ATODA
Alcohol Tobacco & Other Drug Association ACT

ACT Alcohol, Tobacco and Other Drug Sector Service Users' Satisfaction Survey 2012

Final Report

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for the Alcohol Tobacco and Other Drug Association ACT Inc.

January 2013

Incorporating feedback from the ACT ATOD Executive Directors Group

We acknowledge the Traditional Owners and continuing custodians of the lands of the ACT and we pay our respects to the Elders, their families and ancestors.

We also acknowledge the key roles played by the Manager and staff of the Canberra Alliance for Harm Minimisation and Advocacy Inc. (CAHMA) in designing and implementing the Survey.

Suggested reference:
McDonald, D 2013, *ACT Alcohol, Tobacco and Other Drug Sector Service Users' Satisfaction Survey 2012: final report,* Alcohol Tobacco and Other Drug Association ACT, Canberra.

About Social Research and Evaluation Pty Ltd

Social Research & Evaluation Pty Ltd is a Canberra-based consultancy specialising in social science research and policy & program evaluation. The Director is David McDonald, a social scientist with research interests in public health and criminology, particularly alcohol and other drugs policy and better understanding how research can contribute to public policy. As well as being a Consultant in Social Research and Evaluation, he is a Visiting Fellow at the Australian National University's National Centre for Epidemiology and Population Health, and a member of the Drug Policy Modelling Program research team.

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Please note that there is the potential for minor revisions of data in this report. Please check the online version at <www.atoda.org.au> for any amendments.

About the Alcohol Tobacco and Other Drug Association ACT

The Alcohol Tobacco and Other Drug Association ACT (ATODA) is the peak body representing the non-government and government ATOD sector in the ACT. ATODA seeks to promote health through the prevention and reduction of the harms associated with ATOD. ATODA works collaboratively to provide expertise and leadership in the areas of social policy, sector and workforce development, research, coordination, partnerships, communication, information and resources. ATODA is an evidence informed organisation that is committed to the principles of public health, human rights and social justice.

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A Service Users' Satisfaction Survey was conducted across the ACT alcohol and other drug organisations, both government and non-government, on 21 June 2012. It largely replicated the ACT Service Users' Satisfaction Survey conducted on 19 November 2009. This is a report on the findings of the 2012 Survey. It also provides comparisons between the 2009 and 2012 waves.

Ten organisations participated in the Survey, with 346 questionnaires returned.[1] Almost one-third (30%) came from one service, the Health Directorate's Alcohol and Drug Service (ADS) Opioid Treatment Service (OTS). The high proportion of respondents from just one service should be borne in mind in interpreting the data.

The Survey had two purposes. The first was to obtain a snapshot of the levels and patterns of satisfaction of the service users. The second was to provide information on any changes in satisfaction between 2009 and 2012 as this information can be used for monitoring and assessing the outcomes of quality assurance programs implemented by the services that participated in the Survey.

Overall satisfaction

The overall level of satisfaction was high, with 92% of Survey respondents stating that they were overall 'mostly satisfied' or 'very satisfied' with the service that they had received.

The scores obtained from a composite index of satisfaction, the Client Satisfaction Questionnaire (CSQ-8)©, in which the lowest possible level of satisfaction is scored 8 and the highest possible is scored 32, had a mean of 27, well above the mid-point of the scale of 20.

Ninety-four percent of respondents replied in the affirmative when asked 'If you were to seek help again, would you come back to this service?'.

While organisation-by-organisation comparisons need to be made with caution, the highest level of satisfaction was reported from The Salvation Army. It was followed (in sequence) by Gugan Gulwan, CAHMA, Winnunga Nimmityjah and Toora. The lowest scores were recorded at Karralika, Ted Noffs Foundation, Directions (formerly DIRECTIONS ACT) and the Health Directorate's Alcohol and Drug Service (ADS). All organisations had relatively high satisfaction scores, with only small differences observed between the higher and the lower scoring organisations. None of the differences between individual pairs of organisations, on this variable, was statistically significant. These scores reflect, in part, the different types of service users, and the services provided, in the different organisations.

Accessibility of the services

Some 83% of respondents stated that the location of their service was convenient, and 78% indicated that the opening hours were convenient.

Assessments, case management and care plans

Nearly two-thirds of the respondents (62%) stated that they had received a comprehensive assessment from the service for their alcohol and other drug-related

[1] There was only one respondent from CatholicCare's Sobering-up Shelter. To facilitate data analysis, that case is excluded from the subsequent discussion.

needs. 63% stated that they had a case manager/key worker, and 54% stated that they had a care plan.

Wrap-around services

Most organisations provide some wrap-around services, i.e., services that are ancillary to the core services, such as legal advice, debt management, etc.

The services most frequently received within the organisation were achieving abstinence and blood-borne viruses (BBV) information and support (both 73% of respondents). Among referrals out to other services, legal support was most frequent (27% of respondents). Only small proportions reported requesting services but not receiving them.

Smoking cessation advice had been requested by 38% of respondent and 63% had received such advice within their organisation, 10% had been referred to another organisation and 6% stated that they had requested smoking cessation advice but not received it.

Outcomes

The Survey assessed the self-reported service outcomes of the participating service users. The most frequently reported positive outcome was reduced levels of crime, followed in frequency by reduced drug use, improved general health, improved knowledge of BBV transmission prevention, improved parenting/relationships, improved mental health, improved capacity to manage finances, improved housing, improved dental health and improved employment situations. Predictably, improvements in these and other treatment outcomes were associated with high levels of overall satisfaction.

Services' responsiveness and treatment of clients

Fifty-eight percent of respondents stated that they had been asked at some time to give comments on how satisfied or dissatisfied they were with the service or treatment they received. Overall, 72% felt that the service acts on suggestions and complaints.

Being invited by their service to provide feedback on level of satisfaction with the services received was positively related to overall satisfaction, as was perceiving that their service acts on service users' complaints and suggestions. Indeed, the second of these—perceiving that the service acts on complaints and suggestions—was particularly strongly related to overall satisfaction.

Similarly, perceptions of how people treat the service users were closely related to levels of overall satisfaction, particularly regarding being treated with respect by reception staff, doctors, other staff and other service users.

Match between service and felt needs

Overall, a high proportion of respondents indicated that most of their needs were being met through the services that they were receiving. For example, 80% or more expressed agreement with such statements as 'The staff here are efficient at doing their job', 'You are satisfied with the services you receive here', 'This service meets your needs', 'This service is organised and well run', etc.

High satisfaction scores were related to the following variables:

- Housing status, with respondents in settled or permanent housing having relatively high scores
- Length of time attending the service, with new service users showing the lowest levels of satisfaction

- Frequency of attending, with people attending daily having the lowest levels of satisfaction and those attending the least frequently having the highest levels
- The convenience of the services' location
- The convenience of opening hours
- Being aware that they had a case manager/key worker
- Being aware that they had a care plan
- Perceiving that the service welcomes and acts upon complaints and suggestions
- Perceptions of how people treat the service users
- Positive service user outcomes.

Other comments

Respondents provided a range of additional comments about services that they believe should be offered in the ACT but are currently unavailable. The most commonly requested service was heroin assisted treatment (a 'heroin trial'), improved opioid substitution treatment and improved needle syringe programs.

When invited to provide any other comments, the largest proportion indicated that they were happy with, or extremely grateful for, their service. This was followed in frequency by suggestions on how the services they receive can be improved.

Comparisons between the 2009 and 2012 waves of the Satisfaction Survey program

A similar number of organisations and respondents contributed to both surveys. Respondents' demographics were similar in 2009 and 2012.

When asked 'In an overall, general sense, how satisfied are you with the service you have received?', similar proportions between the two waves indicated that they are 'mostly satisfied' or 'very satisfied'.

The mean score on the CSQ-8 increased from 26.2 in 2009 to 27.1 in 2012, indicating an increased level of overall satisfaction. This difference is statistically significant.

The proportions indicating that they had received a comprehensive assessment from their service for their alcohol and other drug-related needs increased from 57% in 2009 to 62% in 2012, although this difference is not statistically significant.

The proportions reporting improvements since starting to use their service on all ten of the outcomes covered in the Survey increased from 2009 to 2012. In all but three outcomes the changes were statistically significant.

The proportion reporting having been asked to give comments on their level of satisfaction with the services they receive increased from 42% in 2009 to 50% in 2012, and the proportion reporting that their service acts on suggestions and complaints increased from 61% to 72%.

Furthermore, higher proportions of respondents indicated that they were treated with respect in 2012 compared with 2009 by their caseworkers, by reception staff and by doctors. The proportions remained stable regarding other staff of the services, pharmacists, other pharmacy staff and other service users.

