



*National Treatment Agency  
for Substance Misuse*

---

**The NTA's 2006 survey of user satisfaction  
in England**

August 2007

---

# Contents

---

In brief .....	3
Introduction .....	3
Findings and implications .....	3
1 Introduction.....	4
1.1 Project rationale.....	4
1.2 Project design.....	4
1.3 Procedure .....	5
1.4 Results.....	5
2 Characteristics of the sample .....	5
2.1 Demographics .....	5
3 Treatment status and objectives .....	6
3.1 Substitute opioid prescription .....	7
3.1.1 Methadone.....	7
3.1.2 Buprenorphine .....	7
3.2 Other treatment interventions .....	7
3.3 Treatment received – adherence to NTA guidelines .....	8
3.3.1 Waiting times .....	8
3.3.2 Care plans .....	8
3.3.3 Composite measures of waiting times .....	9
3.3.4 Composite measures of care planning .....	9
3.4 Perceived gains from treatment and long-term objectives.....	9
3.4.1 Service users’ long-term goals for crack and cocaine .....	10
3.4.2 Service users’ long-term goals for heroin .....	10
3.4.3 Service users’ long-term goals for cannabis.....	10
3.4.4 Service users’ long-term goals for alcohol.....	10
3.4.5 Areas of concern and treatment need .....	11
4 Attitudes to treatment .....	11
4.1 Treatment impact.....	11
4.2 Respect .....	14
4.3 Treatment engagement and support .....	14
5 Overall satisfaction.....	16
5.1 Relationship between total satisfaction and service user characteristics .....	16
5.2 Relationship between total satisfaction and service characteristics .....	16
6 Regional analysis .....	17
7 A comparison of the NTA’s surveys of user satisfaction in 2005 and 2006 .....	20
7.1 Findings and Implications .....	20
7.1.1 Satisfaction .....	20
8 Conclusion.....	21
9 References .....	21

# In brief

## Introduction

---

The 2006 user satisfaction survey demonstrated the NTA's continued commitment to improving the service user's treatment journey. The first user satisfaction survey was carried out in 2005 and was designed to give service users the opportunity to say how satisfied they were with the services they attended. The 2006 survey included a new section on harm reduction, which are in a separate report (Harm Reduction Findings from the NTA's 2006 Survey of User Satisfaction in England) published simultaneously with this document (NTA, forthcoming).

The user satisfaction survey was also designed to contribute to the joint NTA and Healthcare Commission Improvement Reviews, in particular to the overall score for DAT partnerships.

Questionnaires were distributed to all drug treatment services throughout England. Service users were asked to complete the questionnaire during a visit to their service and return it, either in a sealed freepost envelope to a collection point in the service or directly to the NTA.

Approximately 72,000 questionnaires were sent to 1,014 drug treatment services in England. Service users completed and returned 8,765 questionnaires.

## Findings and implications

---

The findings from this survey primarily reinforce the findings of the first survey carried out in 2005, although this year there were no group differences for gender, ethnicity and age and satisfaction with treatment (in 2005, for example, women showed higher satisfaction levels than men). Overall, service users were generally satisfied with their treatment, viewed the treatment they received in positive terms and the majority agreed that drug treatment had made a difference in their lives. For the second year running, the main factors that promoted service user satisfaction with drug treatment were:

- Service users had higher levels of satisfaction with treatment if they received a comprehensive assessment, started treatment and were allocated a keyworker after a short waiting time
- Service users were most likely to be satisfied with their treatment if they had care plans and satisfaction increased the more recently it had been reviewed
- Substantial numbers of service users reported decreases in drug use and involvement in crime since starting treatment
- The majority of service users agreed that they were treated with respect by drug service staff, pharmacy staff and, in particular, service users.

However, service users highlighted a need for higher levels of engagement and increased support for family members, partners and friends. Service users also highlighted service development needs around employment and accommodation.

# 1 Introduction

## 1.1 Project rationale

---

The 2006 user satisfaction survey demonstrates the NTA's continued commitment to improving service users' treatment journeys. It forms part of the NTA's Treatment Effectiveness agenda, launched in June 2005. The strategy places a strong focus on service users' experiences of treatment and the annual user satisfaction surveys ensure that service users' views inform the development of drug treatment.

The first user satisfaction survey was carried out in 2005. It was aimed at all adults in drug treatment and provided service users with the opportunity to indicate how satisfied they were with the services they attended. The intention was to repeat the survey, to enable trends in user satisfaction to be identified. It was also designed to contribute to the joint NTA and Healthcare Commission Improvement Reviews, in particular to the overall score for DAT partnerships.

The 2006 survey was developed from the 2005 survey and included a new section on harm reduction. There have been concerns about the reported increase in the sharing of injecting equipment amongst injecting drug users (HPA, 2004). Recent research (HPA, 2006a; HPA, 2006b) into drug injecting trends, indicated a growing risk of blood borne virus transmission, infections and vein damage. Models of Care for the Treatment of Adult Drug Misusers: Update 2006 (NTA, 2006) advocates a far greater emphasis on harm reduction at all points in the treatment journey, before, during and after all structured treatment.

In order fully to address the issues of harm reduction, a complementary survey was distributed to service users via pharmacy-based needle exchange services in 2006. The harm reduction findings from the 2006 service user satisfaction survey are reported along with the results from the pharmacy-based needle exchange survey in a separate report (Findings of the 2006 Annual User Satisfaction Survey including the Survey of the Clients of Pharmacy-based Needle Exchange Services) published simultaneously with this document. The questionnaire addressed the following:

- 1 The overall satisfaction with the care and drug treatment service users received
- 2 Key aspects of treatment delivery, including waiting times, care planning, substitute prescribing and harm reduction
- 3 The extent to which drug treatment is operating in line with Models of Care (NTA, 2006) and the Clinical Guidelines (Department of Health, 1999)
- 4 Gathering baseline information for measuring change over time.

