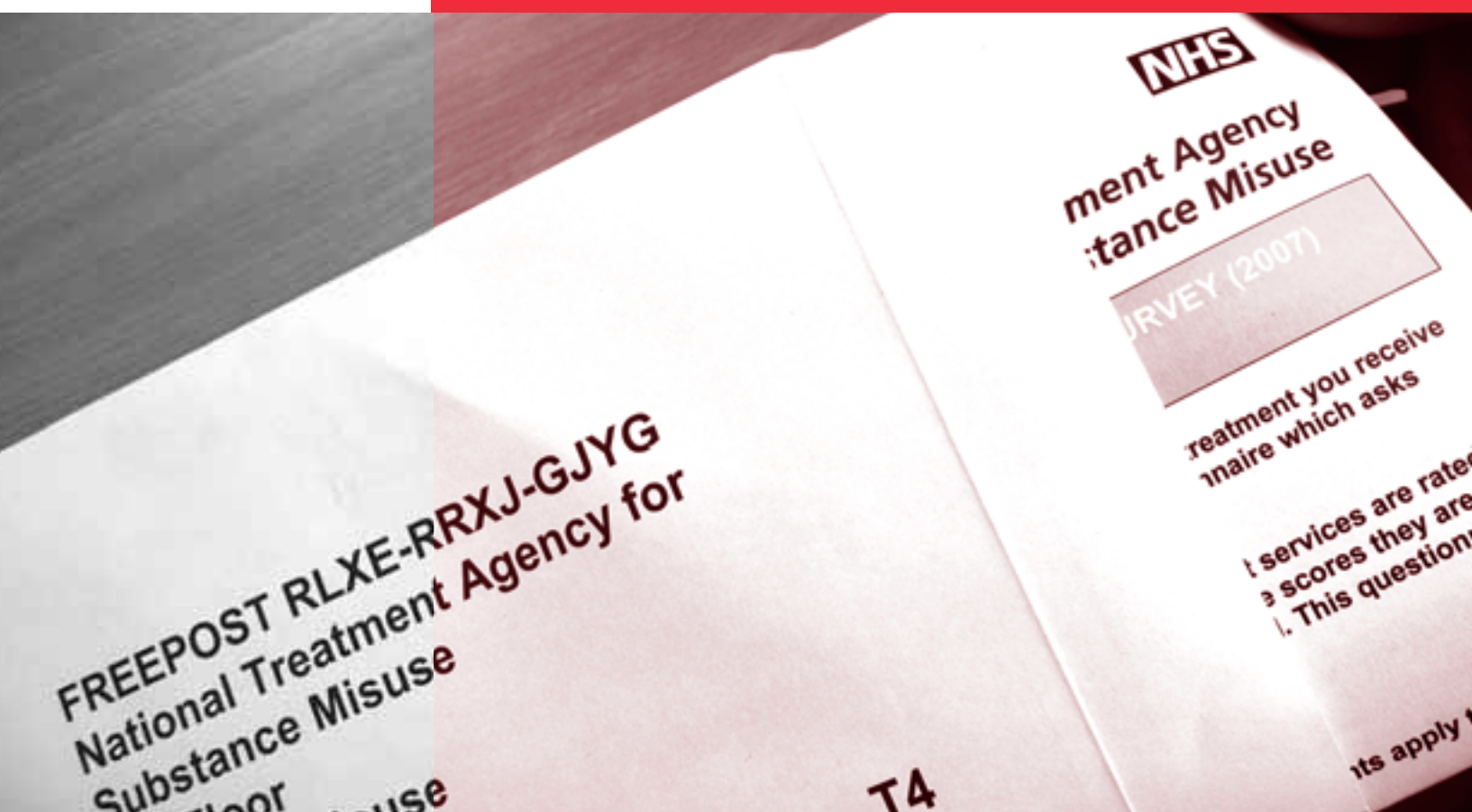


The 2007 user satisfaction survey of Tier 4 service users in England



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Key findings

This document summarises a survey of 1,047 users of 151 Tier 4 drug treatment services (inpatient hospital services, residential rehabilitation and supported housing).

The vast majority of respondents were generally satisfied with their treatment, viewed it in positive terms and agreed that it has had a positive impact on their lives. They also agreed that service staff treated them with respect, were satisfied with treatment engagement and support, and with how services were dealing with diverse needs.

Service users in general reported they were able to choose the service from a range of options and felt well prepared upon entering the service. Clients reported that the length of programmes were appropriate. Services users in general also reported a good approach to care planning and review.

Service users' demographic characteristics – reflecting diverse populations – did not affect their levels of satisfaction (age, gender, ethnicity, sexual orientation and parenting status). The 2007 survey of Tier 4 respondents did, however, show significant differences in levels of satisfaction based on the following:

- The users of residential rehabilitation services were more satisfied than those in inpatient (hospital) services
- Service users were most likely to be satisfied with their treatment if they had care plans, with satisfaction increasing the more recently these had been reviewed. The presence of a care plan had a stronger effect on positive satisfaction than all other factors
- Service users were more likely to be satisfied if they had a worker in the community who was responsible for co-ordinating their care once they have left the service
- Generally speaking, the longer the agreed duration of a residential rehabilitation treatment programme lasted, the more likely service users were to be satisfied. In addition, those who had been in their service for more than three months were more satisfied than those who had been there for three months or less
- The 2007 Tier 4 survey did find room for improvement. The survey highlighted further work in terms of harm reduction interventions and a need to enhance the co-ordination of aftercare. Service users also underlined a need for greater levels of engagement and increased support for family members, partners and friends.