Conclusions and recommendation

The 2012 ACT Alcohol & Other Drug Sector Service User Satisfaction Survey has provided valuable information demonstrating the high overall level of service user satisfaction at the sector wide level, with significant variations on a service-by-service basis. This information provides opportunities for the participating organisations to review their strengths and build upon them, and to explore opportunities for service quality enhancement in areas where client satisfaction levels are relatively low.

The across-the-board increases in levels of satisfaction from 2009 to 2012 observed are encouraging, suggesting that the quality enhancement initiatives that have been implemented by the participating organisations in recent years have been effective.

It is recommended that the Survey be conducted again in 2014 with the aim of continuing to monitor levels and patterns of service user satisfaction in the ACT alcohol and other drug services.

Introduction

A Service Users' Satisfaction Survey was conducted across the ACT alcohol and other drug organisations, both government and non-government, on 21 June 2012. It largely replicated the ACT Service Users' Satisfaction Survey conducted on 19 November 2009.[2] This is a report on the findings of the 2012 Survey. It also provides comparisons between the 2009 and 2012 waves.

The project was implemented by the Alcohol Tobacco and Other Drug Association ACT (ATODA) and was funded by the ACT Government Health Directorate. The Executive Directors/CEOs of the ACT's alcohol, tobacco and other drug organisations, both government and non-government, supported both the development and implementation of the Survey.

The Survey filled two functions. The first was to obtain a snapshot of the levels and patterns of satisfaction of the service users. The second was to provide information on any changes in satisfaction between 2009 and 2012 as this information can be used for monitoring and assessing the outcomes of quality assurance programs implemented by the services that participated in the Survey.

At some points in this report the levels of satisfaction with their services expressed by respondents are presented on an organisation-by-organisation basis. These comparisons should be used with caution owing to the presence of confounders, particularly the differences in types of services and service users in the different organisations. The key point is that the appropriate comparisons are not one organisation with another, but for each organisation comparing the 2009 satisfaction levels with those for 2012 and those ascertained from future satisfaction surveys. This highlights the value of repeating the Survey at regular intervals, preferably every two years.

Acknowledgements

I acknowledge the key roles in conducting the 2012 Survey filled by Ms Amanda Bode, Ms Kathryn Sequoia and Ms Carrie Fowlie from ATODA. The contributions made by Ms Nicole Wiggins (CAHMA), Mr Marty Owen (ACT Health), and Dr Adam Winstock and Mr Toby Lea (Sydney South West Area Health Services) to designing the Survey questionnaire in 2009 are highly appreciated. I also acknowledge the managers and staff of the participating organisations and the service users who provided responses to the Survey.

A new survey instrument was developed for the 2009 Survey and used again in 2012. It is based upon the instrument used by the UK National Treatment Agency for Substance Misuse (NTA) in its 2007 User Satisfaction Survey of Tier 2 and 3 Service Users in England and Wales. Additional items were added by local service organisations, and the NTA instrument was adapted in other ways to meet the local situation. The design of this report is informed, in part, by the NTA's 2007 summary report.[3]

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[2] McDonald, D 2010, *ACT Alcohol & Other Drugs Sector Service Users' Satisfaction Survey 2009: final report*, ACT Health, Canberra, http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1952856156&sid= .

[3] Gordon, D *et al.* 2008, *The 2007 User Satisfaction Survey of Tier 2 and 3 service users in England*, National Treatment Agency for Substance Misuse, London.

The survey instrument incorporates the eight-item Client Satisfaction Questionnaire (CSQ-8)©.[4] It was used under license from the copyright owner, C. Clifford Attkisson PhD. His permission to do so is gratefully acknowledged.

The Survey received ethics coverage from the ACT Health Human Research Ethics Committee, approval number ETHLR.12.107 dated 16 May 2012.

The assessment of ATOD service user satisfaction

The assessment of service user satisfaction is a core component of continuous quality improvement, and is part of the Standards Australia ISO 9000 system. That body emphasises the need for service user ('customer') feedback to be 'relevant, reliable and representative'.[5] The 2004 Health and Community Service Standards, as they applied to alcohol, tobacco and other drug (ATOD) services, included a component 'The organisation has strategies to canvass and act on the views of consumers who are currently or potentially involved in or affected by problematic alcohol and/or other drug use'.[6]

WANADA's *Standard On Culturally Secure Practice (Alcohol and other Drug Sector)*[7] includes service user satisfaction assessment under the heading 'Consumer focussed practice', specifically Standard 3.2: 'Development, utilisation and review of a consumer needs and satisfaction survey tool and consultation processes'. This is elaborated as 'The agency performs ongoing assessment of consumer needs and satisfaction, utilising feedback to review practice with an aim to improving outcomes'. These are the details set out in that standard:

> *Essential criteria*
> a) The agency regularly assesses consumer satisfaction.
> b) The agency seeks feedback from consumers on the appropriateness of the method used to assess consumer satisfaction.
> c) Staff can describe strategies they implement to maximise consumer feedback.
>
> *Good practice criteria*
> d) Data collected on consumer satisfaction is regularly collated and compared with data previously collected.
> e) Collated data sets on consumer satisfaction are used to inform the agency's planning process.
> f) The agency provides staff and consumers with the results of collated consumer feedback.

The Australasian Therapeutic Communities Association's *Australasian alcohol and other drug therapeutic communities standards (TC standards)*, currently being piloted, will also include the assessment of service user satisfaction.

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[4] Attkisson, CC & Greenfield, TK 2004, 'The UCSF Client Satisfaction Scales: I. Client Satisfaction Questionnaire-8', in ME Maruish (ed.), *The use of psychological testing for treatment planning and outcomes assessment*, 3rd edn, Lawrence Erlbaum Associates, Mahwah, N.J., vol. 3, pp. 799-811.

[5] Pedic, F 2004, *Customer satisfaction measurement: a handbook for users of AS/NZS ISO 9001:2000*, cat. no. HB 251-2004, Standards Australia International, Sydney, p. 1.

[6] Quality Improvement Council Ltd 2004, *Alcohol, tobacco and other drug services ATODS standards*, Quality Improvement Council Ltd, La Trobe University, Bundoora, Vic.

[7] Western Australian Network of Alcohol and other Drug Agencies (WANADA) 2012, *Standard On Culturally Secure Practice (Alcohol and other Drug Sector)*, Western Australian Network of Alcohol and other Drug Agencies (WANADA), Perth.

A consortium of international organisations has published a workbook on 'Client Satisfaction Evaluations' in its *Evaluation of psychoactive substance use disorder treatment workbook series*.[8] It includes a number of case studies, including one from Australia (Jeff Ward/NDARC's on 'The case of community methadone treatment programs'). The Workbook points out that service user satisfaction surveys can address:

1. The reliability of services, or the assurance that services are provided in a consistent and dependable manner
2. The responsiveness of services or the willingness of providers to meet clients/customer needs
3. The courtesy of providers and
4. The security of services, including the security of records.

Furthermore, organisations can use regular satisfaction assessment to improve outcomes for individual clients as well as to improve the operation of the organisation as a whole. As the results of a recent study put it, 'Treatment programs should consider administering [satisfaction assessment] to their patients at 3 months post-admission to identify patients with low satisfaction scores who may be at risk for prematurely leaving treatment…Measuring patient satisfaction during treatment may help programs meet patients' needs and improve retention'.[9] Service user satisfaction is a predictor of retention in treatment[10] which is, in turn, a predictor of successful treatment outcomes.[11]

The UK National Treatment Agency conducts regular client satisfaction surveys of both its Tier 2 and 3 services (i.e. those provided in the community)[12] and its Tier 4 (residential) services.[13]

The WA Drug and Alcohol Office conducted client satisfaction surveys in 2008, 2009 and 2010 as part of its ongoing monitoring of the outpatient services and inpatient withdrawal treatment services provided through its Next Step Drug and Alcohol Services. The surveys '…offer clients an opportunity to comment on the services they have received and provide valuable feedback to the program areas to maintain and enhance client focused services'.[14]

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[8] World Health Organization, United Nations International Drug Control Programme & European Monitoring Centre on Drugs and Drug Addiction 2000, 'Workbook 6: client satisfaction evaluations', in *Evaluation of psychoactive substance use disorder treatment workbook series*, World Health Organization, [Geneva].

[9] Kelly, SM *et al.* 2010, 'The role of patient satisfaction in methadone treatment', *American Journal of Drug and Alcohol Abuse*, vol. 36, no. 3, pp. 150-4, p. 150.

[10] Kelly, SM *et al.* 2011, 'Predictors of methadone treatment retention from a multi-site study: a survival analysis'', *Drug and Alcohol Dependence*, vol. 117, no. 2-3, pp. 170-5.

[11] Teesson, M *et al.* 2004, *Twelve month outcomes of the treatment of heroin dependence: findings from the Australian Treatment Outcome Study (ATOS)*, NDARC technical report no. 191, National Drug and Alcohol Research Centre, Sydney.

