PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Patient-Centered Care for Addictions Treatment: A Scoping Review Protocol
AUTHORS	Marchand, Kirsten; Beaumont, Scott; Westfall, Jordan; MacDonald, Scott; Harrison, Scott; Marsh, David; Schechter, Martin; Oviedo-Joekes, Eugenia

VERSION 1 – REVIEW

REVIEWER	Tiago S. Jesus, Ph.D Global Health and Tropical Medicine (GHTM), WHO Collaborating Centre for Health Workforce Policy and Planning, Institute of Hygiene and Tropical Medicine - NOVA University of Lisbon (IHMT-UNL), Rua da Junqueira 100, Lisbon 1349-008, Portugal.
REVIEW RETURNED	11-Jun-2018

GENERAL COMMENTS	Thank you for the opportunity to review this manuscript. Major strengths: The study is both timely and important. The overall method seems adequate for most, however not all, the goals/aims. The involvement is knowledge users – although the exact activities and roles are not depicted. Articles from a substantial amount of languages will be reviewed. Use of the Open Science Framework Major Limitations: There is incongruency across the paper in what are the study aims (relatively well aligned with what a scoping review can provide) and type of information this review will extract and synthesize to inform further endeavors (e.g. outcomes of studies), and these latter are not that suitable for a scoping review - which does not formally assess methodological quality. The authors do not provide a reference when they define the construct being reviewed – and this reviewer strongly disagrees with a component (i.e. structured approach) of that definition. Aligned with that definition, the authors a priori define want to develop a structured approach to PCC. What happens if the review reveals that PCC is at the odds of a highly structured approach? Way ambiguous terms such as person-focused are used apparently in an inter-exchangeable way with PCC, which only adds to the conceptual blurring. No theoretically-grounded, conceptual papers (even with an operational definition of PCC) will be reviewed, while likely relevant to define the concept as aimed. It is unclear whether registration into the Open Science Framework happened or will happen – author state both things at different parts of the paper. The search strategy is not provided for any database, in contrast with PRISMA-P recommendations. The Ethics and Dissemination in the abstract has no corresponding part in the main paper.

	Below, these and other issues are detailed in a section-by-section review. Transcribed contents in italic Abstract Lines 6-7 “Expanded person-focused treatment approaches. Patient-centered care (PCC)….” It seems both are the same thing. Person-focused is ambiguous and may not refer to the same a PCC Lines 7-8 “commonly used for chronic conditions” Commonly used everywhere in healthcare. Line 8 “structured treatment approach that responds to patients’ unique needs” It seems to me at the very odds of a very structured approach. But more important than that, you don’t cite then in the full text any origins of that key operational definition. Line 10-13 “Despite its demonstrated effectiveness, evidence regarding its feasibility and potential outcomes among people with substance dependence remain limited.” Several issues here. Effectiveness isn’t that demonstrated – see my comment then in the Introduction about that. Besides, PCC is relevant and a quality dimension in itself, first and foremost. If it happens to add to care effectiveness, great! But that is not even its main purpose. Line 14-15 “defined, measured and implemented among people with problematic substance use” English issue: implemented in services for people with… 23- “Two reviewers will independently screen and review references.” Review is such an unspecific word here – set review stage(s) 30-32 “This review will generate evidence to inform decision-makers and health care providers on the feasibility, implications and potential outcomes associated with PCC for substance use treatment.” (….) 13-14 “The aim of this scoping review is to explore how patient-centered care has been defined, measured and implemented….” Key issue here: The aim and the stated uses seem not only to be different but to rely on different data and require different types of methodologies. Synthesizing outcomes will be beyond what a scoping review, which do not assess method quality, can nicely handle. 26-27 This scoping review will be registered with Open Science Framework. (…) This iterative scoping review study has been registered with Open Science Framework to enhance its transparency. It happened or will happen? Scoping reviews are inherently iterative Full text Page 3 37-39: “Patient-centered care (PCC) is a structured approach that encompasses these recommendations by prioritizing clients’ unique goals, values, and involvement in the treatment and

