilities approached consumers within their respective service to provide information on taking part in the focus group. Researchers attending the services then obtained written informed consent from interested consumers. Face-to-face focus groups facilitated by the researchers (KH and PK) were conducted at each facility for approximately 1-hour and were audio recorded. Participants completed a demographic and background questionnaire and were introduced to the eight domains of patient centred care using a postcard. Focus groups involved asking participants open ended questions and additional probing questions that explored the participants' experiences of the eight domains in AOD treatment services. The researchers met frequently throughout the data collection period to discuss progress and determine the point at which data saturation was achieved (28). The audio recordings were transcribed verbatim for analysis.

***Analysis*.** Data coding and analysis was conducted using iterative categorisation; a technique developed for analysing qualitative data within the addiction field (36). The Picker Institute domains of patient centred care were used as deductive codes in the preliminary coding framework (29). Coded data was reviewed line by line to identify inductive subthemes that were incorporated into the coding framework. KH developed the initial codes and then throughout significant points of the data analysis KH and PK met to discuss emerging codes and categories and the interpretation of texts. Analysis was conducted using QSR Nvivo 11.4.1.

Stage 2: PREM construction. KH translated each subtheme into two positively worded statements rated on a 5-point Likert scale. Two open ended questions were developed to capture additional experiences. The researchers then collectively reviewed the items to

discern they adequately captured the subthemes until agreement was reached. This process resulted in a 36-item draft PREM.

To enhance face and content validity, consumers and providers of AOD treatment services were then invited to provide feedback on the draft PREM. One of the AOD treatment services within close proximity to the researchers was approached to convene a consumer focus group. Following staff invitation, seven people living with substance use disorders agreed to participate and KH attended the service to obtain written informed consent and conduct the focus group. Participants completed a demographic and background questionnaire and reviewed the draft PREM. Open ended questions and additional probing questions invited the participants to refine the questionnaire items by commenting on wording and content, and to provide feedback on the response options and the questionnaire layout. Concurrently, providers of the AOD treatment services were emailed an invitation to review the draft PREM attached as a Microsoft Word document. Service providers were purposively selected to cover a different range of settings and therapeutic approaches. They were informed of the aims and methods of the research and asked to provide any feedback they thought helpful using tracked changes.

The draft PREM was then revised by the researchers based on the collective feedback from consumers and service providers. Decisions on the final item wording and selection were focused around maximising comprehensibility, acceptability and relevance. Any differences in opinion between consumers and service providers were resolved with these considerations in mind.

Participants and Setting

Consumer focus group and PREM review participants were people living with substance use disorders recruited from five non-government AOD treatment programs in

New South Wales, Australia. Four of the services provided residential care including a therapeutic community for people using opioid substitution (26 beds, 3-6 month stay), therapeutic community for women (26 beds, 3-6 month stay), a therapeutic community for both men and women (102 beds, 10 month stay), and a CBT based residential program (22 beds, 9 week program). The fifth service was a 12-week day program that was primarily based on CBT (23 members, 12-week program). Thirty-nine participants aged from 21 to 53 years (M = 35.18 years, SD = 9.26) participated in the Stage 1 focus groups (see Table 1). Seven consumer participants with mean age of 45.57 years (SD = 12.90, range: 28-65) participated in the Stage 2 consumer focus group (see Table 3). There were no exclusion criteria for participants.

Five service providers took part in the Stage 2 PREM review (n = 4 female). They were team or clinical leaders working across AOD treatment services. Their professional qualifications included psychologist (n = 2), addiction medicine specialist, mental health social worker, and service manager. All service providers reported experience in multiple AOD treatment settings, which collectively included private and public settings and residential and outpatient treatment. Participants reported a range of 8 to 15 years' experience working in the AOD field.

The University of Wollongong Human Research Ethics Committee approved this study.

Insert Table 1 and 2 about here

Results

Stage 1: Focus Groups

Findings. From the eight Picker Institute's domains of patient centred care, seventeen subthemes were identified. Table 3 presents a summary of the data from focus groups organised by theme and subtheme.

Insert Table 3 about here

Stage 2: PREM construction

Findings. Overall, participants had positive impressions of the *PREM for Addiction Treatment* (PREMAT). The draft PREM was revised based on feedback and resulted in a 33-item measure, including 31 statements and 2 open ended questions (Table 4). The statements are rated on a Likert scale that has the following anchors: "strongly agree", "agree", "neither agree nor disagree", "disagree", and "strongly disagree" **.** Consumer and service provider participants agreed that the instructions and layout were appropriate for the AOD treatment setting.