Introduction

Project rationale

Recent guidance – including the NTA's 2005 Treatment Effectiveness strategy, Models of Care for Treatment of Adult Drug Misusers: Update 2006 (NTA, 2006), Drug Misuse and Dependence: UK Guidelines on Clinical Management (DH *et al.*, 2007) and the National Institute for Health and Clinical Excellence's suite of drug misuse guidance (NICE, 2007a–d) – all place a strong emphasis on the evidence that active involvement of service users as partners in their drug treatment is associated with better outcomes. The annual user satisfaction surveys provide a continuing opportunity to explore service users' experiences and ensure that their views are taken into account when developing drug treatment.

This report summarises the findings from the survey of Tier 4 drug treatment services,¹ carried out alongside the main survey of Tier 2 and 3 service users (community-based drug services), the results of which are presented in a separate report (Gordon *et al.*, 2008).

The NTA annual service user satisfaction surveys also contribute to the joint annual NTA and Healthcare Commission Improvement Review, which in 2007 was “endorsed and supported” by the Commission for Social Care Improvement.

The first survey (Best *et al.*, 2006) was carried out in 2005 and each year focuses on a different theme. In 2005 the theme was community care planning and prescribing, and in 2006 the focus was harm reduction and commissioning. In 2007, the theme was diversity, with an added focus on Tier 4 services that was not present in the previous surveys.

Background

Tier 4 interventions are advocated as key elements of every local drug treatment system. They play an important role in enabling drug users with complex needs to stabilise or become drug-free and are in line with the NTA's Treatment Effectiveness strategy.

Models of Care: Update 2006 (NTA, 2006) stipulates that Tier 4 treatment should be care-planned and co-ordinated to ensure continuity of care, as well as ensuring aftercare for individuals who are back in the community. As such, Tier 4 services may be a critical element in some individuals' integrated care pathways and can be a highly effective component in providing routes out of drug dependency for those who cannot achieve stability or abstinence in the community.

¹ Defined as residential drug treatment – both inpatient treatment and residential rehabilitation. Treatment should also include arrangements for further treatment or aftercare for clients finishing treatment and returning to the community.

Project design and method

The Tier 4 survey addressed the following issues:

- Overall satisfaction with the care and drug treatment service users received
- Key aspects of treatment delivery, including care planning, keyworking and the range of interventions included in treatment programmes
- The extent to which Tier 4 treatment is operating in line with Models of Care and other guidance. This included looking at:
 - Service user choice and preparation
 - Care planning and review
 - Co-ordination and continuity of care and aftercare
 - Interventions received.
- Gathering baseline information for measuring change over time
- Diversity.

The questionnaire was designed for service users to complete themselves anonymously and confidentially. Its layout and design retained many of the features of the original 2005 questionnaire, which was constructed from several existing instruments, including:

- The NHS mental health survey questionnaire (Healthcare Commission, 2005)
- The Client Evaluation of Self and Treatment (CEST) questionnaire, satisfaction sub-scale (Simpson and Joe, 2004)
- Assessment of Client Satisfaction with Specialist Drug Treatment, The drug treatment satisfaction audit constructed in the Maudsley Hospital (National Addiction Centre, 1999, unpublished).

In addition, a number of new questions were developed to look at issues specific to Tier 4 interventions. These focused on issues of good practice.

A database of Tier 4 services was compiled using the residential service directory BEDVACS² as well as the database used for the national survey of inpatient drug services in England (Day *et al.*, 2005). In addition, all 149 joint commissioning managers were asked to provide a list of all the Tier 4 drug treatment services they commissioned – based on this list, questionnaires were distributed to all Tier 4 services throughout England. The number of questionnaires each service received was based on the number of beds in that service. Youth, alcohol-only services (or alcohol-only users of substance misuse services) and criminal justice-only services were not included in the survey.

² http://www.nta.nhs.uk/about_treatment/treatment_directories/residential/resdirectory_f.aspx

Services were asked to place promotional materials (a poster advertising the survey, questionnaires and freepost envelopes) in a prominent position. Staff with day-to-day service user contact, such as keyworkers and receptionists, were also asked to explain the purpose of the survey to service users and encourage them to take part. Service users could then return their completed questionnaires in a sealed freepost addressed envelope either to a collection point in the service or directly to the NTA.

It is important to note that this report makes comparisons between responses from residential rehabilitation services and inpatient (hospital) services. These must be treated with caution as both service modalities often represent differing responses to drug misuse and different approaches to treatment.

Comparisons are also made in this report between the findings from the Tier 4 survey and the Tier 2 and 3 survey. Only the survey questions that are common to both questionnaires have been compared and care should be taken when comparing results.