	recovery process." Major flaw. No reference whatsoever for defining the main construct being reviewed – I strongly disagree that it is a structured approach, but more important is that definition you use should be grounded. 47-49 "This is not surprising, since research has shown PCC to be associated with treatment retention and adherence, treatment satisfaction, improved health outcomes, and quality of life.[23-25]." Not entirely true. Systematic reviews have been showing some conflicting results. I cite one example below. This adds to some concerns that the whole body of the PCC literature in healthcare hasn't been sufficiently considered. • Dwamena F, Holmes-Rovner M, Gaulden CM, Jorgenson S, Sadigh G, Sikorskii A, Lewin S, Smith RC, Coffey J, Olomu A. Interventions for providers to promote a patient-centred approach in clinical consultations. Cochrane Database Syst Rev. 2012, Vol. 12:CD003267. PAGE 4 5-6 "enhancing the patient-provider relationship to improve the positive outcomes of treatments". Not only for that. 16- "adapted": Adopted? 23-26 "to inform future research and policy efforts aimed at designing and testing the effectiveness of a structured PCC approach for the treatment of substance use disorders." You a priori define that the approach is going to be structured. What happens if the review aimed to inform that approach says otherwise? PAGE 5 6-9 this scoping review asks: 1. What patient-centered care principles and outcomes have been empirically explored and implemented in health-oriented settings for people with problematic substance use? Aren't the conceptual/theoretical works operationally defining PCC relevant to define the concept? Such definition is one of the stated aims of the paper. 42-43 "the search strategy will be developed." while it is going to be peer-reviewed using "press", it could (and should) be, right now, peer-reviewed along with the study protocol. The PRISMA-P states: "Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated". I could have provided a relevant, expert peer-review of that search strategy, even suggesting aspects for improvement/consideration, based on similar experience, and that is supposed to be an added benefit of publishing a study protocol. But the reviewer remained empty-handed to do that. Also, you don't cite any related paper and/use the solutions they used to overcome the same or similar search challenges. You 'merely' rely on the librarian's technical expertise. PAGE 6

	22 “and” Only stated at this level. I suppose the criteria is cumulative for all items, but I shouldn’t suppose. 40-41 f) “It observed at least one outcome (e.g., treatment compliance, treatment satisfaction) of the patient-centered treatment approach (this criterion pertains to empirical articles only).” What about the studies on implementation (i.e. Whether the approach was or not adopted and/or why) and on the measurement of PCC (e.g. Validation studies). What you do with study protocols which operationally define a PCC approach? PAGE 8 13-14 “We will present a descriptive overview (including numerical summaries; e.g., effect size if available) of the eligible full texts.” Consider take caution with effect sizes and synthesized findings on outcomes from scoping reviews. Maybe a second review on a subset of articles identified with quality appraisal performed would be better than trying to get all done with a scoping review. 35-36 “As is common in directed content qualitative analysis.” There is no rationale for why this is the ‘best’ analytic approach. It may not be the main criterion, but as it is framed it seems to be this is the approach that fits better the methods expertise of the authors. If it is like that, explictly state and acknowledge the limitations in addition to the strengthens of doing so. If it is rather the ‘best’ solution among alternatives, explain why. PAGE 9 “The planned consultation process will therefore empower knowledge users with a broad understanding of how PCC has been conceptually defined and its potential for improving health care outcomes among people with problematic substance use.” It doesn’t say nothing of which (sequence of) activities will be carried out with Knowledge Users and what specific purposes. Will they suggest additional references you may have missed? Will they, within a certain procedure, help refine the results or interpretation and how? Not for the reader to guess DISCUSSION SECTION: No ethics and dissemination section – to match the abstract. This section really adds no – but repeats – information. References The systematic review cited above was missed; and the same happens to other relevant knowledge syntheses: e.g. Scholl I1, Zill JM1, Härter M1, Dirmaier J1. An integrative model of patient-centeredness - a systematic review and concept analysis. PLoS One. 2014 Sep 17;9(9):e107828. doi: 10.1371/journal.pone.0107828. eCollection 2014. Overall, the references list seems poorer (and not totally up-to-date) for the PCC literature in healthcare than it is for the substance abuse literature.

REVIEWER	Molly Magill Brown Univeristy

REVIEW RETURNED	24-Aug-2018

GENERAL COMMENTS	The protocol titled: Patient Centered Care for Addictions Treatment: A Scoping Review presents what could be a worthwhile and important effort. The research objective and question is clearly defined. The proposed work would be of value to the field. My suggestions are about strengthening the presentation of this protocol; its clarity, thoroughness, and completeness. My main concern is with regard to the concept of Patient-Centered Care. This is such a broad term and I sympathize with the authors effort to define and clarify it for addiction care. First, I think the definition in the introduction could be expanded and detailed more completely with further literature cited from medicine. Perhaps several published definitions can be provided and the authors can then land on their own operational definition for the present protocol? Perhaps the authors can describe what PCC is not? Is Motivational Interviewing patient-centered care, because this approach is already widely implemented. My point here is that the definition of this term should be extremely clear, as it will inform the search approach for eligible studies. This relates to my second point. It seems some potential terms for the patient centered care search are missing. In fact, most research on addictions treatment involves some element of patient centered care. Motivational interviewing, strengths-based case management, any evidence-based family models for adolescent use, Jim McKay's Continuing Care research are just a few examples. My suggestion here is that there be a more comprehensive review of what is patient-centered care, a clear operational definition for the project search, and a broadened set of search terms for PCC in addictions. My next concern is that the background review in the introduction could make a stronger argument for why this is needed. At present, the introduction is a very broad, at times cursory, view of the problem and its treatment that does not really argue how the application of patient centered care in addictions will fill an important service gap. There are numerous evidence-based addictions treatments available, most incorporate some attention to the relationship and patient unique needs, many are long-term, and most address biopsychosocial concerns. How will PCC be different? Next, I believe polysubstance use is an important search term for substance use disorders. Finally, I understand there is a journal citation practice that places periods before the citation, but the MS needs a full copy edit for grammar and prose.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1:

Reviewer Name: Tiago S. Jesus, Ph.D
Institution and Country: Global Health and Tropical Medicine (GHTM), WHO Collaborating Centre for Health Workforce Policy and Planning, Institute of Hygiene and Tropical Medicine - NOVA University of Lisbon (IHMT-UNL), Rua da Junqueira 100, Lisbon 1349-008, Portugal.

Please state any competing interests or state ‘None declared’: None declared.

Comments from Reviewer 1 for the Abstract

Lines 6-7 “Expanded person-focused treatment approaches. Patient-centered care (PCC)….” It seems both are the same thing. Person-focused is ambiguous and may not refer to the same a PCC

Thank you for pointing out that our use of these terms might give the impression they are interchangeable, when we agree, that this is not entirely the case. Given the substantial revisions made to the introduction in the main manuscript text, we have made similar changes to the abstract and these sentences have been changed.

Lines 7-8 “commonly used for chronic conditions” Commonly used everywhere in healthcare.

As per the above comments, these sentences have been changed.

Line 8 “structured treatment approach that responds to patients’ unique needs” It seems to me at the very odds of a very structured approach. But more important than that, you don’t cite then in the full text any origins of that key operational definition.

This comment and R1.1 below, have brought our attention to the potentially confusing choice of the word ‘structured’, which we intended to be synonymous with ‘formal’ or to be in line with ‘empirically based definitions of PCC’. This has been revised throughout the manuscript.

Line 10-13 “Despite its demonstrated effectiveness, evidence regarding its feasibility and potential outcomes among people with substance dependence remain limited.” Several issues here. Effectiveness isn’t that demonstrated – see my comment then in the Introduction about that. Besides, PCC is relevant and a quality dimension in itself, first and foremost. If it happens to add to care effectiveness, great! But that is not even its main purpose.

Thank you for the feedback here and in R1.2 below. We have made substantial revisions to the introduction that better reflects the goals and mixed findings regarding outcomes of PCC. This sentence as originally written is no longer included in the revised abstract.

Line 14-15 “defined, measured and implemented among people with problematic substance use” English issue: implemented in services for people with…

We have revised this sentence. It now reads:

The aim of this scoping review is to explore which principles of patient-centered care have been implemented and how these have been operationalized in health care settings for people with problematic substance use.

Line 23- “Two reviewers will independently screen and review references.” Review is such an unspecific word here – set review stage(s)

We have revised this sentence. It now reads:

Two reviewers will independently screen references in two successive stages of title/abstract screening and then full-text screening for those references meeting title/abstract criteria.

Line 30-32 "This review will generate evidence to inform decision-makers and health care providers on the feasibility, implications and potential outcomes associated with PCC for substance use treatment." (….) 13-14 "The aim of this scoping review is to explore how patient-centered care has been defined, measured and implemented…." Key issue here: The aim and the stated uses seem not only to be different but to rely on different data and require different types of methodologies. Synthesizing outcomes will be beyond what a scoping review, which do not assess method quality, can nicely handle.

Thank you for this comment and R1.9 - R1.10 below. We have slightly revised the research question to better communicate the aim of identifying and describing the range of outcomes examined from those implemented principles of PCC. This will improve consistency between the research questions, screening and planned data extraction. These changes are reflected in the main manuscript text. Here in the abstract, we have stated the aim more broadly as:

The aim of this scoping review is to explore which principles of patient-centered care have been implemented and how these have been operationalized in health care settings for people with problematic substance use.

We have also revised the first sentences of the Abstracts' Ethics and Dissemination section to better reflect the stated aim:

This review will examine the nature and extent to which the principles of PCC have been implemented, defined, and measured. Such evidence will contribute to the operationalization of PCC for people with problematic substance use.

26-27 This scoping review will be registered with Open Science Framework. (…) This iterative scoping review study has been registered with Open Science Framework to enhance its transparency. It happened or will happen? Scoping reviews are inherently iterative.

Since the original submission, the scoping review has been registered with Open Science Framework. As the reviewer notes, scoping reviews are inherently iterative, and we have also registered ongoing revisions. The review can be found at: https://osf.io/5swvd/

We have added the OSF registration URL to the abstract and manuscript on pages 2 and 5.