## 1.2 Project design

---

The questionnaire was designed for service users to complete themselves. Its layout and design mirrored the 2005 user satisfaction questionnaire, which was constructed from several existing instruments and amended to suit the substance misuse culture and prevalence in the UK. The instruments included

1. The Healthcare Commission's patient survey report for mental health (Healthcare Commission, 2004)
2. The Client Evaluation of Self and Treatment questionnaire, satisfaction sub-scale (Simpson and Joe, 2004)

3. The drug treatment satisfaction audit constructed in the Maudsley Hospital (National Addiction Centre, 1999, unpublished)

### **1.3 Procedure**

---

Questionnaires were distributed to all Tier 2, 3 and 4 drug treatment services throughout England. The number of questionnaires received by each service was based on the number of service users each service had in treatment. Not included in the survey were young people services, alcohol and criminal justice-only services.

Services were asked to place materials to promote the survey (a poster advertising the survey, questionnaires and freepost envelopes) in a prominent position in the agency. Staff with day-to-day service user contact, such as keyworkers and receptionists, were asked to explain the purpose of the study to service users and encourage them to take part in the survey. Service users were asked to complete the questionnaire during a visit to their service and return it, either in a sealed freepost addressed envelope to a collection point in the service or directly to the NTA. Service users also had the option of completing and submitting the questionnaire online, although take up of this method was low.

### **1.4 Results**

---

Approximately 72,000 questionnaires were sent to 1,014 drug treatment services in England. Service users completed and returned 8,765 questionnaires. Assuming every questionnaire was distributed, this would represent a response rate in excess of 12 per cent. The survey gathered data from all 149 English DAT partnership areas across the nine NTA regional teams covering the nine government offices.

## **2 Characteristics of the sample**

### **2.1 Demographics**

---

Of the 8,765 respondents who completed and returned the questionnaire, male service users constituted 70.1 per cent and females 29.9 per cent. These return rates are similar to those in the 2005 survey. The proportion of forms returned by women are broadly comparable with the proportion of women in drug treatment in 2004–05, according to the National Drug Treatment Monitoring System (NDTMS), which was the most recent period for which figures were available at the time of this analysis.

There was a fairly even age distribution, except a slightly higher proportion of service users were aged between 31 and 40 (40.1%), compared with those between the ages of 22 and 30 (34.8%) and those over 40 (21.2%). The average age of respondents overall was 34 years; men were on average 34.5 and women 32.7, in comparison to the average age of 31 years for males and 30 years for females identified by NDTMS for 2004/05. Four per cent of respondents were aged 18–21.

The ethnicity of the respondents is shown in Table 1. The most frequently reported ethnicity was white (81.5%). The most frequently reported minority ethnic groups were mixed (3.3%), Asian (3.6%), and black (2.8%). Just over one per cent (1.2%) of respondents reported that they were from another ethnic group and just over seven per cent (7.7%) of the total sample did not report their ethnicity. These response rates show a slight over-representation of those from a mixed ethnic background when compared to the NDTMS data for 2004/05.

	<b>Number</b>	<b>Frequency</b>
White	7144	81.5
Mixed	288	3.3
Indian	93	1.1
Pakistani	109	1.2
Bangladeshi	68	0.8
Other Asian	45	0.5
Black Caribbean	140	1.6
Black African	46	0.5
Black other	58	0.7
Chinese	5	0.1
Other ethnic group	95	1.1
Total	8091	92.3
Missing system	674	7.7
Total	8765	100.0

*Table 1: Ethnicity of sample*

The majority of respondents were not in paid employment – 62.4% reported that they were unemployed and 10.5% defined themselves as economically inactive (housewife or husband). Just over twelve per cent (13.6%) were in regular full-time or part-time employment and 3.8% reported that were studying full time or part time.

Service users were asked to report where they had been living most of the time during the last three months. Almost half (47.4%) were living in their own home (rented or owner-occupied) and almost a third (28.3%) lived with family or friends. Fewer than one in ten were living in a hostel or similar temporary accommodation, and just over three per cent reported that they had lived on the streets for the majority of the last three months. Just under five per cent of respondents who answered the question on housing reported living in a residential service at the time of the survey.

As NDTMS only began collecting information on the accommodation of service users in 2006, comparisons cannot be made.

### **3 Treatment status and objectives**

---

Service users were asked to record how long they had been in treatment. Nearly fourteen per cent (13.2%) had been in treatment for less than one month and 14.5 per cent had been attending for between one and three months. Nearly twelve per cent (11.5%) had been attending between four to six months, 12.8 per cent for six months to one year and 48 per cent had been attending for one year or more. Over three-quarters had been attending their service beyond the minimum retention period of three months at the time of this survey.

The frequency with which service users attended their service was also explored. Sixty per cent of community-based service users reported that they attended their service on a weekly basis or more (10.8% attended community services on a daily basis, 26.6% attended on a weekly basis and 23.2% attended 2-4 times a week). Nearly one-quarter (24.7%) attended 2–3 times a month, 11.1 per cent attended monthly and 3.7 per cent attended less than once a month. In addition, residential rehabilitation service users made up 4.9 per cent of respondents.

### 3.1 Substitute opioid prescription

---

#### 3.1.1 Methadone

Approximately 63 per cent of those answering the question on substitute opioid prescriptions reported being prescribed methadone, 52.8 per cent of all respondents. The daily mean methadone dose was 60mg but ranged from 2mg through to 200mg.