[12] Gordon, D *et al.* 2008, *The 2007 User Satisfaction Survey of Tier 2 and 3 service users in England*, National Treatment Agency for Substance Misuse, London.

[13] Abdulrahim, D *et al.* 2008, *The 2007 User Satisfaction Survey of Tier 4 service users in England*, National Treatment Agency for Substance Misuse, London.

[14] Evans, L & McGregor, C 2008, *Client satisfaction 2008: an evaluation of outpatient and inpatient withdrawal treatment services at DAO Next Step*, DAO Monograph 4, Drug and Alcohol Office, Mount Lawley, WA, p. i.

In addition, a number of one-off service user satisfaction surveys have been conducted in Australia. They include a study of satisfaction levels and patterns among people receiving opioid substitution treatment at NSW community pharmacies[15] and through public clinics in that State.[16]

As part of a study of satisfaction among the clients of NSW methadone services, Whitney has documented how service user satisfaction can be conceptualised, and has reformulated thinking in this area.[17] She explains that '…clients are likely to be most satisfied with treatment when they know what to expect from it and it is highly probable or likely that their expectations are realised' (p. 46). Furthermore

> …satisfaction judgments are relative to clients' expectations of treatment. These expectations exert a non-linear influence on client evaluations, resulting in satisfaction when there are minor discrepancies with treatment experiences and dissatisfaction only when there are significant differences. This accounts for the generally high reported levels of client satisfaction in the literature…When their norms for treatment are not fulfilled, clients are likely to express their dissatisfaction behaviourally (p. 48).

The behavioural expressions to which Whitney refers include withdrawing from the service. The views of people who have done this are not captured in this type of service user survey.

NSW researchers have reflected on their experiences in assessing service user satisfaction, drawing attention to the fact that, in discussion, interviewees frequently expressed negative sentiments about their services but nonetheless recorded high satisfaction scores on the survey instrument.[18] The researchers concluded that 'Satisfaction is based on experience and expectation, and if poor service provision is all that a person has experienced then expectation will be low. So when a person then accesses a service that is deemed "better" than past experience it will score higher' (p. 4). This accords with Whitney's observation that, in satisfaction surveys '…when the context in which clients receive treatment is clarified, which usually occurs through the use of qualitative methods such as in-depth, open-ended interviews, more negative ratings of client satisfaction are often generated'.[19]

This links to a body of conceptual scholarship and empirical research which suggests that 'Expectations emerge repeatedly as having a fundamental role in expressions of satisfaction' and that 'As patient satisfaction is a recognised component of Quality Assurance…, it is therefore tempting to equate "high" levels of reported satisfaction with "high" levels of quality of care'.[20] An implication of this research is that it is important not to use levels of client satisfaction as a proxy for service quality. It taps a different construct.

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[15] Lea, T, Sheridan, J & Winstock, AR 2008, 'Consumer satisfaction with opioid treatment services at community pharmacies in Australia', *Pharmacy World and Science*, vol. 30, no. 6, pp. 940-6.

[16] Madden, A, Lea, T, Bath, N & Winstock, AR 2008, 'Satisfaction guaranteed? What clients on methadone and buprenorphine think about their treatment', *Drug and Alcohol Review*, vol. 27, no. 6, pp. 671-8.

[17] Whitney, M 2005, 'The nature of client satisfaction with community and clinic based opioid replacement treatment: a resource exchange perspective', PhD thesis, Australian National University, Canberra.

[18] Madden, A, Lea, T, Bath, N & Winstock, AR 2008, *op. cit.*

[19] Whitney 2005, *op. cit.*, p. 36.

[20] Sitzia, J & Wood, N 1997, 'Patient satisfaction: a review of issues and concepts', *Social Science and Medicine*, vol. 45, no. 12, pp. 1829-43, p. 1834.

Statistical notes

At various points in this report statistics are provided that may not be familiar to some readers. These include the 'F' statistic, used in one-way analyses of variance (ANOVA), and its related 'p' (or probability) values. The 'p' value indicates the probability of the observed relationships between variables having occurred by chance. 'P' values of less than (shown as <) 0.05 (5%) are conventionally considered to be statistically significant, i.e. the observed relationships are taken not to have occurred simply by chance. Although it is conventional to report both the 'F' and 'p' values (and this is done here), readers cannot directly interpret the 'F' values without recourse to statistical tables. The Bonferroni test was used for *post hoc* comparison of means.

Two-sample T-tests have been used to compare the means of various groups on key variables such as satisfaction scores, including 2009/2012 comparisons. The resulting 'p' values of less than 0.05 are treated as statistically significant.

Effect sizes are also reported, although the values of the underlying statistic (eta squared) are not given. Effect size is the proportion of the variance in one variable (e.g. overall satisfaction score) that can be attributed to the variance in another variable (e.g. the suitability to the clients of the service's opening hours). In plain language, the effect size shows how much effect one variable (e.g. gender) has on another variable (e.g. satisfaction score). The effect sizes are classified as small (eta squared of around 0.01), moderate (around 0.06) and large (around 0.14).[21] Some very large effect sizes, around 0.40, are reported in this study.

The chi-square test of independence was used to compare frequencies of nominal level data displayed in cross-tabulation tables (applying Fisher's Exact Test where appropriate), and z-tests were used to compare the significance of the difference between two independent proportions.

[21] Cohen, J 1988, *Statistical power analysis for the behavioral sciences*, 2nd edn, L. Erlbaum Associates, Hillsdale, N.J.

Survey coverage

Ten organisations providing 19 different services participated in the Survey, with the number of questionnaires returned, by organisation and type of service, being shown in Table 1. CatholicCare's Sobering-up Shelter also participated but had only one client on the day of the survey. To facilitate data analysis, that single response is excluded from this report.

In all, 345 service users completed the Survey questionnaire (325 in 2009). 103 of them (30% of all respondents) came from one service, the Health Directorate's Alcohol and Drug Service (ADS) Opioid Treatment Service (OTS). The high proportion of respondents from just one service should be borne in mind in interpreting the data.

Table 1
Number of Survey respondents by organisation and service type within the organisation

Organisation/service	Number	Percent
Alcohol and Drug Service, Health Directorate	**118**	**34.2**
Moore St Counselling Service	7	2.0
Opioid Treatment Service	103	29.9
Withdrawal Service	8	2.3
CAHMA	**39**	**11.3**
Directions	**35**	**10.1**
Woden	16	4.6
Arcadia House	4	1.2
Civic NSP	15	4.4
Gugan Gulwan Youth Aboriginal Corporation	**15**	**4.4**
Karralika Programs Inc.	**35**	**10.1**
Karralika	30	8.7
Nexus Program	5	1.5
Salvation Army	**25**	**7.3**
Treatment	21	6.1
Re-entry/Halfway House	4	1.2
Ted Noffs Foundation ACT	**24**	**7.0**
Program for Adolescent Life Management	9	2.6
Co/Op and CALM (outreach & drop in)	15	4.4
Toora Women Inc.	**24**	**7.0**
Lesleys/Marzenna (residential)	8	2.3
Lesleys/Marzenna (outreach)	3	0.9
WIREDD	13	3.8
Winnunga Nimmityjah Aboriginal Health Service	**30**	**8.7**
Total	**345**	**100.0**

Service users' characteristics

Gender, Aboriginality and age

Of the 345 service users who completed the questionnaires, 56% were male, 43% female and 0.3% transgender. The respondents included 85 people (25%) who indicated that they were of Aboriginal or Torres Strait Islander descent.

The ages ranged from 14 to 65 years, the mean age was 36 years and the median (the point above and below which half the cases fell) 35 years. The largest 10 year age group was the 30-39 year olds (30% of the total), followed by 20-29 year olds and 40-49 year olds (both 24%), 50-59 year olds (10%) and 14-19 year olds (9%).

Employment

Two-thirds of the respondents (67%) stated that they were unemployed, with 13% employed full-time and 14% employed part-time. An additional 7% stated that they engaged in unpaid or voluntary work.

20% were studying at the time of the Survey, 12% part-time and 8% full-time.

Housing situation

More than a third of the respondents (39%) had unstable housing, with 27% being in temporary accommodation and 12% with no fixed place of living. 61% were in settled, permanent housing.

Parental/caring situation

28% of respondents were the parent or carer of children under 16 years of age, where the children were living with the respondent, and 30% were the parent of a child under 16 years who did not live with the respondent.

Overall satisfaction

Embedded in the Survey was a validated instrument called the Client Satisfaction Questionnaire (CSQ-8)©. This instrument produces a composite index of satisfaction derived from eight scale items. As noted in the introduction, the instrument was used under license from the copyright owner. The psychometric properties of the CSQ-8 in various applications have been well documented.[22] These will be explored, with respect to this study, in a separate technical paper.

The CSQ-8 responses are summarised in Table 2. Possible values range from 8 (the lowest possible level of satisfaction) to 32 (the highest possible level of satisfaction). The mid-point of the 8-32 range is 20.