Comments from Reviewer 1 for the Main Manuscript Text

Page 3
R1.1. 37-39: "Patient-centered care (PCC) is a structured approach that encompasses these recommendations by prioritizing clients' unique goals, values, and involvement in the treatment and recovery process." Major flaw. No reference whatsoever for defining the main construct being reviewed – I strongly disagree that it is a structured approach, but more important is that definition you use should be grounded.

As part of our major revision to the background (in response to this comment, R1.15, R2.1 and R2.2), we have provided an expanded overview of PCC on page 2 of the introduction. With this change, we have aimed to provide more context to the different conceptual frameworks from the fields of psychology, nursing and medicine (as these are relevant to our population of interest). We have better organized the references for this section as well to ensure that the reader can see from where our operationalization of PCC is built.

R1.2. 47-49 "This is not surprising, since research has shown PCC to be associated with treatment retention and adherence, treatment satisfaction, improved health outcomes, and quality of life.[23-25]." Not entirely true. Systematic reviews have been showing some conflicting results. I cite one example below. This adds to some concerns that the whole body of the PCC literature in healthcare hasn't been sufficiently considered.
• Dwamena F, Holmes-Rovner M, Gaulden CM, Jorgenson S, Sadigh G, Sikorskii A, Lewin S, Smith RC, Coffey J, Olomu A. Interventions for providers to promote a patient-centred approach in clinical consultations. Cochrane Database Syst Rev. 2012, Vol. 12:CD003267.

As part of our revision to the background, we have raised the reader's attention to the mixed findings related to the consequences and outcomes of PCC. These sentences now read:
That the meaning of PCC is currently somewhat context-specific poses challenges to determining the relationship between PCC and treatment process and outcome indicators. For example, a recent meta-analysis showed mixed effects of PCC (defined as shared control or decisions and/or consultations focused on whole person) on improved quality of care, treatment satisfaction and health outcomes.[41] It also found support for generally positive effects of PCC on consultation process measures (e.g., communication about treatments; levels of empathy),[41] suggesting that these approaches might overcome some of the challenges clients have historically experienced engaging in substance use treatment.

PAGE 4

R1.3. 5-6 "enhancing the patient-provider relationship to improve the positive outcomes of treatments". Not only for that.

As part of our revision to the background, this sentence is no longer included.

R1.4. Line 16- "adapted": Adopted?

As part of our revision to the background, this sentence is no longer included.

R1.5. Line 23-26 "to inform future research and policy efforts aimed at designing and testing the effectiveness of a structured PCC approach for the treatment of substance use disorders." You a priori define that the approach is going to be structured. What happens if the review aimed to inform that approach says otherwise?

As part of our revision to the background, this sentence is no longer included.

PAGE 5

R.1.6. Line 6-9 this scoping review asks: 1. What patient-centered care principles and outcomes have been empirically explored and implemented in health-oriented settings for people with problematic substance use? Aren't the conceptual/theoretical works operationally defining PCC relevant to define the concept? Such definition is one of the stated aims of the paper.

This comment, as well as R.1.9 and R.1.10 below, suggested that our research question could be rephrased to bring better alignment between the overall aims of this review and the planned methods. This does not alter the original guiding question but restates the question into three distinct parts (exploring which principles have been implemented, how they have been operationally defined, and then what outcomes have been measured or tested).

The questions now read:

1. Which patient-centered care principles have been implemented in health-oriented settings for people with problematic substance use?

2. How have these patient-centered care principles been operationalized when used in health-oriented settings for people with problematic substance use?

3. What outcomes from the implementation of patient-centered care principles have been empirically measured or tested?

Regarding the reviewer's specific question about the inclusion of existing conceptual/theoretical works operationally defining PCC. Yes, such references would be considered for inclusion if they meet the full set of criteria since they would respond to question 2.

R1.7. Line 42-43 "the search strategy will be developed." while it is going to be peer-reviewed using "press", it could (and should) be, right now, peer-reviewed along with the study protocol. The PRISMA-P states: "Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated". I could have provided a relevant, expert peer-review of that search strategy, even suggesting aspects for improvement/consideration, based on similar experience, and that is supposed to be an added benefit of publishing a study protocol. But the reviewer remained empty-handed to do that. Also, you don't cite any related paper and/use the solutions they used to overcome the same or similar search challenges. You 'merely' rely on the librarian's technical expertise.

We regret that we did not clearly identify this in the main manuscript text, but we had included a search strategy for Ovid- Medline that was run on May 22, 2018. This was on page 16 of the original manuscript and also identified in the PRISMA-P checklist, as required. However, as the Editor's have pointed out, we should have included citations for the supplementary material in the main manuscript text. This has been corrected in the main manuscript and the PRISMA-P checklist.