People accessing AOD treatment. One item was added following participant feedback. The item "I feel that my lived experience of addiction is valued" was replaced by "Staff treat me like a person and not an addict" based on feedback that being treated as a person was the more important and overarching way that staff can demonstrate respect. The item "I have a chance to get a job, start a course, or do a hobby" was removed following feedback that it was not applicable in many programs. Participants engaged in significant discussion over the items about involvement of family and friends and use of medication. While acknowledging the importance of items about involvement of family and friends, participants raised concerns that they would not be applicable to all consumers. To compromise it was decided to remove the item "My family and friends have been helped to

have realistic expectations of me in recovery" because participants thought it the least applicable and actionable for most participants. Participants also expressed acknowledgement of the importance of items regarding medication due to the presence of significant medical needs in the population, but equally were concerned about the possible inappropriateness of such an item amongst a population with people dependent on pain medications. The item "I am provided with medication when I really need it" was removed to avoid potential issues with and misinterpretation of the item

People working in AOD treatment. The item "I could get into this program when I needed to" was removed because some service provider participants considered it redundant alongside the included item "I think the wait-time to get into this program was okay". Removal of the item had the added benefit of reducing the length of the questionnaire, which some service provider participants believed to be too long. The same concerns raised by consumers regarding the items about family and friends, vocation and hobbies, and medication were also raised by staff.

Insert Table 4 about here

Discussion

Patient centred care has increasingly been recognised as best practice in health care (2). Focus groups and PREMs are recognised ways to monitor the provision of patient centred care to people accessing health services (20). The AOD literature is limited by insufficient qualitative research on patient experiences of patient centred care and an absence of PREMs for this setting. This multisite study has begun addressing these problems by conducting focus groups to investigate experiences of patient centred care in AOD treatment settings and designing a PREM specific to the setting – the *PREM for Addiction Treatment*

(PREMAT). Findings indicate that the Picker Institute's eight domains of patient centred care provide a useful framework for this work and that the PREMAT appears to adequately capture the construct.

Qualitative study of patient experiences of AOD treatment

Participants were able to readily discuss experiences reflective of the Picker Institute domains of patient centred care. Participants wanted people accessing AOD treatment to be recognised as people with values, preferences, and needs like other people accessing health care. They similarly wanted services that coordinate care within and between services and that communicate what to expect within the service. Providing physical comfort and emotional support, and consideration of the involvement of family and friends were key. Participants also emphasised the need to provide timely access to care and ensure adequate plans are in place for discharge.

Although the eight domains of patient centred care appear to be a useful framework to understand patient experiences of AOD treatment, some themes were not well captured by the domains. Nonetheless, these themes were consistent with literature about mental health and AOD treatment. For example, the importance of peers in providing emotional support was not explicitly captured in the eight domains of patient centred care, and yet this has consistently been identified as important by people accessing AOD treatment (e.g., 24). Another theme that was not well captured by the eight domains was the participants' reflections on the process of recovery. Participants discussed developing their identity, engaging in meaningful activities, and taking responsibility for their recovery. These subthemes are consistent with the process of recovery from severe mental illness described by Andresen and colleagues (30). Finally, stigma emerged as an important negative

experience of AOD treatment, consistent with previous research with people accessing mental health services (25).

A strength of this study is that it demonstrates that focus groups are a useful way to measure patient experiences of AOD care. In contrast to patient satisfaction measures (7-10), focus groups appear to capture negative experiences well and this not only validates their experience but also empowers their voice. Other focus group research in the AOD setting identified myriad negative experiences born from disempowerment and the pervasive nature of stigma in the health system among people who inject drugs (19). Furthermore, focus groups can be used to identify and design specific and oft times inconspicuous service improvements (e.g., providing more fresh produce and individual counselling sessions). Another strength of this study is the breadth of experience captured by accessing different AOD treatment services that ranged from therapeutic communities to a CBT day program.