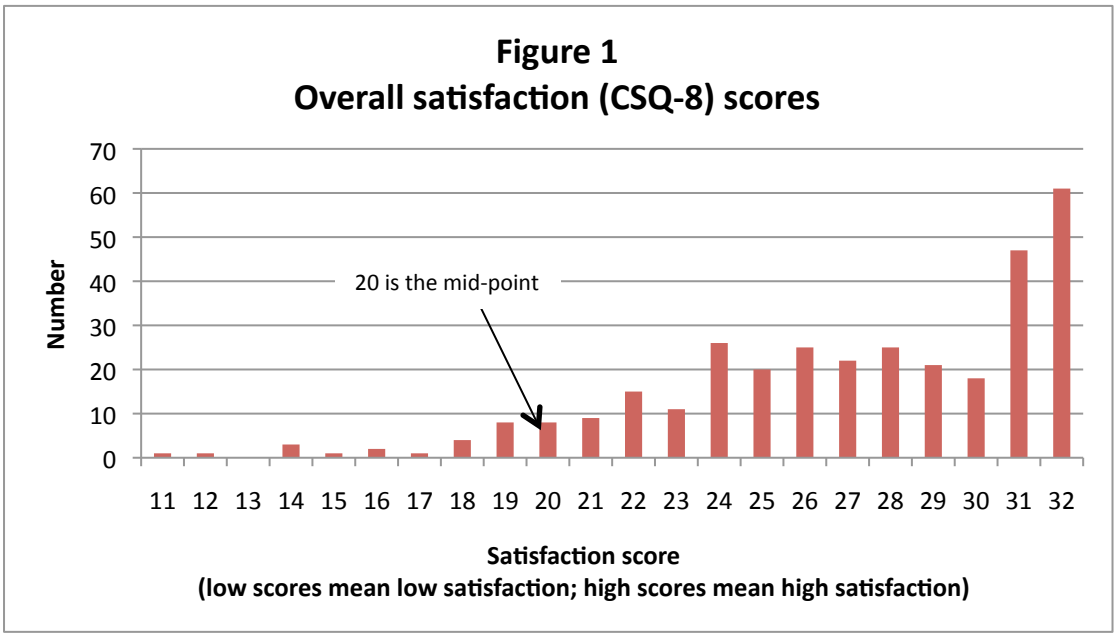
It will be noted that the modal (the most frequent) score was 32. This is also the highest possible score and was provided by 19% of respondents. The lowest score was 11. The average (mean) score was 27.1 and the median was 28.

Table 2
Overall satisfaction scores (CSQ-8)

Score	Number	Percent
11	1	0.3
12	1	0.3
14	3	0.9
15	1	0.3
16	2	0.6
17	1	0.3
18	4	1.2
19	8	2.4
20	8	2.4
21	9	2.7
22	15	4.6
23	11	3.3
24	26	7.9
25	20	6.1
26	25	7.6
27	22	6.7
28	25	7.6
29	21	6.4
30	18	5.5
31	47	14.3
32	61	18.5

[22] Attkisson, CC & Greenfield, TK 2004, 'The UCSF Client Satisfaction Scales: I. Client Satisfaction Questionnaire-8', in ME Maruish (ed.), *The use of psychological testing for treatment planning and outcomes assessment*, 3rd edn, Lawrence Erlbaum Associates, Mahwah, N.J., vol. 3, pp. 799-811.

The distribution of scores is illustrated in Figure 1, below.



Respondents were asked, as part of the CSQ-8, 'In an overall, general sense, how satisfied are you with the service you have received?'. A high level of satisfaction was reported, with 92% of those who answered the question stating that they were 'mostly satisfied' or 'very satisfied'. Table 3 has details.

Table 3
Overall, how satisfied

	Number	Percent
Very satisfied	180	55.7
Mostly satisfied	117	36.2
Indifferent/mildly dissatisfied	20	6.2
Quite dissatisfied	6	1.9
Total	**323**	**100.0**

When asked 'If you were to seek help again, would you come back to this service?', 94% replied in the affirmative. Table 4 has details.

Table 4
Likelihood of returning to the service in the future, if needed help

	Number	Percent
Yes, definitely	211	64.7
Yes, generally	97	29.8
No, not really	11	3.4
No, definitely not	7	2.2
Total	**326**	**100.0**

When asked to respond to the statement 'You have received a lot of help in sorting out your life', 86% of those who felt this question was applicable to them replied that they 'strongly agree' or 'agree'. Table 5 has details.

Table 5
'Received a lot of help'

	Number	Percent
Strongly agree	121	36.9
Agree	148	45.1
Don't know	27	8.2
Disagree	13	4.0
Strongly disagree	5	1.5
Not applicable	14	4.3
Total	**328**	**100.0**

As one would expect, this variable predicts levels of satisfaction with the service ($F=24.27$, $p<0.00$), with the effect size being very large.

Satisfaction score by organisation and service

Although there were overall statistically significant differences in CSQ satisfaction scores between the participating organisations ($F=2.378$, $p<0.02$), and the effect size was moderate, the scores fell within a fairly narrow range, and all indicated relatively high levels of satisfaction. None of the differences between individual pairs of organisations, on this variable, was statistically significant. Table 6 has details. The highest level of satisfaction was reported from The Salvation Army. It was followed by Gugan Gulwan, CAHMA, Winnunga Nimmityjah and Toora. The lowest scores were recorded at Karralika, Ted Noffs Foundation, Directions, and the Health Directorate's Alcohol and Drug Service (ADS).

Table 6
Mean CSQ-8 satisfaction scores, by organisation

Organisation	Number of valid responses	Mean CSQ-8 score
ADS	107	25.9
CAHMA	37	28.2
Directions	34	26.7
Gugan Gulwan	14	28.3
Karralika	35	27.4
Salvation Army	24	28.8
Ted Noffs	24	26.6
Toora	24	28.0
Winnunga Nimmityjah	30	28.0
All organisations combined	329	27.1

Table 7, below, provides corresponding data, broken down by service type within organisations. As noted above, since 30% of respondents came from the ADS Opioid Treatment Service, special attention is drawn to their scores as they impact significantly on the overall average. The mean CSQ-8 score of OTS respondents was 25.3 whereas the mean score for the other services combined was 27.8, a statistically significant difference ($t=4.25$, $df=146$, $p<0.00$). This tells us that OTS clients have lower levels of satisfaction than the clients of other services. That said, the OTS clients' mean score of 25.3 still represents a relatively high level of satisfaction, noting that CSQ-8 scores can range from 8 to 32.

Table 7 Mean CSQ-8 satisfaction scores, by organisation and service type		
Organisation/service	**Number of valid responses**	**Mean CSQ-8 score**
Alcohol and Drug Service, Health Directorate	**107**	**25.9**
Moore St Counselling Service	7	29.6
Opioid Treatment Service	92	25.3
Withdrawal Service	8	28.6
CAHMA	**37**	**28.2**
Directions	**34**	**26.6**
Woden	15	27.3
Arcadia House	4	24.5
Civic NSP	15	26.4
Gugan Gulwan Youth Aboriginal Corporation	**14**	**28.3**
Karralika Programs Inc.	**35**	**27.4**
Karralika	30	27.1
Nexus Program	5	29.2
Salvation Army	**24**	**28.8**
Treatment	20	28.6
Re-entry/Halfway House	4	30.3
Ted Noffs Foundation ACT	**24**	**26.6**
Program for Adolescent Life Management	9	27.3
Co/Op and CALM (outreach & drop in)	15	26.1
Toora Women Inc.	**24**	**28.0**
Lesleys/Marzenna (residential)	8	29.6
Lesleys/Marzenna (outreach)	3	29.7
WIREDD	13	26.6
Winnunga Nimmityjah Aboriginal Health Service	**30**	**28.0**
All organisations combined	**329**	**27.1**

Respondents' characteristics and level of satisfaction

Gender was not related to level of satisfaction with the service, that is, female and male respondents had similar CSQ-8 satisfaction scores. In addition, Aboriginality and employment status were not related to satisfaction level.

In contrast, housing status was related to level of satisfaction ($F=3.183$, $p<0.04$), with respondents in settled/permanent housing having the highest mean scores, followed by those in temporary accommodation. Respondents reporting no fixed place of abode had the lowest satisfaction scores.

Treatment considerations

Matters to do with respondents' treatment are dealt with here in terms of the length of time that service users had been attending their service, frequency of attending, waiting times, accessibility of the service, having case managers and care plans, and the availability and use of wrap-around services.

Length of time attending the service

Service users were asked 'How long have you been coming to this service?'. The length of time reported ranged from one week or less (6% of respondents) to more than one year (52%). The skew towards a long period reflects the relatively large proportions of the clients of ADS, CAHMA and Winnunga Nimmityjah who have been attending for over one year. Table 8 has details.