Regarding the reviewer's specific suggestion to strengthen our explanation of how search terms were identified, we have expanded this briefly on pages 5-6 as follows:

Likewise, as described above, conceptual frameworks of PCC have varied, adding to the complexity of this search. To overcome this challenge, we have developed a search strategy informed by the principles of PCC that have been most consistently (in the previously mentioned frameworks) identified and operationalized, as well as keywords and MeSH terms from systematic reviews[52 53] and empirical references[54-56] previously conducted among our population of interest: (1) understanding the whole person to account for the biological, psychological and social aspects of patients' illnesses; (2) exploring the disease and illness experience to understand the personal meaning of illness and treatment for the patient; (3) finding common ground where power, knowledge and responsibility are shared between the patient and provider; and (4) enhancing the patient-provider relationship to improve the positive outcomes of treatments provided. We have also engaged in an extensive consultation process with an experienced Health Science Librarian (at the University of British Columbia) as well as the knowledge users represented in our team (authors SM and SH). The search strategy will also be peer reviewed (i.e., PRESS) to promote its rigor and feasibility.[57]

PAGE 6
R1.8. Line 22 "and" Only stated at this level. I suppose the criteria is cumulative for all items, but I shouldn't suppose.

We have revised to increase clarity.

R1.9. Line 40-41 f) "It observed at least one outcome (e.g., treatment compliance, treatment satisfaction) of the patient-centered treatment approach (this criterion pertains to empirical articles only)." What about the studies on implementation (i.e. Whether the approach was or not adopted and/or why) and on the measurement of PCC (e.g. Validation studies). What you do with study protocols, which operationally define a PCC approach?

This comment requires a two-part response. First, we want to clarify that our aim is to be able to describe the range of outcomes that have been explored, measured, or tested among empirically-based studies (and not to perform meta-analyses). We anticipate that this will support our understanding of how PCC has been operationalized and measured for this population and context. The revised research questions along with the changes made to section 3.5 (in response to R1.10) on collating, summarizing and reporting the results should strengthen the clarity and consistency of the stated aims, screening and extraction plans.

Our response to the reviewer's specific question about the eligibility of implementation studies, validation studies and protocols is grounded in the inherent iterative nature of the scoping review methodology. Since we are expanding our search to a diversity of disciplines and settings that care for people with problematic substance use, it is very likely that we will encounter a range of reference types; book chapters, commentaries, conference abstracts, study and/or program designs and validation studies. We will continue to refine our criteria according to the different types of references encountered.

We have reminded the reader of these potential iterative changes by adding the below sentence to page 4 in the opening paragraph to the Methods and Analysis.

Accordingly, a reflexive and iterative approach will be maintained; particularly during the study screening and data extraction phases, which may become more refined throughout the review.

PAGE 8

R1.10. Line 13-14 "We will present a descriptive overview (including numerical summaries; e.g., effect size if available) of the eligible full texts." Consider take caution with effect sizes and synthesized findings on outcomes from scoping reviews. Maybe a second review on a subset of articles identified with quality appraisal performed would be better than trying to get all done with a scoping review.

We agree this was presented in a confusing manner. Our aim was to describe through tabular or graphical summaries the range of outcomes that were empirically explored and was not to perform a meta-analysis on these effect sizes. We have clarified this in the manuscript, which now reads:

We will present a descriptive overview (including tabular and/or graphical summaries) of the eligible full texts.

R1.11. Line 35-36 "As is common in directed content qualitative analysis." There is no rationale for why this is the 'best' analytic approach. It may not be the main criterion, but as it is framed it seems to be this is the approach that fits better the methods expertise of the authors. If it is like that, explictly state and acknowledge the limitations in addition to the strengthens of doing so. If it is rather the 'best' solution among alternatives, explain why.

We have rephrased this sentence and now it reads as:

Given that one aim of this review is to understand how PCC has been defined and implemented in health care services for people with problematic substance use, a directed content analysis will be

carried out on included guidelines. This approach has been deemed most suitable to the present review, since it allows existing theory (in our case, principles of PCC defined a priori to guide the coding and analysis), while still allowing new evidence to emerge.[59]

Given our reliance on existing conceptual frameworks for defining PCC, we proposed the use of an analytic approach that permits the analytic process to be guided by such pre-determined codes. For example, this approach allows us to ask how does this particular reference, in this particular population/context, define 'holistic' care? What is new or different about this definition in comparison to existing frameworks? In this way, we can make comparisons to what is already known about PCC in other populations and settings, while also illuminating novel dimensions to this approach. In other words, it provides a valuable blend of deductive and inductive analysis, which is meaningful for our review's design.

PAGE 9
R1.12. "The planned consultation process will therefore empower knowledge users with a broad understanding of how PCC has been conceptually defined and its potential for improving health care outcomes among people with problematic substance use." It doesn't say nothing of which (sequence of) activities will be carried out with Knowledge Users and what specific purposes. Will they suggest additional references you may have missed? Will they, within a certain procedure, help refine the results or interpretation and how? Not for the reader to guess.