This survey shows that the majority (77.7%) of methadone treatment service users had daily supervised consumption (defined in the survey questionnaire as five to seven days a week) during the critical first 12 weeks of the programme. Nearly fifteen per cent (14.4%) of service users reported that they did not have any supervision during the first 12 weeks. In comparison, findings from the 2005 user satisfaction survey showed that 73.4% had daily supervision for methadone during the first 12 weeks.

Supervised ingestion of methadone decreased after the initial 12 weeks, but in general remained relatively high as 62.6 per cent of methadone service users continued to be supervised on a daily basis. Just over a quarter (25.1%) reported no supervision in this period.

#### 3.1.2 Buprenorphine

A smaller percentage of service users received buprenorphine prescriptions (approximately 20% of respondents to this question reported being prescribed buprenorphine, 10.9% of all respondents). The daily mean buprenorphine dose was 10.6mg (median 8mg). In comparison, the 2005 user satisfaction survey found a daily mean dose of 9.6mg. There was slightly less daily supervision during the first 12 weeks for buprenorphine service users (68.8%) than methadone users and 19.5% of those prescribed buprenorphine reported that they had received no supervision during the first 12 weeks. Over half (50.2%) of buprenorphine service users continued to be supervised on a daily basis after the first 12 week period had passed.

### 3.2 Other treatment interventions

---

Service users reported receiving a range of types of treatment. Table 2 lists some of the other treatments received in the previous month.

	<b>None</b>	<b>Once</b>	<b>Twice</b>	<b>2-4 times</b>	<b>5 times</b>
Medical treatment	53.1	25.7	8.3	6.0	6.9
Counselling	13.0	17.4	19.2	19.6	30.7
Complementary Therapy	66.1	9.7	6.2	7.4	10.6
Safer injecting advice	70.6	12.2	4.6	5.4	7.2
Needle exchange	73.6	5.6	4.9	5.0	11.0

*Table 2: Frequency of receipt of interventions in the previous month*

### 3.3 Treatment received – adherence to NTA guidelines

Core components related to treatment delivery were assessed by this survey. These included waiting times and care plans.

#### 3.3.1 Waiting times

The survey assessed the length of time service users had to wait for each component part of their treatment, from first contact to comprehensive assessment; from comprehensive assessment to starting treatment and from starting treatment to having a keyworker allocated. The results are summarised in Table 3.

	<b>Less than one week</b>	<b>One week to one month</b>	<b>More than one month</b>
From contact to comprehensive assessment	46.2	42.3	11.5
From assessment to start of treatment	45.9	45.2	8.9
From start of treatment to allocation of worker	66.0	29.3	4.7

*Table 3: Length of time waited different elements of treatment*

Over forty-five per cent (46.2%) of service users in this survey reported having received a comprehensive assessment within a week of attending their service for the first time. Over half (53.8%) waited one week or more for a comprehensive assessment following initial contact with their service.

The majority of respondents reported that their treatment started within a month of their comprehensive assessment (45.9% of service users waited less than a week between a comprehensive assessment and the start of treatment and 45.2 per cent waited one week to a month). A small percentage (8.9%) of service users waited more than a month. This year's findings suggest that service users were either waiting less than a week before they started treatment, or between one week to a month before the start of treatment. In comparison, last year the majority of service users (78.4%) waited less than a week with only 10.6 per cent waiting one week to a month.

Sixty-six per cent of respondents reported they were allocated a keyworker within a week of starting treatment. Almost a third (29.3%) waited between one week to a month and only a small number (4.7%) were allocated a keyworker after a month had passed. A comparison with data from the 2005 survey suggests that waiting times for the allocation of a keyworker have increased, as last year a larger percentage of service users (79.5%) were allocated a keyworker less than a week after the start of treatment.

#### 3.3.2 Care plans

One of the critical success factors in delivering improvement in service users' lifestyles and drug-related behaviour identified in the NTA's Treatment Effectiveness strategy, is effective care planning. This survey revealed that 65.7 per cent of service users receiving treatment had a care plan and 15.7% reported that they did not have a care plan. Of those with a care plan, just over half reported that a review had taken place in the last month (58.1%), and 26.3 per cent had theirs reviewed between one

and three months previously, 6.5% had their care plan reviewed four to 12 months ago, and 1.1 per cent over a year ago. Eight per cent reported that they had never had their care plan reviewed.

Service users with care plans that had been recently reviewed were significantly more satisfied with their treatment than those that had not ( $F=21.14$ ,  $p<0.001$ ). Again, these findings replicate the 2005 user satisfaction survey.

The combination of items about waiting times and care plans allowed us to create both a composite measure of waiting times and a composite measure of care planning (broadly defined as “adherence to Models of Care”). Both scores were between zero and three, where three was the best score and zero the worst, in terms of NTA targets and Models of Care objectives.

### 3.3.3 Composite measures of waiting times

When looking at the composite measure for waiting times, the mean score across the entire sample was 2.73, implying the sample did well in terms of accessing treatment. Though there was no gender difference, there was a significant difference when looked at by ethnic background, with better adherence (2.84) identified in black service users ( $F= 2.970$ ,  $p<0.05$ ). In addition, there was also a significant difference when comparing age groups, with better adherence (2.83) identified in service users aged 21 years or under, and scores declining as age increases, to 2.72 for those aged over 40 years ( $F=7.87$ ,  $p<0.001$ ).

### 3.3.4 Composite measures of care planning

When looking at the composite measure for care planning, the mean score across the entire sample was 1.81. There was a significant difference when looked at by gender, with better adherence (1.94) identified in females, compared to males (1.78;  $F=17.73$ ,  $p<0.001$ ). There was no significant difference when the composite measure for care planning was looked at by both ethnic background and age.