Results

A total of 6,180 copies of the questionnaire were distributed in September 2007 to 318 Tier 4 services. Service users from 151 services, who had lived in 122 of the 149 English DAT partnership areas in the four weeks before entering Tier 4 treatment, completed and returned 1,047 questionnaires. Assuming that every questionnaire was distributed, this represents a response rate of approximately 17%.

Throughout this report, reference is made to statistical tests and statistical significance. Where a reference to F and p is found, this means that a statistical test called analysis of variance (ANOVA) was used to determine whether the differences between the average scores of different groups are statistically significant (for example, average scores among women compared to men).

Tests are carried out to obtain a factor (F) which that refers to the independent variable under consideration (for instance, gender). In this example, the F factor tests how far gender affects satisfaction and is used to derive the probability value (p). This in turn tells us if there is a difference between the groups under comparison.³ The p value can lie anywhere between 0 and 1, and the smaller the p, the more significant the result is. Anything which is larger than 0.5 is not significant, while values of <0.001 are highly significant. Care should be taken when interpreting results that are not statistically significant.

³ It is customary when reporting on ANOVA tests that the F and p values are reported. The F values, however, need to be read in conjunction with statistical tables that are not included in this report.

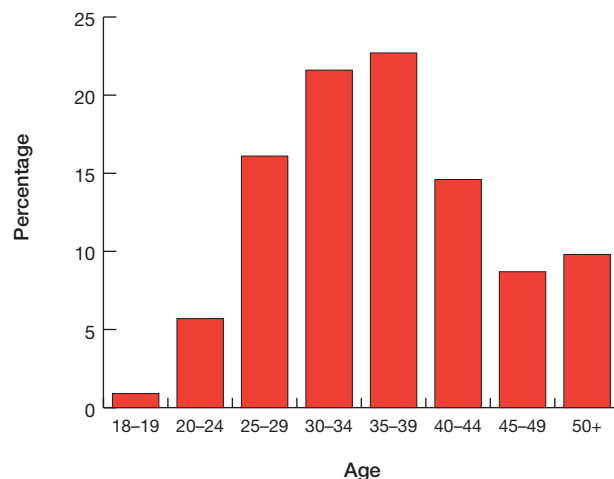


Figure 1: Respondents by age group

Characteristics of the sample

In comparison to the users of Tier 2 and 3 services, Tier 4 service users tended to be older and more likely to be unemployed and in receipt of Incapacity Benefit, and less likely to have lived in secure accommodation prior to admission.

Of the 1,047 service users who returned questionnaires, over two-thirds were men (71.2%) and just under a third were women (28.8%). This largely matches the gender split of the Tier 2 and 3 survey, and the most recently published data (2006/07) from the National Drug Treatment Monitoring System (NDTMS).

Ages ranged from 18 to 83 years but the average age was 36.8 years (with a median of 36 years), with a little over two in five respondents being in their 30s (44.3%). This is shown in Figure 1. In comparison to service users in the community, Tier 4 service users were on average two-and-a-half years older. They were also older than those in the full NDTMS 2006/07 dataset, where the median age was 31 years.

Turning to ethnicity, the vast majority of service users who took part in the survey reported themselves as white (88.7%). Table 1 also shows that fewer than one in 25 said that they were of mixed race (3.9%) or black (3.5%), while approximately one in 50 reported themselves as either Asian (2.1%) or another ethnic group (1.8%).

There were no significant differences by ethnicity between Tier 4 respondents and those in the Tier 2 and 3 survey. There was a similar proportion of white service users when compared to the NDTMS 2006/07 data (88%) a higher percentage of mixed race service users (2% in NDTMS data) and fewer black and Asian service users (4% and 4% respectively).

The majority of respondents described themselves as heterosexual (90.6%), with 2.9% saying that they were gay or lesbian, 3.9% bisexual and 2.6% preferring not to disclose their sexual orientation. There were no differences between Tier 4

	Percentage
White British	83.1
White Irish	4.0
White other	1.6
Mixed race	3.9
Asian Indian	0.9
Asian Bangladeshi	0.2
Asian Pakistani	0.6
Asian other	0.4
Black Caribbean	2.7
Black African	0.4
Black other	0.5
Chinese	0.1
Other	1.7

Table 1: Ethnicity of sample

service users and those in Tier 2 and 3 services in terms of sexual orientation.

Approximately one in seven respondents (14%) were parents or carers of children under 16 who lived with them in the four weeks prior to admission to Tier 4 treatment. By contrast, 22% of Tier 2 and 3 service users had dependent children. The Tier 4 parents were significantly more likely to be women ($p < 0.001$) accounting for approximately 30% of women and 8% of men.

Most respondents (68.3%) described themselves as having been unemployed in the four weeks prior to entering a Tier 4 service. One in ten (10.5%) were economically inactive (such as pensioners, people with disabilities, and housewives and househusbands). A similar proportion (8.9%) had been in full-time employment and 2.2% had been in part-time employment. Only 1.6% described themselves as students, with the remainder (8.5%) citing some other form of employment status.