However, it is important to note that since participants were self-selected to participate in the focus groups this research may be limited by selection bias. Hence it is unclear from our findings whether the sample consisted of individuals from systematically distinct sociodemographic backgrounds, such as people from cultures in which it is more acceptable to speak up about services and institutions. As a result the generalisability of our findings to a diverse range of backgrounds was potentially impacted. The current study predominately focused on residential programs provided by the non-government AOD sector. In 2017-2018, 61% of treatment services were provided by non-government agencies and these agencies provided 70% of closed treatment episodes (31). However, only 16% of closed treatment episodes in Australia are provided within residential facilities. It is likely that results will be broadly applicable to other medium to longer-term residential programs (e.g. therapeutic communities, rehabilitation services). However, it is important that future research focus on the patient experience across other treatment settings (e.g. outpatient

counselling, detoxification, outreach). Likewise, as the current study was focused on adults, it is important that future research consider the experiences of both younger and older people accessing AOD treatment. Furthermore, participants tended to discuss positive or negative experiences, and to overlook neutral experiences. To illustrate, only one focus group voiced that hygiene was a problem at their treatment facility, although it was probably an important aspect of care to all participants. As a result, important experiences may not have been captured. This issue highlights the importance of ongoing assessment of patient experiences within individual services and designing improvements tailored for each service.

Development of the PREM for Addiction Treatment (PREMAT)

A 33-item PREM was developed to capture what people identified as important aspects of patient centred care in AOD treatment. The development of a PREM for AOD treatment settings contributes to the effort to introduce a standard PREM for AOD treatment settings, necessary to permit benchmarking and comparison of services (9, 12).

The development of the PREMAT followed a structured process of development guided by recommendations (18, 20) . As such, consumers were involved at all stages of questionnaire development which enhanced the content validity of the measure (32). The inclusion of open-ended items further enhances the content validity of the measure by allowing opportunity to capture patient experiences that are not included in the PREMAT statements. The importance of this opportunity is highlighted by the significant discussion from consumers and service providers around the items for involvement of family and friends and access to medications. It is not surprising that these domains attracted debate given they are inherently complex, multifaceted and emotionally charged issues. As such it seemed that their measurement is more appropriate on more of a case-by-case basis when it is personally meaningful to the consumer and the open-ended items provide the opportunity to collect such

information. Overall, it was considered that the review of the PREMAT by consumers and service providers revealed promising indications of good face and content validity.

Future research and conclusions

Rigorous validation of the PREMAT is the next stage of the ongoing process of developing this measure. It is necessary to investigate the factor structure of the measure, which may help reduce the number of items and provide evidence toward construct validity. Other important psychometric properties to investigate include test re-test reliability, internal consistency, and criterion validity (33). Pending this future research, the PREMAT is expected to have implications for the delivery of quality care to people living with substance use disorders.

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Table 1. *Demographic and background information of focus group participants (N = 39).*

Characteristic	*N*	%
Gender		
Male	21	54
Female	18	46
Country of birth		
Australia	36	92
Other	3	8
Highest level of education		
High School Diploma or less	31	80
Associate's or Technical degree	4	10
University Degree	4	10
Aboriginal or Torres Strait Islander		
Yes	9	23
No	30	77
Primary Substance of Abuse[a]		
Alcohol	12	31
Heroin	6	15
Methamphetamine	15	38
Other	6	15
Previously Received Mental Health Treatment		
Yes	26	67
No	13	33

[a] Where participants indicated more than one substance that causes them the greatest concern the first substance has been coded.

Table 2. *Demographic and background information of consumer PREM review participants (N = 7).*

Characteristic	*n*	%
Gender		
Male	5	71
Female	2	29
Country of birth		
Australia	5	71
Other	2	29
Highest level of education		
High School Diploma or less	6	86
Associate's or Technical degree	0	0
University Degree	1	14
Aboriginal or Torres Strait Islander		
Yes	0	0
No	7	100
Primary Substance of Abuse[a]		
Alcohol	4	57
Methamphetamine	3	43
Previously Received Mental Health Treatment		
Yes	5	71
No	2	29

[a] Where participants indicated more than one substance that causes them the greatest concern the first substance has been coded.

Table 3. *Key quotes from focus groups by theme and subtheme.*

Theme, Subtheme and Description	Quotes
Access to care	
Waitlist: Participants reported feeling vulnerable the longer they stayed on waitlists to treatment programs and emphasised the risk to health and safety. Participants indicated that weekly telephone check-ins appear to ease feelings of vulnerability.	"I rang for months because I couldn't get in."; "Whether they have a physical death or a spiritual death they are still dying while they are waiting to get into rehab."; "You might not have overdosed if you got an immediate or near immediate admission."; "It is good they are checking in with you the whole time for that waiting period, and it does demonstrate how committed you are, but at the same time you are left in addiction."
Respect for preferences, values, and expressed needs	
Meaning: This subtheme captures the significance participants placed on engaging in meaningful activities during their admission, such as personally valued work, study or play.	"Since I've been here… I've seen people go to work, I've seen people start studying, I've seen people dabble in a course here and there, while still being part of the program… I'm impressed with that."; "It makes you feel like you've got more things going on, so then you are less likely to go back to the drugs."; "If I want to do something and it's within reason they won't stop me from doing it. They sort of let you tailor your own program, and they work with you."; "I am blood bored. I don't