The specific activities (sequence and purpose) were previously integrated throughout the iterative stages of the scoping review. It seems that this was not very clear and we have expanded this section to more clearly define the roles of each Knowledge User and the contributions made. These updates read:
Consulting with the teams' health care providers and decision-makers (authors SH, SM, and DCM) will promote a methodology that reflects the realities of patient-provider roles and the health care system's organization. Also, our team's drug policy knowledge user (author JW) represents a national organization of people who use drugs and this critical perspective will ensure that all aspects of this review are rooted in the client-centered needs of this diverse population. The specific contributions of the Knowledge Users to each stage of this review have been defined throughout. At this time, Knowledge Users have reviewed early drafts of the search strategy, identifying additional terms that are important for inclusion given the population, concept, and contexts of interest (e.g., trauma-informed care and culturally-safe care). Knowledge Users have also provided several grey-literature references (clinical guidelines and reports) to be considered for inclusion. As the project continues to evolve, all Knowledge Users will be involved in supporting the interpretation of findings and their dissemination.

DISCUSSION SECTION:
R1.13. No ethics and dissemination section – to match the abstract. This section really adds no – but repeats – information.

Since the discussion repeated information from the methods and consultation plans sections, we have removed this and instead describe our team's plans for dissemination.

R1.15. References
The systematic review cited above was missed; and the same happens to other relevant knowledge syntheses: e.g. Scholl I1, Zill JM1, Härter M1, Dirmaier J1. An integrative model of patient-centeredness – a systematic review and concept analysis. PLoS One. 2014 Sep 17;9(9):e107828. doi: 10.1371/journal.pone.0107828. eCollection 2014.
Overall, the references list seems poorer (and not totally up-to-date) for the PCC literature in

healthcare than it is for the substance abuse literature.

We have added this reference within our expanded background.

Reviewer 2:
Reviewer Name: Molly Magill
Institution and Country: Brown University
Please state any competing interests or state 'None declared': none

R2.1 My main concern is with regard to the concept of Patient-Centered Care. This is such a broad term and I sympathize with the authors effort to define and clarify it for addiction care. First, I think the definition in the introduction could be expanded and detailed more completely with further literature cited from medicine. Perhaps several published definitions can be provided and the authors can then land on their own operational definition for the present protocol? Perhaps the authors can describe what PCC is not? Is Motivational Interviewing patient-centered care, because this approach is already widely implemented. My point here is that the definition of this term should be extremely clear, as it will inform the search approach for eligible studies.

Thank you for your comment and for recognizing our efforts to define and clarify this concept. You are correct, elements of PCC have been implemented or recommended as part of existing therapeutic approaches (e.g., Motivational Interviewing, Strengths-based care). In our revisions to the Introduction section, we have provided an expanded definition of this concept from psychology, nursing and medicine; the three disciplines that are most relevant to the treatment of problematic substance use. In this revision, we have endeavoured to bring cohesion to the principles that overlap within and between these disciplines. This overlap then provides the framework for our working definition of PCC that will be applied as part of the inclusion criteria for the search. This working definition has also been is added to section 3.2 on page 5.

Your comments here and below raise another very important point of consideration for both defining PCC in this population/context and justifying its role and potential benefits in the treatment of problematic substance use. As you have observed, elements of PCC (e.g., empowerment, empathy) have been recommended or defined as part of some other clinical approaches, including motivational interviewing, strengths-based treatments, and harm reduction, to name a few. To our knowledge, it is not known to what extent each of the dimensions have been purposefully implemented, operationalized or measured across approaches, settings, and disciplines. As such, this review provides an opportunity to bring greater attention and understanding of the role that each of the PCC principles has.

We will extract the specific type of addiction treatment approach, setting, and health professionals involved as variables for analysis to be able to assess under what circumstances the principles of PCC have been implemented and to gain better understanding of the discipline specific definitions.

R2.2 This relates to my second point. It seems some potential terms for the patient centered care search are missing. In fact, most research on addictions treatment involves some element of patient centered care. Motivational interviewing, strengths-based case management, any evidence-based family models for adolescent use, Jim McKay's Continuing Care research are just a few examples. My suggestion here is that there be a more comprehensive review of what is patient-centered care, a clear operational definition for the project search, and a broadened set of search terms for PCC in addictions.

Thank you for the feedback. We have significantly revised the introduction to the protocol, providing a

more comprehensive review of PCC. As mentioned in our response to R2.1., we have also provided a clearer working definition of PCC to be used for the present review.