## 3.4 Perceived gains from treatment and long-term objectives

The survey showed that substantial numbers of service users reported that entering drug treatment had a positive impact on their lives. Table 4 shows that the majority of service users reported a decrease in drug use and decrease in involvement in crime since starting treatment. The 2005 user satisfaction survey reported similar findings.

	<b>Strongly agree</b>	<b>Agree</b>	<b>Don't know</b>	<b>Disagree</b>	<b>Strongly disagree</b>
Drug use has reduced	58.4	31.4	4.1	4.6	1.6
Crime has reduced	67.4	24.8	3.0	3.0	1.7

*Table 4: Reported percentage changes in drug use and crime as a result of treatment*

Service users were asked about their long-term goals around their use of several drugs. Table 5 showed that the majority of heroin and cocaine users reported wanting to stop using these drugs completely. The picture for service users that reported using methadone was a little different, although 49.2% reported that they wanted to stop using this drug completely and 37.2% were happy with their levels of

use. Service users who used cannabis or alcohol seemed happier with their levels of use and less inclined to want to stop.

	I'm happy with my level of use	I would like to reduce my use but not stop	I would like to stop using this drug completely
Heroin	13.0%	9.5%	77.5%
Methadone	37.2%	13.6%	49.2%
Crack and cocaine	17.0%	10.2%	72.9%
Amphetamines	28.1%	12.2%	59.7%
Cannabis	60.3%	16.4%	23.3%
Alcohol	49.0%	22.5%	28.6%
Benzos	46.9%	13.6%	39.5%

*Table 5: Perceived objectives in relation to differing aspects of drug use*

### **3.4.1 Service users' long-term goals for crack and cocaine**

When looking at crack and cocaine use, Asian users were the most likely (77.2 per cent) to report that they would like to stop using the drug completely, compared to those from "other" ethnic groups (62.9 per cent). However, differences with respect to ethnicity were not statistically significant. The same was true for age where, although not statistically significant, 22–30-year-old crack and cocaine users were the most likely (75.1 per cent) age group to report that they would like to stop using the drug completely. Equally, there was no clear difference between males and females.

### **3.4.2 Service users' long-term goals for heroin**

Asian service users who used heroin were more likely (88.4%) to report that they wanted to stop using the drug, compared to black service users (78.6%), white service users (77.3%), mixed service users (73.6%) and those from "other" ethnic backgrounds (73.8%,  $X^2 = 15.750$ ,  $p < 0.05$ ). Male heroin users were more likely (13.9%) to report being happy with their levels of heroin use, compared to female heroin users (10.4 per cent), with female heroin users more likely (80.6%) to report that they wanted to stop using the drug completely, compared to 76.6% of male heroin users ( $X^2 = 8.690$ ,  $p < 0.05$ ). In addition, heroin users aged 22–30 were significantly more likely (82%) to report that they want to stop using heroin completely, followed by under 21s (81.2%), 31–40 year olds (77.5%) and those aged over 40 years (68.1%;  $X^2 = 48.771$ ,  $p < 0.000$ ).

### **3.4.3 Service users' long-term goals for cannabis**

When looking at cannabis use, white cannabis users were the most likely (62.2%) to report that they were happy with their use of the drug, and least likely (22.3%) to report that they wanted to stop using the drug completely. Asian cannabis users were least likely (39%) to report being happy with their level of use, and most likely (37%) to want to stop using the drug completely ( $X^2 = 38.435$ ,  $p < 0.001$ ). There was no clear difference across different age groups or between males and females.

### **3.4.4 Service users' long-term goals for alcohol**

Although mixed race service users were most likely (30.2%) to report that they were happy with the amount of alcohol they use (with service users from "other" ethnic backgrounds being the least happy – 23.5%), differences across ethnic groups were not statistically significant. Service users aged between 22 and 30 were the most

likely (32.2%) to report that they were happy with the amount of alcohol they used, followed by those aged 21 years and under (30.2%), 31-40 year olds (27.2%) and those over 40 year olds (19%;  $X^2 = 74.863$ ,  $p < 0.001$ ). Males were more likely (29.2%) to report being happy with their level of alcohol use, compared to females (22.6%).

### 3.4.5 Areas of concern and treatment need

Figure 1 shows the percentage of respondents who had requested assistance for non-drug related issues. It shows that the most common requests were for assistance or help with housing, education, employment and mental health issues. Fewer service users needed advice or assistance with debts and from social services. Advice on legal issues was the least requested. Respondents were most likely to have been referred to housing services, education services and mental health services although there were fewer referrals than requests for support.