In comparison to Tier 2 and 3 service users who were asked about their employment status at the time of the survey, Tier 4 service users were significantly more likely to have reported being unemployed in the four weeks prior to admission ($p < 0.001$).

Half of those who answered the question reported receiving Incapacity Benefit in the four weeks before entering treatment (48.1% – around 10% did not answer the question). Tier 4 service users were significantly more likely to have been receiving Incapacity Benefit than their counterparts in Tier 2 and 3 services (39.2% of the latter did; $p < 0.001$).

Nearly half of service users in the survey said that they were living in settled or permanent accommodation in the four weeks before entering Tier 4 treatment (46.1%). A sizable proportion, however, reported housing problems (19.7% were in temporary accommodation and 15.2% were of no fixed abode). One in 15 (6.6%) had been in prison in the four weeks before entering treatment and 2.5% had been in hospital (inpatients), with 10% reporting that they had lived in “other” accommodation.

Tier 2 and 3 service users were significantly more likely to have lived in settled or permanent accommodation in the four weeks prior to treatment than Tier 4 service users ($p < 0.001$).

Treatment status

Respondents were receiving treatment in 151 services or organisations (38 inpatient units, 109 residential rehabilitation services and four supported housing projects).

Four in five service users (79.9%) were in residential rehabilitation services or other non-NHS services that provided residential drug treatment (detoxification only or crisis intervention). For the sake of convenience, this group will be referred to as “residential rehabilitation” respondents.

Over two in three residential rehabilitation clients (70%) reported that they chose the service in which they were receiving treatment from a range of options. A similar proportion (67%) reported that they had visited the service before admission. Furthermore, over 90% said that the philosophy or method of the service was explained to them before entering the service.

Approximately one in six (17.9%) were in NHS inpatient services. Of those who specified the type of NHS inpatient hospital service:

- The majority reported being in NHS specialist drug and alcohol units (83.5%)
- 13.9% reported being in NHS general psychiatric wards
- 2.5% reported being on general medical wards.

The vast majority of respondents who were in NHS inpatient settings were there for detoxification (90.4%), with one in ten (9.6%) there for crisis intervention, stabilisation or dose titration.

Only 2.2% of the sample reported being in supported housing projects (not attached to residential rehabilitation services). Because of the very small numbers of respondents and services in this group, they will be excluded from comparisons between the types of Tier 4 services (which will focus on inpatient services and residential rehabilitation services).

Keyworker allocation

Most respondents – whether in residential rehabilitation or inpatient treatment – had a keyworker allocated at admission and over four in five had one within a week of admission (see Table 2).

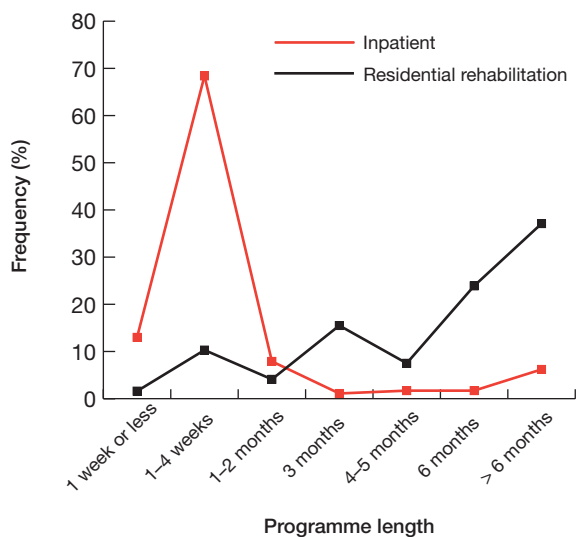


Figure 2: Treatment programme length by type of service

Only around 4% said they had never been allocated a keyworker. There were some significant differences between inpatient and residential rehabilitation services, with respondents in inpatient services more likely to have reported not having a keyworker.

Length of programme

Figure 2 shows the reported length of agreed treatment programmes in Tier 4 services. For the majority of inpatient hospital service users (almost 70%), treatment programmes lasted between one and four weeks. A small percentage reported their programmes lasted six months or more (almost 8%). It is not possible to determine why this is the case, but it may be assumed that some had complex needs or co-morbidities such as severe and enduring mental illness or physical health problems.

As would be expected, treatment programmes in residential rehabilitation units tended to last much longer. Two in three respondents (around 64%) were in programmes that lasted six months or more. Approximately 15% were in programmes that lasted three months. Some respondents reported much shorter programmes in residential rehabilitation services (such as 1-4

	Inpatient	Residential rehabilitation
At admission	60.5%	54.5%
Within a week	22%	33.7%
1-4 weeks	5.6%	6.7%
1-3 months	4%	1.5%
Have no keyworker	7.9%	4.3%

Table 2: Allocation of a keyworker

	Inpatient	Residential rehabilitation
Within the last four weeks	56.8%	32%
1-4 weeks ago	25.2%	39.8%
1-3 months ago	2.7%	16.3%
4-6 months ago	0.9%	3.4%
Never	1.8%	0.8%
Don't know	12.6%	7.7%

Table 3: Last care plan review by treatment type

weeks), which may suggest they were undergoing detoxification-only at their services.