Table 8
Length of time a client of the service

Length of time	Number	Percent
1 week or less	20	5.9
1-4 weeks	32	9.4
1-3 months	35	10.2
4-6 months	37	10.8
7-12 months	42	12.3
More than 1 year	176	51.5
Total	**342**	**100.0**

Service users who had been attending for between 4 and 6 months had the highest overall satisfaction scores (mean CSQ-8 of 28.2), though the differences in scores by length of time was not statistically significant. The lowest satisfaction was recorded among the newest service users, i.e. those having attended for one week or less (mean CSQ-8 score of 26.3).

Frequency of attending

The frequency of attending the non-residential services, detailed in Table 9 (below), varied markedly, presumably reflecting the service modality. 42% attended daily; many of these would be opioid substitution therapy and NSP service users.

Although the relationship between this variable and overall satisfaction (CSQ scores) was not statistically significant, it is noted that the daily attenders had the lowest levels of satisfaction (mean CSQ-8 score of 25.7) and those who attended least frequently (less than monthly) had the highest levels of satisfaction (mean CSQ-8 score of 28.2).

Table 9 Frequency of attending the service		
Frequency	**Number**	**Percent**
Daily	110	42.2
5-6 times a week	10	3.8
2-4 times a week	29	11.1
Weekly	50	19.2
2-3 times a month	19	7.3
Monthly	25	9.6
Less than monthly	18	6.9
Total	**264**	**100.0**

Waiting times

The length of time that service users had to wait for the various components of their treatment was assessed, specifically the time until a comprehensive assessment was undertaken, and from that point until treatment commenced.

Nearly two-thirds of the respondents (62%) stated that they had received a comprehensive assessment from the service for their alcohol and other drug-related needs. A substantial proportion (15%) did not know if this had happened or not. Table 10 has details.

Table 10 Received comprehensive assessment		
	Number	**Percent**
Yes	211	62.4
No	75	22.2
Don't know	52	15.4
Total	**338**	**100.0**

Of those who had received a comprehensive assessment, waiting times between first contact with the organisation and completion of the assessment were generally short, with 56% of service users to whom this applied receiving their assessment within a week, and 92% within a month. The waiting times from assessment to commencing treatment were similar, with 54% waiting less than a week and 90% less than one month. Waiting times were not related to level of satisfaction measured by the CSQ-8.

Accessibility

Service accessibility can be operationalised in terms of the location of services, their opening hours and respondents' access to information. All three were assessed in the Survey.

Location

First, service users were presented with the statement 'This service location is convenient for you' and were asked to indicate their level of agreement or disagreement with the statement. 83% 'agreed' or 'strongly agreed' that the service location was convenient; see Table 11, below. As one would expect, this variable was a predictor of the satisfaction scores, with respondents stating that they 'strongly agree' that the location is convenient having the highest satisfaction scores and those disagreeing having the lowest scores (F=27.75, p<0.00, a very large effect size).

Table 11
'Service location is convenient'

	Number	Percent
Strongly agree	136	42.0
Agree	132	40.7
Don't know	10	3.1
Disagree	29	9.0
Strongly disagree	17	5.3
Total	**324**	**100.0**

Relatively high proportions of the service users of the ADS (26%), Karralika Programs (18%) and Toora (13%) 'disagreed' or 'strongly disagreed' that the location was convenient.

Convenience of opening hours

Secondly, participants were asked 'Does this organisation provide the services you want at hours that are convenient to you?', and 78% responded in the affirmative.

Differences existed on an organisation-by-organisation basis, as shown in Table 12, below. Over 90% of the respondents from each of CAHMA, Gugan Gulwan and the Salvation Army found the opening hours convenient. In contrast, the opening hours were more likely to be identified as inconvenient at Ted Noffs and the ADS.

The perceptions of the convenience of organisations' opening hours did not differ significantly between service users who were employed full-time, employed part-time, unemployed or doing unpaid/voluntary work (Chi-square = 7.99, df 6, p<0.24).

The convenience of opening hours predicted significantly higher CSQ-8 satisfaction scores (F=35.50, p<0.00, a large effect size).

Table 12 Opening hours convenient?					
Organisation	**Yes (percent)**	**No (percent)**	**Don't know (percent)**	**Total (number)**	**Total (percent)**
CAHMA	94.9	5.2	0.0	39	100.0
Gugan Gulwan	93.3	0.0	6.7	15	100.0
Salvation Army	91.7	4.2	4.2	24	100.0
Karralika Programs	85.3	11.8	2.9	34	100.0
Toora	83.3	8.3	8.3	24	100.0
Winnunga Nimmityjah	83.3	13.3	3.3	30	100.0
Directions	80.0	8.6	11.4	35	100.0
Ted Noffs	66.7	12.5	20.8	24	100.0
ADS	64.9	30.7	4.4	114	100.0
Total	**78.2**	**15.9**	**5.9**	**339**	**100.0**

Accessibility to information

The availability of information in an understandable form is another component of service accessibility. Overall, the Survey respondents largely agreed with the statement that 'I understand what is being said to me in this service'. They stated that they understood most what was being said to them by their caseworkers/key workers (95%), followed by the reception staff at their organisations (93%), and thirdly by doctors (92%). With regard to written sources of information, 89% agreed that they understood the information in leaflets and flyers, and 87% in letters. Table 13 has details.

Table 13 'I understand what is being said to me in this service' (percent)						
Information source	**Strongly agree**	**Agree**	**Don't know**	**Disagree**	**Strongly disagree**	**Total**
By my caseworker/key worker	59.7	35.1	3.6	1.3	0.3	100.0
By reception staff	49.7	43.8	4.3	1.6	0.7	100.0
By doctors	48.2	44.0	4.3	3.2	0.4	100.0
In leaflets or flyers	44.0	45.3	8.7	0.7	1.3	100.0
In letters	45.9	41.5	8.2	2.6	1.9	100.0

Case managers and care plans

Almost two-thirds of the respondents (63%) stated that they had a case manager/key worker, in response to the question 'Do you have a case manager/key worker assisting you to receive your drug and alcohol related services?' Some 13% did not know. Table 14 has details.

Having a case manager/key worker was related to high satisfaction scores ($F=10.020$, $p<0.000$), and had a moderate effect size.

Table 14
Has a case manager/key worker

	Number	Percent
Yes	211	63.4
No	80	24.0
Don't know	42	12.6
Total	**333**	**100.0**

When asked 'Do you have a care plan for your drug or alcohol needs?' just 54% of those who felt that this question was applicable to them stated that they had a care plan, 30% said they did not, and 16% said that they did not know, as shown in Table 15. The proportions differed between organisation, with 96% of the Salvation Army clients stating that they have a care plan, followed by Karralika Programs (70%), Toora (67%), Ted Noffs (57%), Gugan Gulwan (54%), Winnunga Nimmityjah (52%), Directions (46%), CAHMA (42%) and the ADS (41%).

Having a care plan was also related to level of satisfaction ($F=13.79$, $p<0.00$), and had a moderate to large effect size.

Table 15
Has a care plan

	Number	Percent
Yes	156	54.2
No	86	29.9
Don't know	46	16.0
Total	**288**	**100.0**

Wrap-around services

Most organisations provide some wrap-around services, i.e. services that are ancillary to the core services, such as referral to legal advice, debt management, etc. Information on 17 wrap-around services was elicited in the Survey; Table 16, below, has details. Respondents were asked:

1. if they had *requested* the particular type of support from the service
2. if they had *received* it within the service
3. if they had been *referred* to another service for the support and
4. if they had requested the particular type of support from their service but *had not received* it.

The most frequently *requested* type of support was with respect to housing (49% of respondents), with 51% receiving such support within the service and 19% being referred out. (Note that these categories are not mutually exclusive, multiple responses are possible, so the individual percentages sum to more than 100%.) The services most frequently *received within the organisation* were achieving abstinence and BBV information and support (both 73% of respondents). Among *referrals out* to other services, legal support was most frequent (27% of respondents). Only small proportions reported *requesting services but not receiving them*. In this category, support with education and debt management had the highest frequencies, 8% and 7% respectively.

It will be noted that, for each type of wrap-around service, the proportion of respondents receiving the service within their organisation was higher—often substantially so—than the proportion requesting it.