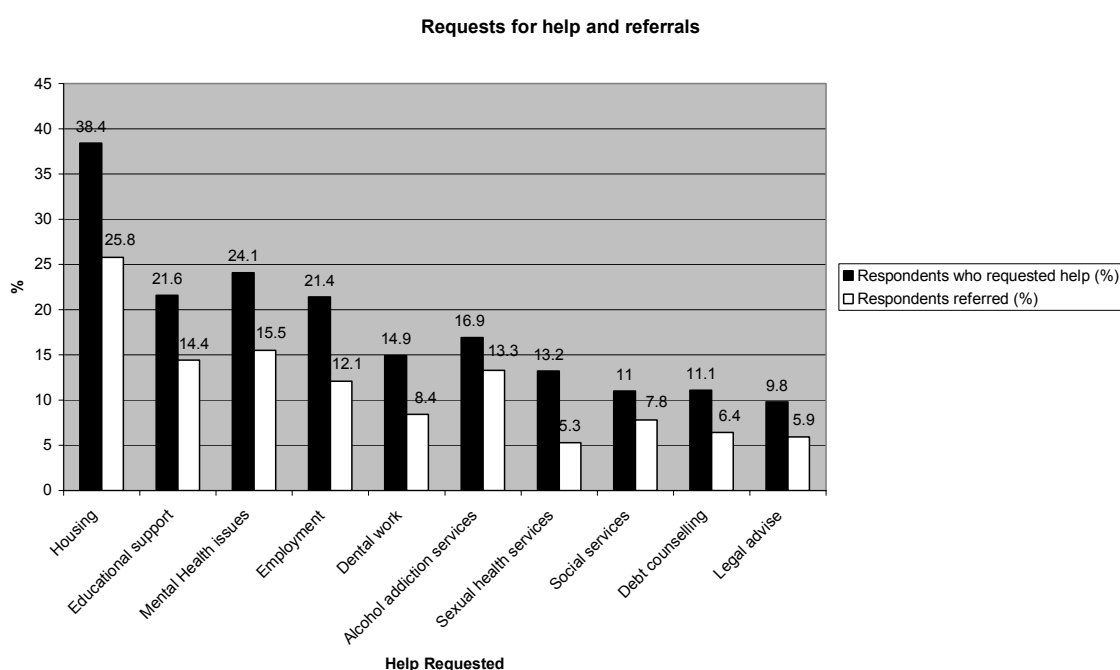


Figure 1: Help with non-drug-related concerns

## 4 Attitudes to treatment

### 4.1 Treatment impact

Table 6 shows the positive impact of treatment on general health, mental health and relationships with other people on the majority of respondents. It is worth noting that treatment may have had less impact on improvements in mental health and on social relationships than it did on decrease in (illicit) drug use, decrease in crime (please see Table 5) or improvements in general health.

	<b>Strongly agree</b>	<b>Agree</b>	<b>Don't Know</b>	<b>Disagree</b>	<b>Strongly disagree</b>
Your general health has improved	45.7	36.1	11.3	5.4	1.5
Your mental health has improved	36.7	35.3	17.0	8.4	2.6
Your relationships have improved	31.6	37.6	13.6	12.7	4.4
Your housing situation has improved	32.1	27.4	12.1	20.0	8.4
Your employment situation has improved	19.3	21.1	17.6	32.5	9.5

*Table 6: Improvements since starting treatment*

Starting treatment had less impact on changes in respondents' housing and employment situation than on their health and relationships. Nevertheless, 32.1 per cent strongly agreed that their housing situation had improved since starting treatment. Almost twenty per cent (19.3%) strongly agreed that their employment situation had improved since starting treatment.

Table 7 shows that the majority of respondents felt that their service was good at considering users' views. However, when combining the responses "strongly agree" and "agree" 14.5% of respondents reported that they felt the service discouraged users from making complaints.

It is also important to note that 11 per cent strongly agreed that they were attending a service that was not right for them.

	<b>Strongly agree</b>	<b>Agree</b>	<b>Don't know</b>	<b>Disagree</b>	<b>Strongly disagree</b>
I have received a lot of help	41.6	42.1	7.3	6.7	2.3
I have enough say in decisions about my medication	37.2	43.6	7.0	8.0	4.1
The service is good at taking users' views into account	39.6	44.0	10.3	3.7	2.4
Your care plan reflects what you need	34.7	43.6	16.8	3.1	1.8
You contributed to your care plan	33.5	46.1	15.8	3.0	1.6
The service discourages complaints	6.8	7.7	18.8	34.5	32.2
This is not the right service for you	11.0	8.6	6.8	29.6	44.1

*Table 7: Statements about service components*

The items in Table 7 were combined with the items on tables 4 and 5 to create an fourteen-item measure of perceived treatment benefit (adjusted for negative items), creating a scale in which the most positive score is 28 (strongly agree to all six positive items and strongly agree to both negative items) and the most negative score is -28 (strongly disagree to all positive items and strongly agree to both negative items). The overall mean score on this section was 13.9, suggesting that across the population there was generally a positive response to the questions asked about treatment impact.

- Although not significant, those from a black ethnic background (mean = 13.7) were slightly less positive about treatment effects than mixed race service users (mean = 13.7), other ethnic origins (mean = 13.5), Asians (mean = 13.2) and whites (mean = 14.1)
- There were no significant differences in scores for ethnicity
- Females reported slightly higher levels of perceived treatment benefits (14.7 vs. 13.7) and this was significant (F=19.1, p<0.001)
- There was no clear age effect regarding the benefits of treatment effects.
- For the second year running, there has been a strong association between care plans and perceived benefit of treatment. The highest score was achieved by service users with a care plan that had been recently reviewed in the last month (mean = 16.5). Those who had been reviewed one and three months ago had an average score of treatment benefit of 15.7. It was 14.2 for those reviewed at four to 12 months and 11.5 for those who had been reviewed more than a year ago and 11 for those who had never had their care plan reviewed (F = 46.5, p<0.001).
- There was a significant relationship between perceived treatment benefit and waiting times. Time waiting for assessment, treatment entry and keyworker to be assigned showed the longer service users had been made to wait at the start of their treatment, the less satisfied they were with impact of the treatment they had received.

## 4.2 Respect

The majority of service users agreed that drug service staff and pharmacy staff treated them with respect (see Table 8 below). Keyworkers in particular were perceived to be the most respectful group of service users.