R2.3 My next concern is that the background review in the introduction could make a stronger argument for why this is needed. At present, the introduction is a very broad, at times cursory, view of the problem and its treatment that does not really argue how the application of patient centered care in addictions will fill an important service gap. There are numerous evidence-based addictions treatments available, most incorporate some attention to the relationship and patient unique needs, many are long-term, and most address biopsychosocial concerns. How will PCC be different?

As part of our major revisions to the background, we have devoted one paragraph that expands on how PCC may fill an important gap in the treatment of problematic substance use.

There are numerous treatments available for problematic substance use and some overlap with elements of PCC. Unfortunately, evidence continues to suggest that few people who need substance use treatment receive it; and qualitative data suggests that those receiving treatment experience challenges with engaging or staying in treatment. By synthesizing empirical and grey literature on which PCC principles have been implemented and their operationalization across settings and treatments, we can contribute evidence that builds a stronger operationalization of PCC for people with problematic substance use.

R2.4 Next, I believe polysubstance use is an important search term for substance use disorders.

In our earlier drafts of the search strategy, we had considered the terms ‘polysubstance’ or ‘polydrug’ and elected not to include them because we are interested in whether the population included people with problematic substance use (which by definition includes polysubstance users). In our experience, and based on the terms of other recent systematic reviews and papers examining PCC in people with problematic substance use, the papers are indexed with the MeSH term for ‘Substance Related Disorders’ with keywords for the primary population of interest (e.g., opioid use disorder), sometimes with a second term for other drugs.

Having said this, we have re-run our latest search draft adding this term and it brought one additional paper that would not meet our currently defined criteria (its focus is on inter-professional practice for a very specific population of women engaging in sex work and using drugs).

R2.5 Finally, I understand there is a journal citation practice that places periods before the citation, but the MS needs a full copy edit for grammar and prose.

We have carefully reviewed the manuscript for grammar and prose.

Editorial Office Formatting Amendments Required:

EO.1. Please re-upload your supplementary files in PDF format.

We have re-uploaded our supplementary files, including the Medline (Ovid) developed search terms and PRISMA-P.

EO.2. Please ensure to cite all supplementary files (i.e. Supplementary file 1, Supplementary file 2, etc.) within main text only (not in statements) that needs to be published as supplementary file. Please ensure that these were cited in ascending order.

Thank you, we have added citations to the supplementary files within the main text.

EO.3. We have implemented an additional requirement to all articles to include 'Patient and Public Involvement' statement within the main text of your main document. Authors must include a statement in the methods section of the manuscript under the sub-heading 'Patient and Public Involvement'. This should provide a brief response to the following questions:
How was the development of the research question and outcome measures informed by patients' priorities, experience, and preferences?
How did you involve patients in the design of this study?
Were patients involved in the recruitment to and conduct of the study?
How will the results be disseminated to study participants?
For randomised controlled trials, was the burden of the intervention assessed by patients themselves?
Patient advisers should also be thanked in the contributorship statement/acknowledgements. If patients and or public were not involved please state this.

Thank you for bringing our attention to this additional requirement. We have added the following brief response to those questions to the Methods section of the manuscript, on page .

This scoping review protocol has engaged the expertise of a national organization of people who use drugs through the involvement of this organizations' President. This knowledge user (author JW) has made contributions to the development of the research question and will also be extensively involved during the interpretation and dissemination phases of this project.

VERSION 2 – REVIEW

REVIEWER	Tiago S. Jesus, Ph.D Global Health and Tropical Medicine (GHTM), WHO Collaborating, Centre for Health Workforce Policy and Planning, Institute of Hygiene and Tropical Medicine - NOVA University of Lisbon (IHMT-UNL), Rua da Junqueira 100, Lisbon 1349-008, Portugal
REVIEW RETURNED	07-Oct-2018

GENERAL COMMENTS	Thank you for the opportunity to review this revised paper. My comments below: The authors have taken reviewers' suggestions into account and the protocol paper is much improved, especially in the quality of its reporting – including the Introduction, which is much more effective. Improvements in key parts of the paper, such as the Objective, Study Questions, etc also are notorious. The only recommendation at this stage is perhaps to revise the element of "ethics and dissemination" within the Abstract, which differs no only in the use of words from the respective content in the Full Text. The latter seems more aligned with a what a scoping review typically provides (e.g. a review of which evidence exists; how a literature has been approaching a topic, etc) . Abstract: "Ethics and dissemination: This review will examine the nature and extent to which the principles of PCC have been implemented, defined, and measured"

	Full text “Ethics and dissemination: To our knowledge, this review will be the first to systematically examine the extent and nature of existing evidence of PCC in addiction research and clinical practice.” Note: Examine the extent and nature "of existing evidence" makes a substantial difference, per the issue detailed above.