Table 16
Services requested and received
(percent of cases; multiple responses possible)

Type of service/support	Requested	Received within organisation	Referred out	Requested but not received
Employment/skills training	42.9	44.4	21.4	6.3
Education	35.9	58.0	19.1	8.4
Debt management	30.6	56.1	22.4	7.1
Housing	48.7	50.6	18.8	6.5
Legal advice	35.3	56.9	26.7	2.6
Centrelink or related payments	29.6	54.2	13.4	2.8
Smoking cessation advice	37.8	63.0	10.1	5.9
Sexual health	31.7	60.8	16.7	5.8
Dental health	48.0	59.0	21.4	4.0
Mental health	42.4	63.4	16.3	4.1
BBV information & support	38.9	72.5	15.4	2.7
BBV screening	39.3	63.0	16.3	5.2
Other general health services	39.0	64.2	20.1	2.5
Counselling	48.0	64.9	11.1	3.6
Achieving abstinence	38.8	73.0	11.2	3.9
Parenting/relationships	36.6	66.9	9.9	4.9
Family concerns, incl. family violence	42.4	62.7	16.1	2.5

It is now generally accepted that organisations providing AOD treatment and harm reduction services should actively promote smoking cessation among their service users and staff.[23] In this survey, 38% of respondents stated that they had requested smoking cessation advice, 63% had received it within their organisation, 10% had been referred to another organisation for such advice, and 6% stated that they had

[23] Lee, N *et al.* 2005, *Smoking cessation: working with clients to quit*, Clinical Treatment Guidelines for Alcohol and Drug Clinicians, no. 12, Turning Point Alcohol and Drug Centre Inc., Fitzroy, Vic.

requested it but not received it. Considering that a certain (unknown but low) proportion of respondents would not have been smokers, the high proportion who had received smoking advice, either within the organisation or on referral to another, is encouraging.

Outcomes

Outcomes were assessed in 10 domains, as detailed in Table 17. The table excludes responses where the service users classified the question as not being applicable to them, e.g. NSP clients would not necessarily expect to have reduced their drug use since commencing use of the service.

The most frequently reported positive outcome was with respect to reduced levels of crime, with 93% of service users to whom the question applied stating that they 'agree' or 'strongly agree' with the statement that, since starting to receive the service, they had become less involved in crime. This was followed in frequency by reduced drug use (89%), improved general health (86%), improved knowledge of BBV transmission prevention (83%), improved parenting/relationships (82%), improved mental health (79%), improved capacity to manage finances (78%), improved housing (72%), improved dental health (60%) and finally improvements in their employment situation (56%).

Table 17
Outcomes: 'Since starting to receive this service…'
(percent, 'not applicable' responses removed)

Outcome domain	Strongly agree	Agree	Don't know	Disagree	Strongly disagree	Total
You are less involved in crime	69.1	24.0	3.3	2.4	1.2	100.0
Your drug use has reduced	63.7	25.0	5.8	5.2	0.3	100.0
Your general health has improved	50.0	36.0	6.8	6.2	1.0	100.0
Your knowledge of preventing transmission of blood borne viruses has improved	50.0	33.3	9.6	4.4	2.6	100.0
Your parenting and/or other relationships have improved	44.2	38.2	7.6	7.6	2.4	100.0
Your mental health has improved	47.5	31.2	12.2	7.5	1.7	100.0
Your capacity to manage your finances has improved	38.3	40.2	9.3	10.4	1.9	100.0
Your housing situation has improved	39.3	32.9	13.7	10.7	3.4	100.0
Your dental health has improved	32.5	27.8	19.5	17.7	2.5	100.0
Your employment situation has improved	31.2	24.8	17.4	21.6	5.1	100.0

On all of these outcome variables, the level of agreement with the statements is positively associated with CSQ-8 satisfaction scores, i.e. reported good outcomes are associated with high levels of satisfaction with the service. The effect sizes are particularly large with respect to improvements in general health, mental health, BBV transmission prevention knowledge, housing, employment, relationships and capacity to manage their finances.

Services' responsiveness

Respondents' perceptions were elicited about the extent to which their comments and complaints were welcomed, and acted upon, by the organisations from which they received services.

Asked to give comments

When asked 'Have you ever been asked by this service to give comments on how satisfied or dissatisfied you are with the service or treatment you receive?', more than half (58% of those who knew if they had been asked or not) responded positively, 42% negatively. Table 18 has details.

Table 18
Asked to give comments?

	Number	Percent
Yes	169	49.9
No	121	35.7
Don't know	49	14.5
Total	**339**	**100.0**

A statistically significant relationship exists between having been asked to comment and satisfaction with the service ($F=4.89$, $p<0.01$) with a small to moderate effect size.

More than one-third of the respondents from four organisations stated that they had not been asked to give comments on their satisfaction with the services received there: ADS and Winnunga Nimmityjah (both 47%), Directions (44%), and Karralika Programs (34%).

The service acts on suggestions and complaints

When presented with the statement that their 'Service acts on suggestions and complaints', 93% of those who felt that this question was applicable to them indicated that they 'strongly agree' or 'agree' with the statement. Only 6% felt that their service does not act on suggestions and complaints. Table 19 has details.

Table 19
'Service acts on suggestions & complaints'

	Number	Percent
Strongly agree	86	29.3
Agree	127	43.2
Don't know	64	21.8
Disagree	10	3.4
Strongly disagree	7	2.4
Total	**294**	**100.0**

Again, a statistically significant relationship exists between this variable and service satisfaction ($F=20.05$, $p<0.00$) with a very large effect size. The distribution of responses between organisations was broadly similar.

How the service users feel they are treated

The Survey ascertained service users' perceptions of how they are treated by the various people they are in contact with at their services, including staff and other service users. Details are in Table 20. High proportions reported being treated with respect by all categories of personnel. The highest proportions stating that they 'agree' or 'strongly agree' that they are treated with respect relate to caseworkers/key workers and reception staff (both 96%), other staff (90%), doctors and other service users (both 87%). The lowest proportions referred to pharmacists (77%) and pharmacy staff other than pharmacists (74%).

This variable is closely related to levels of overall satisfaction, with the effect sizes being particularly large with respect to being treated with respect by reception staff, doctors, other staff and other service users.

Table 20
Service users feel they are treated with respect
(percent)

You are treated with respect by …	*Strongly agree*	*Agree*	*Don't know*	*Disagree*	*Strongly disagree*	*Total*
Your caseworker/key worker	61.2	35.1	2.3	0.7	0.7	100.0
Reception staff	58.8	37.3	1.6	2.0	0.3	100.0
Staff other than those separately listed	48.6	41.1	6.6	2.8	0.9	100.0
Doctors	49.3	38.1	6.3	5.9	0.4	100.0
Other users at this service	41.3	45.9	5.3	5.0	2.5	100.0
Pharmacists	44.4	32.5	12.7	7.5	2.8	100.0
Other pharmacy staff	41.4	32.5	15.7	7.6	2.8	100.0

Match between service and felt needs

Eleven additional questions were asked to assess the extent to which a variety of needs were seen as being met; Table 21, below, has details. (Some of these questions have been covered elsewhere in this report. They are repeated here so that the responses can be seen in context.)

80% or more of respondents expressed agreement ('agree' or 'strongly agree') with the first eight statements, in descending order from the first ('The staff here are efficient at doing their job'), with 79% agreeing with the seventh ('You are usually able to get appointments at this service at the times you want them').

The two negatively expressed statement 'Family members/partners do not get enough support' and 'You only use this service because there is nothing better available' warrant attention. 35% responded affirmatively to 'Family members/partners do not get enough support' and the same proportion to 'You only use this service because there is nothing better available'.

Table 21
Match between service and felt needs
(percent)

Type of need	*Strongly agree*	*Agree*	*Don't know*	*Disagree*	*Strongly disagree*	*Total*
The staff here are efficient at doing their job	43.38	47.69	5.85	2.77	0.31	100.0
You are satisfied with the services you receive here	39.33	50.61	5.18	3.66	1.22	100.0
You get enough personal support from the staff at this program	44.94	44.62	4.43	5.38	0.63	100.0
This service meets your needs	42.15	47.38	5.54	4.31	0.62	100.0
The service is organised and well run	36.5	50.31	8.28	3.68	1.23	100.0
This service location is convenient for you	41.98	40.74	3.09	8.95	5.25	100.0
You have enough say in decisions about your service or treatment	40.25	41.8	9.6	6.5	1.86	100.0
This service expects you to learn responsibility and self-discipline	31.63	49.2	15.34	2.88	0.96	100.0
You are usually able to get appointments at this service at the times you want them	26.98	52.38	8.89	9.84	1.9	100.0
Family members/partners do not get enough support	12.88	22.35	28.79	24.62	11.36	100.0
You only use this service because there is nothing better available	14.56	19.94	14.24	33.86	17.41	100.0

Services or programs that service users believe should be offered in the ACT but are currently not available

Service users were asked 'Are there any drug or alcohol services or programs that should be offered in the ACT that are not being offered at present? If so, what are they?' In all, 103 responses to this question were received. Heroin assisted treatment[24] (sometimes characterised by the respondents as a 'heroin trial') was nominated most frequently (19 times) as a service that is needed but that is not currently available.