	want to sit around doing nothing… I want to start studying."; "I asked staff [if I could get a job] just to, you know, get my money flow back again, because if you earn 50 bucks a fortnight here that's fuck all… one of them said, "Yes, but are you going to pay us?" And I said, "How does that work?!""
Identity. Developing a new identity beyond addiction appears to be an important process in AOD treatment. Participants identified that programs can support this process by modelling nurture and care, teaching skills to regulate emotions and refuse substances, and facilitating self-reflection. The program rules and routines seemed to permit self-reflection by simplifying life.	"This place built me up again, it made me realise that I'm not that worthless whatever that I thought I was, that's not who I am."; "Since we are nurtured here… we are taught to nurture ourselves, we are taught to care for ourselves."; "It gets you looking at yourself."; "Here its more about a self-discovery of your behavioural patterns and all that kind of stuff."; "I don't regret anything in my life, because as far as I'm concerned it's made me the person I am today. But I can't forget because I don't want to ever go back there."; "It's really grounding for me and basically, it allows you to restore your identity – who you are."
Privacy: Participants spoke about services achieving the balance between respecting privacy and providing	"They are not going to pressure you into talking, they respect your distance."; "Just a little bit more time out for yourself would be nice."; "So much love and

emotional support. Participants explained that while a positive result of emotional support from peers can be learning to tolerate negative affect, such support can also feel intrusive.	understanding from the girls can sometimes be a little bit too much and you just think, "Don't ask me if I'm okay, I don't want to tell you what's wrong, it's not your business."; "There is no privacy."
Responsibility. Participants who experienced the service as holding them responsible for their behaviour emphasised the importance of this to recovery. At the same time, participants who did not feel supported to take responsibility voiced the importance of agency.	"It's entirely up to us, and I believe it's got to be up to us."; "It's your decision whether you work on it or not."; "If there is one thing I have learnt in the 50 weeks I've been here, fucking worry about yourself."; "You need to get yourself sorted."; "You keep telling me you are holding me responsible for my own recovery. Let me be responsible."
Coordination of care	
Psychological services. Participants emphasised the need for services to address the precipitating and maintaining factors of addiction through group and individual sessions. Participants considered individual rather than	"It's not just the drug addiction, it's the behaviours behind the drug addiction. We work on that."; "I've found it to be a really effective treatment because it's practical, and also addresses the mental illness and trauma that a lot of addicts suffer."; "It's not so much education on why we need to put substances aside, it's education behind why

group therapy to be a more appropriate way of addressing mental health problems and trauma. Participants identified that understanding the treatment rationale is an important part of experiencing quality care in psychological services.	we have turned to substances and what leads to that."; "I've got PTSD from trauma and I think maybe they could have incorporated more one-on-one."; "I needed more one-on-one stuff because these groups brought up a big of stuff about my addiction and what lead me to my addiction and with the PTSD stuff, you don't really want to voice it in front of your group of people."
Other services. Coordinating access to other services and professionals to address health, dental, financial, legal, and family problems was identified as an important aspect of patient centred care.	"It's not just about the drug addiction because the drugs are such a small part of the problems we meet."; "I think they get it because out there I wouldn't be doing anything, I would just be running around getting my drugs, so here you can go to a dentist and all that type of stuff."
Information and communication	
Rules. Participants appeared to benefit from clearly stated instructions and consistently applied consequences for not following instructions. Many participants explained that this experience of boundaries created a sense of safety and readiness for re-integrating into society. However,	"It's kind of a dictatorship, you've got to do what you've got to do, there is not really any getting out of it."; "You have to participate in the program. You have to do things."; "They are allowing mistakes to happen ten times before a consequence is applied. They should go twice and consequence is applied, so people that are, you know, responsible."; "Some girls were trying to get drugs into the rehab, and straight