REVIEWER	Molly Magill Brown University
REVIEW RETURNED	18-Oct-2018

GENERAL COMMENTS	The protocol titled: Patient Centered Care for Addictions Treatment: A Scoping Review presents what could be a worthwhile and important effort. The authors have responded well to peer review, and the review protocol is much clearer. My lingering comment is about patient outcomes. The protocol is a bit unclear on whether the primary interest is engagement and satisfaction outcomes and/or use reduction outcomes. In the project framing, it seems engagement is most important but in other parts of the manuscript, it seems treatment effectiveness is of interest as well. This should be clarified and further defined in Table 1 (2.6; 3.5).

VERSION 2 – AUTHOR RESPONSE

Reviewer(s)' Comments to Author:

Reviewer: 1

Reviewer Name: Tiago S. Jesus, Ph.D

Institution and Country: Global Health and Tropical Medicine (GHTM), WHO Collaborating Centre for Health Workforce Policy and Planning, Institute of Hygiene and Tropical Medicine - NOVA University of Lisbon (IHMT-UNL), Rua da Junqueira 100, Lisbon 1349-008, Portugal

Please state any competing interests or state ‘None declared’: None Declared.

Please leave your comments for the authors below

Thank you for the opportunity to review this revised paper. My comments below:

The authors have taken reviewers’ suggestions into account and the protocol paper is much improved, especially in the quality of its reporting – including the Introduction, which is much more effective. Improvements in key parts of the paper, such as the Objective, Study Questions, etc also are notorious. The only recommendation at this stage is perhaps to revise the element of “ethics and dissemination” within the Abstract, which differs no only in the use of words from the respective content in the Full Text. The latter seems more aligned with a

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Full text

"Ethics and dissemination:

To our knowledge, this review will be the first to systematically examine the extent and nature of existing evidence of PCC in addiction research and clinical practice."

Note: Examine the extent and nature "of existing evidence" makes a substantial difference, per the issue detailed above.

As suggested, we have revised the sentence in the abstract we a stronger reflection of the aims of a scoping review. This sentence now reads:

> *This review will systematically examine the extent and nature of existing evidence of PCC in addiction research and clinical practice.*

Reviewer: 2

Reviewer Name: Molly Magill

Institution and Country: Brown University

Please state any competing interests or state 'None declared': none

Please leave your comments for the authors below

The protocol titled: Patient Centered Care for Addictions Treatment: A Scoping Review presents what could be a worthwhile and important effort. The authors have responded well to peer review, and the review protocol is much clearer. My lingering comment is about patient outcomes. The protocol is a bit unclear on whether the primary interest is engagement and satisfaction outcomes and/or use reduction outcomes. In the project framing, it seems engagement is most important but in other parts of the manuscript, it seems treatment effectiveness is of interest as well. This should be clarified and further defined in Table 1 (2.6; 3.5).

Thank you for bringing the opportunity to clarify our plans for data extraction. As described in the background, the broader literature on PCC has provided quite mixed results when examining its relationship with treatment effectiveness. This may be due to diversity in the outcomes measured. From the cited Cochrane review by Dwamena et al. (2012), outcomes of PCC tend to fall into two categories – patient outcomes (e.g., treatment satisfaction, retention or adherence, health status) and/or treatment process outcomes (e.g., consultation process, provider communication skills). In the substance use field specifically, treatment effectiveness studies frequently focus on patient outcomes, especially treatment engagement (measured as initiation, retention, compliance) and changes in substance use behaviours (usually measured as reduced frequency or severity of related problems).

We plan to extract data on both patient outcomes and treatment process outcomes. This will increase the alignment of our scoping review's findings with those broader operationalizations of PCC. Capturing all such outcomes will also facilitate our future directions stemming from this review (e.g., discussion of common measures, operationalization of PCC among sub-groups). Although, we cannot fully anticipate the range of possible outcomes of PCC in this field specifically, we recognize that this could be made clearer to the reader and have made the following revisions:

- In Section 3.3 on Study Selection, we have expanded criterion f, offering some examples of what kinds of outcomes we anticipate. This now reads:
  f) It observed at least one patient outcome (e.g., treatment engagement, substance use behaviours, treatment satisfaction) and/or treatment process outcome (e.g., provider communication skills) of the patient-centered care approach (this criterion pertains to empirical articles only).
- In Section 3.4 Table 1, line 2.6 now reads:
  For quantitative studies, what types of patient outcomes and/or process outcomes were measured (e.g., treatment engagement, changes in substance use behaviours, health status, treatment satisfaction, provider communication)? For qualitative studies, what outcomes were described?
- In Section 3.4 Table 1, line 3.5 now reads:
  If applicable, was a specific patient-centered intervention described (e.g., a training module, a clinical approach)? Were any patient outcomes and/or process outcomes of PCC reported (e.g., treatment engagement, substance use outcomes, treatment satisfaction, provider communication)?