	<b>Strongly agree</b>	<b>Agree</b>	<b>Don't know</b>	<b>Disagree</b>	<b>Strongly disagree</b>
Keyworkers treat me with respect	58.8	38.0	1.9	0.9	0.4
Reception staff treat me with respect	52.1	43.0	2.3	1.7	0.8
Pharmacy staff treat me with respect	39.1	44.9	4.9	7.8	3.2
Other users treat me with respect	31.2	49.9	12.4	5.1	1.4

*Table 8: Perceptions of level of respect shown by staff at services*

The components of this table allowed a composite scale of respect to be created with a range of 8 to -8 with higher scores indicating greater perceptions of respect. The overall mean score was 5.17, indicating that across the respondents there were very positive attitudes about the level of respect from staff and fellow users. More detailed analysis suggests the following:

- Females reported that they were more satisfied with the respect accorded them than males (female mean = 5.3, male mean = 5.1;  $F=14.4$ ,  $p<0.05$ )
- Service users aged 40 and over (mean = 5.4,  $F=6.68$ ,  $p<0.05$ ) reported higher levels of perceived respect than those aged 31 to 40 (mean = 5.1), 22 to 30 (mean = 5.1) and under-21's (mean = 5.1)
- The highest levels of perceived respect was reported by whites (mean = 5.2), followed by Asians (mean = 5.0) and then black service users (mean = 5.0). Lower levels of perceived respect were reported by service users from a mixed ethnic background (mean = 4.9) and from other ethnic groups (mean = 4.4,  $F=3.35$ ,  $p<0.05$ )
- There was a strong relationship between care planning and perceived respect. Those who reported not having a care plan reported the lowest perceived respect in the services (mean = 4.8). The highest mean respect scores were reported by those whose care plans had been reviewed in the last month (mean = 5.4,  $F=3.23$ ,  $p<0.05$ )
- There was a link between waiting times and perceived respect. As with treatment impact, the longer service users had to wait overall the lower the level of respect they perceived they had received from the service.

## 4.3 Treatment engagement and support

There was strong evidence to suggest that service users were satisfied with the services provided by drug treatment agencies. As can be seen in the table below 40.3 per cent of respondents strongly agreed that their treatment programme was well organised and 43.3 per cent strongly agreed that they were satisfied with their

treatment programme. Similarly 48.7 per cent strongly agreed that staff were efficient at doing their jobs and 42.6 per cent strongly agree that they received enough of personal counselling or keyworking.

An important area for service development was, however, identified by respondents as 18.3 per cent “agreed” and 9.8 per cent “strongly agreed” that family members, partners and friends did not receive enough support from drug treatment services. A similar finding was made by the 2005 survey. It is clear that this is an area of concern for service users. There is a need for higher levels of engagement and increased support for family members, partners and friends.

	<b>Strongly agree</b>	<b>Agree</b>	<b>Don't know</b>	<b>Disagree</b>	<b>Strongly disagree</b>
The staff are efficient	48.7	43.1	4.4	2.7	1.1
I am satisfied with the programme	43.3	46.5	5.2	3.4	1.6
I receive plenty of counselling	42.6	44.4	7.3	3.9	1.8
The location of the service is convenient	42.4	44.9	2.9	7.1	2.8
The programme is well-organised	40.3	48.0	6.4	3.6	1.7
I have had enough say in treatment decisions	35.5	48.8	7.5	6.2	2.1
Time schedules are convenient	33.4	54.1	5.9	4.9	1.6
The service promotes responsibility and self-discipline	27.0	51.4	15.6	4.7	1.3
Families/partners do not get enough support	9.8	18.3	28.8	28.8	14.3
I am only attending because nothing better is available	8.6	14.6	10.7	40.3	25.7

*Table 9: Treatment engagement and support*

The final set of satisfaction items are reported in Table 9. The same scoring approach was used as in Table 8. This ten-item scale yield a total score ranging from 20 to -20, with the overall sample providing a mean score of 10.59 indicating that across the respondents there were generally positive views on treatment engagement and support. More detailed analysis suggests the following

- There was no statistically significant relationship between age and satisfaction
- Women were slightly more satisfied with treatment engagement and support (mean 11.2 women and 10.39 men,  $F = 25.88$ ,  $p < .001$ )
- Asian clients were the least satisfied with treatment engagement and 30 (mean 9.5), while black clients were the most (11.0). The figures for white clients was 10.7, mixed race clients 10.3). The mean score for those aged 21 and other

ethnicities 10.0. These differences were statistically significant ( $F=2.75$ ,  $p=.026$ ).under was 8.6. The overall effect was statistically significant ( $F = 6.10$ ,  $p<0.001$ )

- There was no clear gender difference regarding satisfaction with treatment engagement and support
- There was no clear ethnicity difference regarding satisfaction with treatment engagement and support
- Similar to 2005 findings there was a significant difference with satisfaction with treatment engagement and support and care plan status. Service users with a care plan that had been reviewed in the last month showed the highest levels of satisfaction with treatment (mean = 12.05,  $F = 20.20$ ,  $p<0.001$ ). Those who "never" had a care plan review had a mean score of 9.5
- There was a link between waiting times and treatment engagement and support. As with treatment impact and perceived respect the findings suggest that longer waits for assessment, start of treatment and allocation of a keyworker are associated with lower levels of satisfaction with treatment engagement and support. These findings are similar to those in 2005.

## **5 Overall satisfaction**

---

Finally, a single overall index of satisfaction was created by combining the three sub-scales for treatment impact, respect and treatment engagement and support, to create an overall measure of treatment satisfaction. The composite satisfaction yielded a total score of 28.5, with a range of -56 to 56 and a standard deviation of 16.52. This score was equivalent of all service users stating that they agree with all the positive statements. The section below outlines the key factors associated with variations in this score.

### **5.1 Relationship between total satisfaction and service user characteristics**

---

- Higher satisfaction reported by females (mean = 31.0), than by males (mean = 29.0) this was statistically significant,  $F=29.13$ ,  $P<.001$ )
- Higher overall satisfaction was reported by black service users (mean = 29.1), white service users (mean = 29.7), Asian service users (mean = 27.7) and service users from other ethnic origins (mean = 28.2) than by mixed ethnicity service users (mean 29.1) although this was not statistically significant
- Age did not have a significant impact on overall satisfaction.