Treatment, care and aftercare

Care planning

Just over three-quarters of respondents reported having a care plan (76.4%, with 9.3% saying they did not and 14.3% saying that they did not know). The users of residential rehabilitation services were significantly more likely than their peers in inpatient facilities to report having a care plan (79.1% and 63.3% respectively).

The users of Tier 4 services were significantly more likely to have care plans than the users of Tier 2 and 3 services, where two-thirds of service users (65.9%) had care plans.

The majority of respondents (73.7%) reported that their care plans had been reviewed in the past month (36.3% within the past week and 37.5% between one and four weeks ago). One in seven (14.1%) said their care plans had been reviewed 1-3 months previously and 2.9% said they had been reviewed in the past 4-6 months. Less than 1% said that their care plans had never been reviewed and 8.3% did not know. There were differences by treatment setting as can be seen in Table 3.

The users of Tier 4 services were significantly more likely to have had their care plans reviewed more recently than their peers in Tier 2 and 3 services ($p < 0.001$).

More than 90% of respondents who had care plans reported that these plans reflected what they needed from treatment (see Table 6). In this area as in others, there were significant differences between the users of inpatient and residential rehabilitation services, with the latter more likely to agree or strongly agree that their care plans reflected their needs ($p < 0.01$).

More than 90% also strongly agreed or agreed that they contributed to their care plans.

The users of inpatient services were significantly less likely than those in residential rehabilitation services to agree that they contributed to the development of their care plans ($p<0.01$).

Interventions received

Nearly all Tier 4 service users in the survey received medication for detoxification or their drug use, took part in group work and received one-to-one keyworking. Four in five also reported receiving counselling or psychotherapeutic interventions.

Overall, service users were more likely to receive the interventions listed in Table 4 – and receive a wider range of them – in residential rehabilitation services than inpatient services ($p<0.001$).

Fewer than half of all respondents reported receiving overdose prevention advice, with only a quarter of those in inpatient units reporting receiving this intervention. Interventions relating to the prevention of the spread of blood-borne viruses also appear to be limited in Tier 4 services, with one in six respondents being immunised for hepatitis B. However, it is possible that many respondents who did not report hepatitis B immunisation had previously been vaccinated in the community.

As for preparation for life after Tier 4 treatment, three in five respondents reported receiving skills training. Other interventions – such as money management advice and assistance with family relationships – were much less widespread.

There are also some difference between the various types of inpatient units – namely between specialist drug and alcohol units

	Total	Inpatient	Residential rehabilitation
Medication for drug use or detoxification	97.2%	94.7%	97.7%
Group work	96.1%	88.8%	97.7%
One-to-one keyworking	92.1%	81.3%	94.4%
Counselling or psychotherapy	83.4%	65.8%	87.2%
Relapse prevention	73.1%	50.3%	77.9%
Skills training	60.6%	40.1%	65%
Overdose prevention advice	45.4%	26.2%	49.6%
Assistance with family relationships	32.8%	17.6%	36.4%
Money management advice	23.2%	12.8%	25.7%
Hepatitis B immunisation	16.2%	7%	18.4%
Testing for BBVs	5.6%	3.7%	6.1%

Table 4: Interventions received

on the one hand and general psychiatric and medical wards on the other. The small number of respondents – and most particularly from the latter type of units – makes any robust comparison impossible. However, data suggests that respondents in general psychiatric wards and those in general medical wards were less likely to participate in group work and have one-to-one keyworking than respondents in specialist substance misuse units. Those in specialist drug and alcohol units were also more than two-and-a-half times more likely to have received relapse prevention support or advice, and were twice as likely to have overdose prevention as part of their programmes.

Continuity of care and aftercare

Three in five Tier 4 service users in the survey (60.4%) reported that there was a drug worker in the community who was responsible for supporting them and co-ordinating their care after they leave the service in which they were surveyed. Of the remainder, 17.9% reported that they did not have a drug worker in the community for co-ordinating their aftercare needs and 21.7% did not know whether they had one.

There were significant differences by type of Tier 4 service, with respondents in inpatient facilities much more likely to say that they did have a worker in the community to co-ordinate their aftercare needs (78.9%) than those in residential rehabilitation (57.1%) ($p<0.001$).

The majority of respondents with a care plan reported that this plan addressed their aftercare needs in the following areas:

- Attendance at self-help groups (84.4% of respondents)
- Housing needs (77.1%)
- Skills or employment training needs (68.9%)
- Employment needs (65.1%).

There were some differences by type of Tier 4 service used. Residential rehabilitation service users were more likely than those in inpatient units to have a care plan which mentions all of these factors ($p<0.001$ in all cases).

Drug treatment impact

Substantial numbers of respondents reported that entering treatment had a positive impact on their lives, as demonstrated in Table 5. Most Tier 4 service users reported falls both in drug use and in crime since starting treatment in their particular service. Treatment was also reported to have a positive impact on general health. It was also reported to have a positive impact on mental health and relationships with others, albeit less so than on the factors mentioned previously.