some participants experienced the boundaries as oppressive.	away the staff intervened. If they have to get rid of the whole community they will, just to keep the girls safe."; "I thought I was in the army at first, not allowed to do this, not allowed to do that… For so long we've just pretty much done what the hell we like I can see why this place gets us back to sort of conforming and discipline."; "That's a really big part of recovery because if you are not living by certain rules… then are you are not going to really benefit from recovery."
Routine. Participants also seemed to benefit from following a clearly communicated program schedule that set an expectation for people to be engaged in activities at designated times. Following a schedule appeared to re-establish a sense of structure that participants lost in addiction. In the absence of adequate routine, participants expressed concerns about people spending unstructured time engaged in unhealthy behaviours (e.g., smoking).	"There is a timetable we go off and we know that timetable."; "It's good instruction. It's like a business day and then we go for dinner after that and usually an NA [Narcotics Anonymous] meeting at night."; "I find that really beneficial because when I was using I had no structure and I was never held accountable."; "This program is really important to me because it's got the routine that I need and I lost that routine after my daughter was taken out of my care."; "You got nothing to do here, it's so crazy. There is no program, just smoke yourself to death."; "I think too much free time on your hands, it's not good anyway, because you get inside your head, you just sit out there smoking in it."

Physical comfort

Health. Experiencing an environment that promotes health by providing nutritious food including fresh fruit and vegetables and by facilitating adequate exercise emerged as a subtheme of physical comfort. Participants appeared concerned about gaining weight due to excessive carbohydrate intake and insufficient exercise while admitted. According to participants, weight gain increases the risk of relapse.	"We are able to go for walks."; "You can always go get a piece of fruit." "That is why a lot of people you know are starting to put on a lot of weight… the food is just fucking carbs."; "In jail you get better nutrition, we were getting at least two pieces of fruit a day and not as much bread."; "We were intimidated for having a voice about staff that is really important about our health."
Illness. Another subtheme was the desire for adequate hygiene as well as appropriate and prompt responses to illness. Some participants described negative experiences of being unwell in the program. For example, participants commonly described insufficient access to medication to manage pain and cold and flu symptoms.	"I nearly died of blood poisoning in detox for the three days because I was pretty much just left there to die. I had an infection."; "I don't like living in a dirty house with dirty people."; "Infection control in the building is disgusting."; "It took me two days to get some cough mixture."

Emotional support

Peers. Many participants indicated that peers play an important role in providing emotional support. Participants described positive experiences of bonding, growing, and healing together through a shared lived experience of addiction. However, participants also appeared to have negative peer experiences when peers were not committed to recovery, for example when people access AOD treatment only to avoid jail. Nonetheless, participants seemed to find it particularly inspirational when people who were court mandated to attend treatment showed recovery.	"We've got more of an insight than anyone else does, so we help each other."; "If it wasn't for these people, these loving people, you know, I'd be lost."; "I am sorry if this offends anybody, what I am about to say, but there are just some people in here not wanting to go to jail. So, they don't take the program seriously."; "They are playing the game, they get here and they are going 'fuck this place' but I've seen them change. People that you think would never change, change."
Staff. Staff were considered most effective when they were experienced as authentic people who genuinely care, as opposed to staff who were perceived as only doing	"The ones that are exceptional, well, they really do care… the other ones… they just do it as a job… they don't care."; "You have to care about what you are doing because that's what we lack, self-care, we lack self-love."; "They treat you equally

their job or as stigmatising people with substance use disorders. When participants felt emotionally connected to staff they reported feeling more able to talk freely and to care for themselves. Furthermore, some participants appeared to prefer staff who have struggled with addictions themselves. Staff in recovery were perceived by some participants as providing more understanding of addiction and more hope for recovery.	like a human being."; "At the end of the day to have that real connection with a real person is so much better than having someone read from a text book."; "If you have any issues of if you don't feel safe or if you are emotionally unstable you can speak to staff about it and they will do something."; "It took me six months and 27 no-shows to get here… they just kept supporting me through, they never let me go."; "You know, you can do all the university in the world and you'll never know what it feels like to have walked in the shoes of someone that's been through that much pain, that much horrible stuff, to fucking rock bottom, like to have it come from someone that has lived it themselves is more powerful."; "We had two facilitators here and they were recovering addicts themselves, they've been clean for a long time, they've found their way into this industry and it spoke for itself. People would walk out the door, going, wow that stuff they are putting forward to us, I mean the way that they put it to us, it just made sense."
Involvement of family and friends	
Connection. Opportunities to connect with family and friends through phone calls, visitation times, program	"They gave me 40 minutes to leave with my family to go and sit in the park and have a coffee. The little things are the big things, you know."; "[The program] has given