### **5.2 Relationship between total satisfaction and service characteristics**

---

- A clear effect was found in relation to care planning, with markedly lower satisfaction with treatment reported by those with no care plan (mean = 24.1) and those whose care plan had never been reviewed (mean = 24.6). More satisfaction was expressed by those whose care plans had been reviewed between four and 12 months ago (mean = 29.7) and the highest satisfaction score was reported by those whose care plans had been reviewed in the last month (mean = 33.6). These differences were significant ( $F = 41.2$ ,  $p<0.001$ ) and these findings mirror those in the 2005 survey and together emphasise the importance of care plans in the drug treatment system

- Waiting times showed a similar pattern as service users were more satisfied with their treatment when their comprehensive assessment took place within a week of attending their service (F=89.3, p<0.001). They were more satisfied with their treatment if they waited less than a week from comprehensive assessment to start of treatment (F=74.9, p<0.001). It was also significant to note that service users had higher levels of satisfaction with treatment if they had been allocated a keyworker within a week of starting treatment (F=108.9, p<0.001)
- There was a strong relationship between overall satisfaction and perceived impact on drug use. Those who "strongly agreed" that their drug use had reduced since starting treatment had a mean overall score of 36; those who "agreed" had a mean satisfaction score of 23.3; those who were uncertain had a mean score of 15.7; those who "disagreed" had a mean score of 11.7 and those who "strongly disagreed" had a mean satisfaction score of -1.5. This effect was significant (F = 611.19, p<0.001).

## 6 Regional analysis

Table 10 shows response rate by the nine Government Office regions.

Region	Number	Percentage
London	1672	19.1
North east	764	8.7
South east	900	10.3
Eastern	542	6.2
West Midlands	877	10.0
South West	853	9.7
East Midlands	385	4.4
Yorkshire and Humber	1229	14.0
North West	1539	17.6

*Table 10: Regional breakdown by response rate*

There were some differences in a range of characteristics, as shown in Table 11.

Region	Gender (% female)	Ethnicity (% White)
London	27.3	71.1
North East	28.6	95.8
South East	30.9	92.5
Eastern	31.2	89.8
West Midlands	32.7	86.6
South West	31.4	92.2
East Midlands	29.2	93.7
Yorkshire and Humber	31.4	91.5
North West	28.9	94.8

*Table 11: Regional breakdown of responses to questionnaire by gender and ethnicity*

The regional difference in gender was not statistically significant, with the proportion of female respondents ranging from 27.3 per cent in London to 32.7 per cent in the West Midlands. By contrast, there was a statistically significant difference in ethnicity by region, with London the most likely to be non-white, compared to other NTA

regions ( $X^2 = 694.94$ ,  $p < 0.001$ ). Given the overall, reporting effects by gender and ethnicity, this should be borne in mind when interpreting data.

<b>Region</b>	<b>Residential</b>	<b>Methadone prescribing</b>	<b>Buprenorphine prescribing</b>	<b>Other community treatment</b>
London	4.8%	47.2%	9.8%	38.2%
North East	2.4%	70.0%	10.2%	17.4%
South East	7.7%	40.0%	15.6%	36.7%
Eastern	2.3%	36.5%	13.8%	47.4%
West Midlands	3.6%	57.6%	13.1%	25.7%
South West	11.1%	40.7%	7.4%	40.8%
East Midlands	3.2%	49.1%	7.3%	40.4%
Yorkshire and Humber	1.2%	64.3%	11.6%	22.9%
North West	6.5%	57.0%	9.2%	27.3%

*Table 12: Type of treatment attended by region*

There are marked variations across the regions in terms of services attended by respondents, with residential treatment ranging from between 1.2 per cent (Yorkshire and Humber) to 11.1 per cent (South West) and between 17.4 per cent (North East) and 47.4 per cent (Eastern) in other community treatments.

Table 13 presents the variations by region in the time of the most recent care plan review. The North East reported the lowest rates of care plans that had been reviewed in the last three months and service users from the West Midlands reported the highest rate of recent care plan reviews.

Region	Care plan reviewed in last three months	Care plan last reviewed 4-12 months ago	Care plan last reviewed more than one year ago	Care plan never reviewed
London	80.1	6.8	2.0	11.1
North East	80.4	11.6	1.4	6.6
South East	85.0	7.1	.06	7.3
Eastern	84.7	5.2	1.6	8.5
West Midlands	85.9	6.4	1.1	6.6
South West	83.8	4.8	0.6	10.8
East Midlands	84.4	9.0	1.4	5.2
Yorkshire and Humber	88.4	5.1	0.4	6.2
North West	86.1	6.1	1.2	6.6

Table 13: Care plan review by region based on all clients with a care plan

Region	Adherence to MoC (Waiting times)	Adherence to MoC (Care planning)	Perceived treatment impact	Perceived respect received	Perceived treatment engagement and support	Total attitudinal score
London	2.76	1.70	13.2	5.2	10.5	27.8
North East	2.85	1.44	13.2	5.1	10.2	27.4
South East	2.71	1.81	13.8	5.1	10.3	28.3
Eastern	2.80	1.74	15.9	5.7	12.1	32.6
West Midlands	2.65	1.94	13.7	5.1	10.1	27.8
South West	2.64	2.00	14.3	5.0	10.8	29.1
East Midlands	2.72	1.75	14.5	5.3	10.3	28.6
Yorkshire and Humber	2.73	1.87	14.4	5.2	10.8	28.7
North West	2.74	1.93	13.6	5.0	10.5	28.2

Table 14: Satisfaction by region

The overall rating of the various satisfaction measures, as well as composite scores for adherence to Models of Care are given in Table 14. When looking at adherence to Models of Care (waiting times), the North East region is identified as having the highest level (2.85;  $F=12.028$ ,  $p<0.001$ ). When looking at adherence in terms of care planning, the South West is identified as the highest scoring region (2.00;  $F=11.029$ ,  $p<0.001$ ). The table also shows that the highest levels for "perceived treatment impact" (15.9;  $F=5.67$ ,  $p<0.001$ ), 'perceived respect received' (5.7;  $F=4.879$ ,  $p<0.001$ ) and 'perceived treatment engagement and support' (12.1;  $F= 5.079$ ,  $p<0.001$ ) were reported in the Eastern region.