As shown in Table 6, respondents generally agreed that services were good at taking service users' views into account. There were

significant differences by type of service ($p < 0.003$), with respondents from residential rehabilitation services more likely to have agreed that this was the case.

The majority of respondents (86.6%) agreed or strongly agreed that they had received a lot of help from the service. Although most respondents suggested that the service that they were using was the right service for them (69.4%), it should be noted that a quarter believed that their current service was not right for them and that approximately one in seven felt that their service discouraged complaints.

Composite measures for treatment benefits

It is possible to create a measure of perceived treatment benefit (adjusted for negative items) based around the statements in Tables 5 and 6. The scale for this measure ranges from +22 (strongly agree with all positive items and strongly disagree with both negative items) to -22 (strongly disagree with all positive items and strongly agree with both negative items).

The overall mean score of the combined questions was +14.3, suggesting that across the population there was a generally positive response to the questions asked about treatment impact.

- There was no clear age effect relating to the benefits of treatment impact, but those between the ages of 25 years and 34 years appeared to be most positive about treatment benefit
- There were no statistically significant differences by gender or sexuality
- Higher levels of satisfaction with treatment benefits were reported by respondents who described themselves as mixed race (average score +14.84), "other ethnic groups" (average score +14.78), black respondents (average score +14.7) and white respondents (average score +14.3) than by Asian respondents (average score +10.9), who were overall the least positive about treatment impact, although this was not statistically significant

	SA	A	DK	D	SD
Drug use has decreased	88.5%	9.1%	1.5%	0.2%	0.6%
Crime has decreased	86.5%	11.1%	0.7%	0.9%	0.7%
General health has improved	71.1%	21.1%	4.9%	2.1%	0.7%
Mental health has improved	58%	24.3%	10.6%	5.3%	1.7%
Relationships have improved	51.1%	27.1%	16%	4.3%	1.5%

Table 5: Improvements since starting treatment

SA=strongly agree; A=agree; DK=don't know; D=disagree; SD=strongly disagree

	SA	A	DK	D	SD
You have received a lot of help	54.5%	32.1%	7.9%	3.9%	1.5%
The service are good at taking users' views into account	51.0%	36.4%	7.9%	2.6%	2.1%
Your care plan reflects what you need	57.5%	33.9%	7%	0.7%	0.9%
You contributed to your care plan	54.7%	36%	6.1%	1.9%	1.4%
The service discourages complaints	10.5%	6%	13.7%	32.1%	37.7%
This is not the right service for you	16%	8.7%	5.9%	19.4%	50%

Table 6: Statements about service components

SA=strongly agree; A=agree; DK=don't know; D=disagree; SD=strongly disagree

- There were significant differences by the type of service ($F=39.247$; $p < 0.001$). Respondents who were in inpatient (hospital) services were less positive about treatment effects (average score +10.6) than those in residential rehabilitation services (average score +15.0) and those in supported housing, who appeared to be very positive about treatment impact (average score +17.5)
- There was a strong association between care plans and perceived treatment benefits ($F=53.78$; $p < 0.001$). Those with care plans were significantly more positive (average score +15.4) than those who did not have care plans (average score +10.3) and those who did not know if they had a care plan (average score +10.9)
- Respondents in Tier 4 services were significantly more likely to have reported a positive treatment impact than their counterparts in Tier 2 and 3 services ($F=181.4$; $p < 0.001$). They were also significantly more likely to have reported a positive treatment impact than the respondents in the Tier 2 and 3 survey in relation to all the factors listed in the Tables 5 and 6 ($p < 0.001$ for all factors).

Dignity and respect

As can be seen in Table 7, the majority of Tier 4 service users agreed that drug service staff treated them with respect. Keyworkers in particular were perceived to be the most respectful group by service users.

	SA	A	DK	D	SD
Your keyworker treats you with respect	68.8%	27.1%	2.5%	1%	0.5%
Doctors treat you with respect	51.4%	36.9%	6.5%	3.5%	1.8%
Other staff treat you with respect	59.5%	34.4%	3.4%	2.2%	0.8%
Other users treat you with respect	46.7%	44.6%	2.8%	4.6%	1.3%

Table 7: Levels of respect shown by staff at services

SA=strongly agree; A=agree; DK=don't know; D=disagree; SD=strongly disagree

Composite measures for dignity and respect

The components of Table 7 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 of the combined questions was +5.8, indicating that respondents were generally positive about the level of respect they received from staff and fellow users.

More detailed analysis suggests that there were no differences by gender or ethnicity. Small – albeit not statistically significant – differences existed by age group, with those under the age of 20 years least satisfied with the level of respect they received.

Respondents from residential rehabilitation services reported higher levels of satisfaction with the respect given to them by staff than those in inpatient services (average scores of +5.3 and +5.9 respectively; $F=9.350$; $p<0.05$).