This was followed in frequency (11 mentions) by the need for new and improved services related to opioid substitution treatment. Some respondents pointed to the need for residential rehabilitation for withdrawal from opioid substitution therapy, others emphasised a more user-friendly methadone program, and a number of respondents called for methadone to be available in tablet form. More dosing outlets were called for, and at a cheaper price. The waiting time for entry to a methadone program was also mentioned.

The third most frequently mentioned need (mentioned 10 times) related to the availability of sterile injecting equipment. Respondents pointed to the need for more appropriate opening hours of NSPs, with a number stressing the need for a peer-operated NSP. This was linked to a perceived need for a drop-in centre for people who use illegal drugs.

The types of services requested, along with a number of mentions, are listed in Table 22, below. Further details are available from the author.

Table 22
Services or programs that should be offered in the ACT but are currently unavailable

Service/program	N.*		Service/program	N.*
Heroin assisted treatment	19		More appropriate location of services	2
Opioid substitution treatment	11		Treating service users in a more trusting and respectful manner	2
NSPs	10		Reduced waiting times	2
Rehab	9		Improved services opening hours	2
Withdrawal	6		More consumer participation	2
Accommodation/half-way houses	5		Improved detoxification/withdrawal services	2
Supervised injecting place	4		Increased awareness of Narcotics Anonymous	1
Information and education	3		Recovery focus	1
Services for young people	3		Service users finances	1
Services for parents and children	3		Funding and staffing of services	1
Counselling	3		Health	1
Services for women	3		Indigenous issues	1
Drop-in centres	3		Cannabis treatment	1
Treatment for amphetamine related problems	3		Co-dependency meetings	1

[24] Strang, J, Groshkova, T & Metrebian, N 2012, *New heroin-assisted treatment: recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*, EMCDDA Insights no. 11, European Monitoring Centre for Drugs and Drug Addiction, Lisbon.

	Alcohol treatment	1
	More takeaways	1
	Legalise drugs	1

* Number of mentions

Other comments provided by service users

Survey respondents provided 73 comments in response to an open-ended 'any other comments' question. By far the most frequent—24 comments—were statements that everything is fine with their service, or similar wording, e.g. 'All good'. In addition, and linked to this, were more explicit and heartfelt expressions of gratitude to the service for the assistance that they had provided to the respondents—there were 16 such comments. An example is 'I'm so grateful to have been given a chance to recover in Lesley's Place & Marzenna' and 'I owe this place my life'.

The third largest group, at 10 comments, covered detailed suggestions for improvements in the services that respondents were receiving. Examples include 'I think not enough focus is put on exercise, meditation and healthy diet' and 'I would like to see this service expanded so more of us can be a part of helping our peers. It's empowering to know this kind of org exists, they do great work so let's expand'.

Six comments were provided about the Opioid Substitution Treatment program. Two of these were critical of the volume expansion initiative, some found the opening hours difficult, and there were concerns about restrictions on takeaways.

The types of comments, along with a number of mentions, are listed in Table 23, below. Further details are available from the author.

Table 23
Other comments

Category of comment	**N.***
'All good'	24
Extremely grateful for the service	16
Suggestions for program improvements	10
Suggestions for improvement to the Opioid Substitution Treatment program	6
NSP services	3
Excellent peer support services	3
Problematic operating times of services	3
Inadequate funding of services	3
Additional rehabilitation services needed	2
Problems with the volume expansion initiative	2
Better food needed	2
Better dental care needed	1
Women's services	1
More services needed	1
More staff needed	1

* Number of comments

Comparisons between the 2009 and 2012 waves of the Satisfaction Survey program

This satisfaction survey program was established in 2009, with one of its aims being to track changes in levels and patterns of service user satisfaction across the ACT ATOD services over time. Comparing the 2009 baseline data with the 2012 observations provides the first set of information on trends.

Survey coverage

Nine organisations participated in 2009 and ten in 2012,[25] the difference being the involvement of Gugan Gulwan Youth Aboriginal Corporation in the 2012 wave, contributing 15 responses, 4.4% of the total. The Health Directorate's ADS Opioid Treatment Service (referred to as the 'Alcohol & Drug Program (ADP) Building 7, TCH' in the 2009 report) contributed similar proportions in each wave: 31% in 2009 and 30% in 2012.

The total number of participants, from all organisation, increased by 6%, from 325 in 2009 to 345 in 2012.

Respondents' demographics

The demographic characteristics of the respondents were similar in the two waves with respect to their age distributions, employment status, housing status and parenting. There was a higher proportion of female participants in the second wave (43% compared with 38% in 2009) and of people who indicated that they were of Aboriginal or Torres Strait Islander descent (25% compared with 15% in 2009). The inclusion of Gugan Gulwan in the 2012 survey (15 participants), and the doubling of the number of Winnunga Nimmityjah participants (from 14 in 2009 to 30 in 2012) largely explain the increased proportion of Indigenous respondents.

Overall satisfaction

When asked 'In an overall, general sense, how satisfied are you with the service you have received?', similar proportions between the two waves indicated that they are 'mostly satisfied' or 'very satisfied': 90% in 2009 and 92% in 2012.

The mean score on the Client Satisfaction Questionnaire (CSQ-8) increased from 26.2 in 2009 to 27.1 in 2012, indicating an increased level of overall satisfaction. This difference is statistically significant ($t=-2.48$, $df=611$, $p<0.01$). The inclusion of Gugan Gulwan in 2012 has not caused the increase in the mean satisfaction score: Gugan Gulwan's 2012 mean score (28.3) is not statistically different from that of the other organisations combined (27.0) ($t=1.03$, $df=327$, $p<0.11$).

Similar proportions indicated that they were likely to return to their service in the future if they needed help again: 91% in 2009 and 94% in 2012; the difference is not statistically significant.

The proportions indicating that they had 'Received a lot of help in sorting out your life' increased from 77% in 2009 to 86% in 2012, a statistically significant difference ($z=2.66$, $p<0.01$).

The proportions indicating that they had received a comprehensive assessment from their service for their alcohol and other drug-related needs increased from 57% in 2009 to 62% in 2012, although this difference is not statistically significant.

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[25] These figures include the single response from CatholicCare's Sobering-up Shelter in both 2009 and 2012. They are excluded from this analysis.

Similar proportions in the two waves of the Survey indicated that the locations of the services were satisfactory: 82% in 2009 and 83% in 2012; the difference is not statistically significant.

Respondents' perceptions that the services' opening hours were convenient to them increased, from 73% stating that the hours were convenient in 2009 to 78% in 2012, although this difference is not statistically significant.

Case manager and care plan

The proportion of respondents who indicated that they have a case manager/key worker increased from 51% in 2009 to 63% in 2012, a statistically significant difference ($z=-3.07$, $p<0.00$).

Similarly, the proportion that indicated that they had a care plan increased from 45% in 2009 to 54% in 2012, a statistically significant difference ($z=-2.249$, $p<0.02$).

Outcomes

The proportions reporting improvements since starting to use their service on all ten of the outcomes covered in the Survey increased from 2009 to 2012, as shown in Table 24, below. In all but three the changes were statistically significant.

Table 24
Outcomes: 'Since starting to receive this service…'
Proportions agreeing or strongly agreeing
2009 and 2012

Outcome domain	2009	2012	Statistical significance*
You are less involved in crime	86.5	93.1	sig.
Your drug use has reduced	83.7	88.7	sig.
Your general health has improved	78.2	86.0	sig.
Your knowledge of preventing transmission of blood borne viruses has improved	78.3	83.3	NS
Your parenting and/or other relationships have improved	64.8	82.3	sig.
Your mental health has improved	71.5	78.7	sig.
Your capacity to manage your finances has improved	67.3	78.4	sig.
Your housing situation has improved	59.2	72.2	sig.
Your dental health has improved	52.5	60.3	NS
Your employment situation has improved	48.2	56.0	NS

* This column indicates whether or not the changes observed from 2009 to 2012 are statistically significant at $p = 0.05$. 'sig.' = statistically significant. 'NS' = not statistically significant.

Services' responsiveness

The proportion of respondents who reported having been asked to give comments on their level of satisfaction with the services they receive increased from 42% in 2009 to 50% in 2012, a statistically significant difference ($z=-2.038$, $p<0.04$).

The proportion reporting that their service acts on suggestions and complaints increased from 61% to 72%, a statistically significant difference ($z=-4.163$, $p<0.00$).

How the service users feel they are treated

Some changes have been observed between the 2009 and 2012 waves of the Survey program regarding how service users feel they are treated by various categories of people. Higher proportions of respondents indicated that they were treated with respect in 2012 compared with 2009 by their caseworkers (92% in 2009 and 96% in 2012), by reception staff (92% cf. 96%) and by doctors (84% cf. 87%). The changes were statistically significant with regard to caseworkers and reception staff, but not with regard to doctors. The proportions in the two surveys remained stable with regarding other staff of the services (90% in both surveys), pharmacists (76% cf. 77%), other pharmacy staff (78% cf. 74%) and other service users (85% cf. 87%).