## 7 A comparison of the NTA's surveys of user satisfaction in 2005 and 2006

---

The first annual user satisfaction survey was carried out in 2005 and received completed questionnaires from 6,770 respondents compared to 8,765 in 2006. Section 7.1 compares the findings from 2005 and 2006. There were a number of additional questions in the 2006 survey. To have a fair comparison between the two years, we have only compared those questions which were asked in both years. This means that the satisfaction scores from 2006 differ from those reported earlier in this document.

### 7.1 Findings and Implications

---

#### 7.1.1 Satisfaction

In both years, the vast majority of clients were highly satisfied with the treatment they received. Although overall satisfaction was marginally higher in 2005, this was not a large difference. As figure 1 below illustrates, the overall satisfaction scale. In 2005 this score was 26.1 compared to 25.3 in 2006 (based on -46 for the lowest possible satisfaction score to + 46 for the highest satisfaction score). This is approximately equivalent of all respondents answering they agree to each of the statement. Additionally there were only marginal differences between the years for perceived treatment impact, engagement and support as well as respect shown by staff. With the exception of respect shown by staff, these differences were not statistically significant.

	Score	2005	2006
Overall satisfaction	-46 to 46	26.1	25.3
Perceived treatment impact	-18 to 18	9.9	10.0
Perceived treatment engagement and support	-20 to 20	10.5	10.4
Perceived respect shown by staff	-8 to 8	5.2	5.2

*Table 15: Comparison of the different aspects of satisfaction – 2005 and 2006 (positive numbers represent higher levels of satisfaction)*

There were a number of significant differences between the two years. In 2006

- A greater proportion of clients received methadone – 62.9 per cent in 2006 compared to 60.7 per cent in 2005
- Higher doses of both methadone and buprenorphine were prescribed in 2006 – an average of 59.7mg of methadone in 2006 compared to 57.5mg. For buprenorphine the figures were 10.6mg for 2006 and 9.6mg (2005).
- There was more widespread supervised consumption both for the first 12 weeks of prescribing and afterwards in 2006 than in 2005. A total of 77.7 per cent of methadone clients were supervised daily in 2006 compared to 73.4 per cent. For buprenorphine clients, the figures were 68.8 per cent in 2006 and 65.7 per cent in 2005. After 12 weeks, 62.6 per cent methadone clients were supervised daily in 2006 compared to 56.6 per cent in 2005, and for buprenorphine the figures were 68.8 per cent (2006) and 65.7 per cent (2005)

- More clients had care plans in 2006, with 65.7 per cent reporting they had one, compared to 62.9 per cent the previous year.

In 2005:

- Those clients with care plans were more likely to have had it reviewed in the last three months – 87.3 per cent had theirs reviewed within the last three months compared to 84.4 per cent in 2006
- Waiting times were generally shorter in 2005
- Clients were more likely to report that their drug use had reduced since starting treatment 92.5 per cent in 2005, compared to 89.8 per cent in 2006. They were also slightly more likely to report that they were less likely to be involved in crime – 93.6 per cent in 2005 compared to 92.2 per cent in 2006.

A number of themes emerged over the two years, particularly around the areas of care planning and waiting times.

Higher satisfaction was reported in both years for those clients who:

- Had care plans
- Had care plans which were reviewed within the last three months
- Had lower waiting times for assessment, treatment starting and being assigned a keyworker.

Data from both years also supported the finding that those clients who believed that drug treatment had made a difference also reported higher levels of satisfaction.

## 8 Conclusion

---

The findings from the second annual user satisfaction survey primarily reinforce the findings of the first survey carried out in 2005. Service users were generally satisfied with drug treatment, viewed the drug treatment they received quite positively and the majority agreed that drug treatment had made a difference to their lives.

## 9 References

---

Best D, Campbell A and O'Grady A (2006). *The NTA's First Annual User Satisfaction Survey 2005*. London: NTA

Best D and Campbell A (2006). *Summary of the NTA's National Prescribing Audit*. London: NTA

Healthcare Commission (2004). *Patient Survey Report 2004 – Mental Health*. London: Healthcare Commission

Health Protection Agency, Health Protection Scotland, National Public Health Service for Wales, CDSC Northern Ireland, CRDHB, and the UASSG (2005). *Shooting Up: Infections Among Injecting Drug Users in the United Kingdom 2004*. London: HPA

Health Protection Agency (2006). *Shooting Up: Infections Among Injecting Drug Users in the United Kingdom 2005. An Update*. London: HPA

National Treatment Agency for Substance Misuse (2006). *Models of Care for Treatment of Adult Drug Misusers: Update 2006*. London: NTA

National Treatment Agency (2006). *Care Planning Practice Guide*. London: NTA

National Treatment Agency for Substance Misuse (2006). *Towards Treatment Effectiveness: Business Plan 2006/07*. London: NTA

Rhodes T, Briggs D, Holloway G, Jones S and Kimber J, The Centre for Research on Drugs and Health Behaviour, Imperial College (2006). *Visual Assessments of Injecting Drug Use: A Pilot Study*. London: NTA

Simpson DD and Joe GW (2004). A Longitudinal Evaluation of Treatment Engagement and Recovery Stages. *Journal of Substance Abuse Treatment* 27(2), 2004, 89-97