	SA	A	DK	D	SD
This programme expects you to learn responsibility and self-discipline	59.3%	34.5%	4.6%	0.9%	0.6%
The staff are efficient	57.8%	35.5%	3.3%	2.6%	0.8%
You are satisfied with this programme	56.7%	36%	4.3%	2.1%	0.9%
This service meets your needs	55.5%	37.3%	4.2%	1.9%	1.1%
This programme is organised and well-run	53.6%	37.4%	4%	4.1%	0.9%
This service location is convenient	51.4%	37.1%	4.2%	5.5%	1.8%
You get enough personal keyworking at this programme	45.5%	34.9%	8.2%	8.7%	2.7%
You have had enough say in decisions about your treatment	35.8%	45.5%	8.7%	8%	1.9%
Time schedules for keyworking are convenient	35.2%	48.6%	8.8%	5.8%	1.6%
Family members and partners do not get enough support	13.8%	18.4%	28.5%	24%	15.3%
You only use this service because there is nothing better available	10.9%	13.3%	8.9%	34.5%	32.4%

Table 8: Treatment engagement and support

SA=strongly agree; A=agree; DK=don't know; D=disagree; SD=strongly disagree

There was a strong relationship between care planning and perceived respect. Those who reported having a care plan reported the highest perceived respect (average score +6) compared those who did not know whether they had a care plan (average score +5.2) and those who reported not having a care plan (average score +4.9).

There was also a strong relationship between perceived respect and treatment tier, with those in Tier 4 services reporting higher levels of perceived respect than their counterparts in Tier 2 and 3 (average scores of +5.8 and +5.2 respectively; $p<0.001$).

Treatment engagement and support

There is strong evidence to suggest that respondents were satisfied with the support offered by Tier 4 services.

Table 8 demonstrates that approximately three in five service users strongly agreed that they were expected to learn responsibility and self-discipline, that the staff do their job well and that they are satisfied with their treatment programme.

Furthermore, around half agreed that the service met their needs, was well-run and conveniently situated, and that they received enough keyworking. Across all the measures in Table 8 – with two exceptions – at least four in five either strongly agreed or agreed with the statements.

The first exception related to whether the service was a default choice because “there is nothing better available”. A quarter or respondents (24.2%) reported that they were in this position, with two-thirds (66.9%) disagreeing that they used their service because there was nothing else available. These figures are similar to results from the previous NTA user satisfaction surveys – and to the views of Tier 2 and 3 service users in 2007 (where 25.3% of respondents felt that there was nothing better available).

The second exception is that of family support. A third or respondents (32.2%) felt that family members and partners did

	SA	A	DK	D	SD
You understand what your keyworker says	53.8%	40.9%	2.9%	1.6%	0.7%
You understand written information from the service	52.0%	43.0%	2.8%	1.3%	0.9%
Workers have experience of treatment of all drugs used	50.7%	34.1%	11.4%	2.5%	1.3%
Your children are able to visit you	48.2%	36.1%	8%	3.8%	3.8%
This service provides you with the possibility to practice your religion	35.6%	33.8%	21.1%	5.5%	3.9%
Food provided does not take into account needs and restrictions	11.0%	14.5%	8.3%	33.5%	32.7%
Service does not provide privacy	13.6%	20.7%	7.1%	35.1%	23.5%

Table 9: Satisfaction with how services deal with needs of diverse populations

SA=strongly agree; A=agree; DK=don't know; D=disagree; SD=strongly disagree

not receive enough support. Again, this figure is almost identical to that in the Tier 2 and 3 survey (33.6%) and is in line with previous results.

The 2008 Drug Strategy (HM Government, 2008) and the suite of NICE drug treatment guidelines (2007a-d) both place a greater emphasis on the needs of the families and carers of drug-misusing patients. They identify the importance of families and carers as a valuable resource in drug treatment but point out that they are often in need of support themselves and that their needs should not be overlooked.

The level of support for families is an area of concern for a significant minority of service users, whether in the community or in residential treatment. They have identified a need within drug treatment systems for higher levels of engagement and increased support for family members, partners and friends.

There were no differences by respondent demographic characteristics (gender, age, ethnicity or sexuality) in reported levels of satisfaction with treatment engagement and support. Significant differences, however, existed by service type, with those in residential services reporting higher levels of satisfaction (p<0.001 for all factors).

Composite measures for treatment engagement and support

As with the other measures of treatment, a composite scale was created for “engagement and support”, with a range from -22 to +22. Overall, a mean score of +12.8 was achieved, indicating that across the respondents there were generally positive views on treatment engagement and support.

- Although differences by ethnicity were not statistically significant, it is worth noting that Asian respondents reported the lowest level of satisfaction with treatment engagement and support (average score +8.8). They were followed by black respondents (average score +12), “other ethnic groups” (average score +12.7) and white respondents (average score +12.9). Mixed race respondents had the highest levels of satisfaction with an average score of +13.7
- There was a very strong link between satisfaction with support and care planning (F=36.304; p<0.001). The average score of those with a care plan was +13.7, in comparison with a score of +9.2 for those who did not have one
- There were significant differences between Tier 4 service types, with higher levels of satisfaction reported by respondents from residential rehabilitation services than those in inpatient units (average scores of +13.43 and +9.48 respectively; F=53.950; p<0.001)
- There were also significant differences between tiers, with respondents in the Tier 4 survey reporting a higher level of engagement and support than respondents in the Tier 2 and 3 survey (F=33.4; p<0.001).