Conclusions and discussion

The Survey

The 2012 ACT Alcohol & Other Drug Sector Service User Satisfaction Survey filled two functions, namely (1) providing a snapshot of the levels and patterns of satisfaction of service users and (2) providing information for monitoring and assessing trends in service user satisfaction by drawing comparisons between the 2009 and 2012 waves of the Survey program. It is expected that information derived from the Survey will assist participating organisations to evaluate the outcomes of quality assurance programs that they have implemented over the last three years. By repeating the Survey at intervals into the future, it will be possible to continue to observe trends in service user satisfaction.

Satisfaction levels and patterns

As is usual with client satisfaction surveys, especially those covering treatment clients, high overall levels of satisfaction were reported. This reflects (in part) the fact that dissatisfied clients tend to withdraw from the service, leaving the more satisfied clients occupying the service places. In the case of ATOD clients, however, this is not as marked as in some other setting because (1) some survey respondents are involuntary clients and (2) some have no other source of service available (e.g. many opioid maintenance therapy clients).

The mean CSQ-8 score was 27.1 and the median 28, both well above 20 which is the midpoint of the range of possible scores.

While organisation-by-organisation comparisons need to be made with caution, the highest level of overall satisfaction was reported from the Salvation Army, closely followed by Gugan Gulwan, CAHMA, Winnunga Nimmityjah and Toora. The lowest scores were recorded at the ADS, Directions and Ted Noffs. Karralika Programs fell between these higher and lower satisfaction levels. It is important to note that there was only a small spread of satisfaction scores, that is, the gap between the higher and lower scoring organisations was narrow, with all recording relatively high levels of satisfaction.

High satisfaction scores were related to the following variables:

- Housing status, with respondents in settled or permanent housing having relatively high satisfaction scores
- Length of time attending the service, with new service users showing the lowest levels of satisfaction
- Frequency of attending, with people attending daily having the lowest levels of satisfaction and those attending the least frequently having the highest levels
- The convenience of the services' location
- The convenience of opening hours
- Being aware that they had a case manager/key worker
- Being aware that they had a care plan
- Perceiving that the service welcomes and acts upon complaints and suggestions
- Perceptions of how people treat the service users
- Positive service user outcomes.

It is emphasised that being invited by their service to provide feedback on levels of satisfaction with the services received was related to overall satisfaction, as was

perceiving that their service acts on service users' complaints and suggestions.[26] Indeed, the second of these—perceiving that the service acts on complaints and suggestions—is particularly strongly related to overall satisfaction.

Similarly, perceptions of how people treat the service users were closely related to levels of overall satisfaction, particularly regarding being treated with respect by reception staff, doctors, other staff and other service users.

The Survey also assessed the self-reported service outcomes of the participating service users. The most frequently reported positive outcome was reduced levels of crime, followed in frequency by reduced drug use, improvements in general health, improved knowledge of BBV transmission prevention, improved parenting/relationships, improved mental health, increased capacity to manage finances, improved housing situation, improve dental health, and improved employment situations. Predictably, improvements in these and other service user outcomes were associated with high levels of overall satisfaction.

The trends between the 2009 and 2012 waves of the Survey program are all in the hoped-for direction. Overall levels of satisfaction as evidenced by CSQ-8 scores have improved. This has been corroborated in the specific areas assessed including:

- Respondents' assessment of the amount of help they have received and the likelihood of returning to the service if warranted both increased
- The proportion that had received comprehensive assessments increased
- The organisations' locations and opening hours were reported to be more suitable
- The proportions of respondents who had case managers and care plans increased
- The proportions doing well on all ten outcomes increased
- The proportion who had been asked to give comments on service user satisfaction increased, and
- The proportion who felt that their organisation acts on suggestions and complaints increased.

The 2012 ACT Alcohol & Other Drug Sector Service User Satisfaction Survey has provided valuable information demonstrating the high overall level of service user satisfaction at the sector wide level, with significant variations on an organisation-by-organisation basis. The service user and organisation variables that are associated with level of satisfaction have also been made explicit. This information provides opportunities for the participating organisations to review their strengths and build upon them, and to explore opportunities for service quality enhancement in areas where client satisfaction levels are relatively low.

The across-the-board increases in levels of satisfaction are encouraging, suggesting that the quality enhancement initiatives that have been implemented by the participating organisations between the 2009 and 2012 waves of the Survey program have been effective.

It is recommended that the Survey be conducted again in 2014 with the aim of continuing to monitor levels and patterns of service user satisfaction in the ACT alcohol and other drug services.

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[26] This is consistent with observations from other studies, e.g. Brener, L *et al.* 2009, 'Exploring the role of consumer participation in drug treatment', *Drug and Alcohol Dependence*, vol. 105, no. 1-2, pp. 172-5.

Appendix: Survey methodology

The Survey instrument was developed in 2009 for the first wave of this Survey program by David McDonald from Social Research & Evaluation Pty Ltd, with extensive support from Nicole Wiggins from CAHMA and Marty Owen from ACT Health. Additional inputs were provided by the members of the ACT alcohol and other drug organisations' Executive Directors/CEOs Group. It was based on the UK National Treatment Agency's instrument, modified and expanded to meet local needs. The same core questionnaire was used for the 2009 and 2012 surveys, with different organisation-specific addenda between the two waves (details below).

Ethics approval was provided by the ACT Health Human Research Ethics Committee.

The 2012 wave of the Survey was funded by the ACT Government Health Directorate and managed by Amanda Bode and Kathryn Sequoia from ATODA. Data collection took place in Canberra on 21 June 2012 as a Drug Action Week initiative. Some organisations combined data collection with other Drug Action Week activities.

In preparation for the Survey, ATODA staff contacted each participating organisation to provide posters advising about, and promoting, the Survey. Participating organisations were the alcohol and other drug services funded by ACT Health. Some of the organisations asked for the responses to be coded by the name of specific services provided as they anticipated that service user characteristics (potentially including satisfaction levels) would differ between services. For example, responses from the ACT Government Health Directorate's Alcohol and Drug Service separately identified service users of its Moore St Counselling Service, its Opioid Treatment Service and its Withdrawal Service.

There were five versions of the Survey instrument. These were different to allow organisations to have questions specific to them included. The ADS, CAHMA, Directions, Karralika Programs and Toora requested organisation-specific questions to be included in the version of the Survey implemented at those locations.

Each of the participating organisations nominated a contact person to

- Accept from ATODA delivery of the questionnaire forms for that organisation
- Brief staff on providing the forms to service users
- Provide payment to service users
- Return the completed questionnaire forms to ATODA.

Implementation guidelines were developed and disseminated to the contact person in each organisation in advance of the data collection. On the day of the Survey each service user of a participating organisation was invited to participate in the study. The service user was given a 'Participant Information Sheet and Consent Form' to explain the Survey, including who would be involved in the Survey and the purpose and use of the results, along with information on the approval process through the ACT Health Human Research Ethics Committee.

This Information Sheet also explained how service users would be able to access the Survey results, and that participation was entirely voluntary, with no impact on the services they receive.

Participants were offered $10 in cash as recompense for their out-of-pocket expenses and their contribution of time in completing the questionnaire, as per the approval received from the ACT Health Human Research Ethics Committee.

If the service users agreed to participate in the Survey, they were

- Handed a copy of the questionnaire to fill out in a 'pen-and-paper' question-and-answer format, and an envelope into which to seal the completed form.
- Encouraged to complete the Survey in private.
- Asked to seal the questionnaire form in an envelope provided for that purpose, and hand it to the staff member to allow the payment to be processed. There were no markings identifying the participant on the Survey instrument nor on the envelope.
- Staff were on hand to assist any respondent who had trouble understanding any of the questions, owing to the relatively low literacy levels of some respondents. Steps were taken to ensure that, in these cases and all others, the responses remained confidential.
- Given $10.00 in cash and indicated in writing on the acquittal sheet that they had received the money.

Two services, the ADS Moore Street Counselling Service and Directions Civic NSP, indicated that internal procedural problems meant that they had substantially more clients on the day of the survey than completed the questionnaires.

The Survey forms were returned to ATODA. The forms were removed from the envelopes, coded to identify the service from which they came, and provided to a commercial data entry firm which converted the data on the forms to digital files, operating within the provisions of a confidentiality agreement. Double data entry was undertaken to maximise the accuracy of data capture.

The resulting data files were provided to a consultant—the author—for him to analyse the data and prepare this report on the results of the Survey. Quantitative data analysis took place using AcaStat™ version 8 and IBM SPSS Statistics™ version 20. ATLAS.ti™ version 7 was used for qualitative data analysis.

ATODA plans to prepare a flyer and/or other material, in plain English, summarising the results of the Survey, for distribution through ACT drug and alcohol services to their service users, to feed back to them the results of the Survey.