leave, and recreational activities appeared to be an aspect of quality care for participants. However, participants reported that connecting with family and friends could also jeopardise recovery when people with substance use disorders put the needs of others before their recovery. Some participants reported that they did not want their family and friends to be involved because their family and friends were still using drugs.	me the comfort and the strength in myself to go see friends that I haven't seen for a long time due to the things I might have done to them in addiction."; "I've got two young children… I'm really disconnected from them."; "We can have kids like twice a week and you look at what happens… people leave because things happen outside and they are so invested on what's going on outside they think they need to get outside and help someone else when they need to fix themselves, like they forget about themselves."; "For me, I don't want my family to be a part of my program."; "Think about if your family or parents were in addiction and if you are speaking to them every day, you have a high change of going and using, because they don't know how to support you."
Education. Participants thought that it was important to provide information about addiction to families and friends of people accessing AOD treatment. Participants indicated that providing information to family and friends may assist people accessing AOD care to receive better support from their social network.	"They need some more information about our addiction and about recovery."

Continuity and transition

Discharge. Working towards discharge throughout the AOD treatment program emerged as an important aspect of quality care provision. Participants discussed ways that programs can facilitate readiness to leave the program to ensure successful discharge, including opportunities to practice skills in everyday life and allowing people accessing the service to stay longer if necessary.	"It doesn't just put you in a bubble world, like you still have life going on and you still have to deal with everyday life."; "They don't just shut the door, you can come back and do it again."; "When we do leave here we are not walking back into the same problems that we had before we came in here."; "You can't take somebody away from the world and then push them back out having not addressed any of the issues that they have before they come in."; "[We are] at risk of dying… so when you get clean and you've been in a place like this, I don't know why… but I think everyone needs to admit that."
Referral. Participants appeared to feel more confident of success after discharge when staff are knowledgeable about available services and make appropriate referrals.	"That's relapse waiting to happen, if you're on the streets again or if you've got that much time on your hands. It's alright getting you clean, and shit that's what their job is, but they could help us with a few steps after. That would be great.": "It's good to know that when you do finish there are other programs you can go into."

Note. Quotes were edited to increase readability by removing false starts, filler words, or grammatical errors, or by adding punctuation.

Table 4. *PREM for Addiction Treatment statements by theme and subtheme.*

Theme	Subtheme	Item
Access to care	Waitlist	1. I think the wait-time to get into this program was ok
		2. I felt welcome when I started this program
Respect for preferences, values, and expressed needs	Meaning	3. I have been supported to start doing things that I want to do
	Identity	4. I feel better about myself because of this program
		5. I am more aware of myself because of this program
	Privacy	6. I have enough privacy here
		7. I am given enough space by other people in this program
	Responsibility	8. I am held responsible for my behavior
		9. I know my recovery is up to me because of this program
Coordination of care	Psychological services	10. I better understand why I have used drugs and/or alcohol because of this program
		11. I have enough one-to-one sessions
	Other services	12. I am supported to look after my health, financial, and legal problems
		13. I can get help for any difficulties I have
Information and communication	Rules	14. I know what the rules are and what will happen if I don't follow the rules

		15. I think the rules make sense
	Routine	16. My day is structured here
		17. I am provided with a schedule so that I know what to do with my time
Physical comfort	Health	18. I am provided with opportunities to exercise
		19. I am provided with fresh fruit and vegetables
	Illness	20. I think that this place is clean and hygienic
Emotional support	Peers	21. I feel supported and understood by other people in this program
	Staff	22. I am inspired by other people here who have time up in recovery
		23. Staff genuinely care about me
		24. Staff treat me like a person and not an addict
Involvement of family and friends	Connection	25. I can connect with my family and friends
		26. I am supported to focus on myself and on my recovery
	Education	27. My family and friends have been provided with information about recovery
Continuity and transition	Discharge	28. I am more able to cope with my everyday life outside the program
		29. I think that I will be ok when I leave this program

	Referral	30. I have been linked up with other services to support me when I leave this program 31. I can get information from staff about where else I can go for help

Note: The PREMAT includes the instruction, "Thinking about your current contact with this alcohol and other drug treatment program, please respond to the following questions about your experience." The PREMAT also includes two open ended questions: 32. "How could your experience at this service have been improved?" and 33. "What have been the best things about your experience here?".