Meeting diverse needs

The Tier 4 survey asked a number of questions relating to services’ abilities to meet the needs of diverse populations (ability to communicate with staff, contact with children, and practice of religion, diet and privacy, as well as workers’ experience of the range of drugs used).

As can be seen in Table 9, there was near universal general agreement that information – both verbal and written – is communicated clearly. Over four in five also agreed that workers had the experience to be able to treat all drugs and that their children were able to visit, while two in three agreed that they could practice their religion if and when required and that the food met requirements and restrictions.

Nearly three in five also felt that services provided privacy (58.6%) although a third (34.3%) felt that they did not.

There were no differences by gender to all but one question: women and those with dependent children were significantly more likely to agree that their children were able to visit them than men and respondents with no such dependent children (such as those

with children in the care of the local authority) ($F=20.73$; $p<0.001$; $F=64.64$; $p<0.001$).

Although there were generally good levels of agreement across all respondents to all these statements, there were also differences in the levels of satisfaction between the users of inpatient and residential services on all these factors (all <0.005) – with the exception of the question relating to privacy where no difference was reported.

Users of residential rehabilitation services had higher levels of agreement than those in inpatient services that drug workers in the service in which they were surveyed had experience in treatment for all the drugs they have used. They also had higher levels of agreement about their ability to practice their religion in the service, that the food took account of their needs and restrictions and that their children were able to visit them. They also reported higher levels of agreement with statements on understanding what the keyworker said to them and on understanding written information provided by the service.

Composite measures for diverse needs

As with the other measures, another composite scale can be created for “meeting diverse needs”, with a range of -14 to +14. The overall mean score was +7.3, indicating that by and large, respondents were satisfied that their services were able to cater for diverse needs.

At the composite level, users of residential rehabilitation services were significantly more likely to express higher levels of satisfaction with services meeting diverse needs than users of inpatient services ($F=25.08$; $p<0.001$).

The overall satisfaction measure

Throughout this report, reference has been made to overall satisfaction. This index of satisfaction was created by combining the three sub-scales for treatment impact, respect and support to create an overall measure of treatment satisfaction.

This overall satisfaction score does not include the diverse needs sub-scale, to allow for comparison with previous years and with the Tier 2 and 3 survey.

The scale for this measure ranges from -52 (strongly disagree with all positive statements and strongly agree with both negative statements) to +52 (strongly agree with all positive items and strongly disagree with both negative items). The composite satisfaction yielded an average score of +32.0.

- There were no significant differences by gender or age in the overall level of satisfaction of respondents, although respondents under the age of 25 years – and particularly under the age of 20 years – reported lower levels of satisfaction than their older peers
- There were some differences in reported overall satisfaction by ethnic group, although these differences were not statistically significant. Higher levels of satisfaction were reported by respondents from mixed race backgrounds (average score +33.0), white respondents (average score +32.5), black respondents (average score +32.1) and respondents from “other” ethnic groups (average score +31.1). As in many other areas in this survey, Asian respondents reported the lowest levels of satisfaction (average score +23.7)
- Significantly higher levels of overall satisfaction were reported by the users of Tier 4 services than the users of Tier 2 and 3 services (+32.0 compared with an average score for Tier 2 and 3 on the same questions of +27.2; $p<0.002$)
- A clear effect was found in relation to the type of Tier 4 service, with markedly higher levels of satisfaction reported by respondents in residential rehabilitation (average score +33.67) and supported housing services (average score +36.7) compared to those in inpatient services (average score +24.0) ($F=39.668$; $p<0.001$). As previously discussed, this data has to be interpreted with caution, as it was not comparing like with like and these are very different types of interventions
- Care planning had the strongest effect on the level of satisfaction. There was a clear effect in relation to care planning and overall satisfaction ($F=56.037$; $p<0.001$), with markedly lower levels of satisfaction reported by those who did not have a care plan (average score +23.5) and those who did not know if they had one (average score +24.9), than those who had a care plan (average score +34.7)
- Another highly significant factor relates to the provision of information. Service users who had the philosophy or method of the service explained to them before they entered the service were significantly more likely to be satisfied than those who had not (average scores of +33.73 and +23.15 respectively; $F=43.97$; $p<0.001$). Further analysis shows that this was the second strongest factor after care planning
- The third strongest factor driving satisfaction was choice. Respondents who had chosen the service from a range of options were significantly more likely to be more satisfied than those who had not (average scores of +34.74 and +27.87 respectively ($F=43.521$; $p<0.001$). Similarly, those who visited the service prior to admission were more satisfied than those who had not (with average scores of +34.61 and +29.41 respectively $F=26.20$; $p<0.001$)
- There was a strong link between overall satisfaction and the agreed duration of an individual's residential rehabilitation programme: the longer a respondent's agreed programme was, the more likely the respondent was to be satisfied. The overall composite satisfaction score showed that those whose programmes were due to last three months or less were significantly less satisfied (average score +30.7) than those

whose programmes were over three months (average score +35.3; $F=21.515$; $p<0.001$)

- A link also existed between overall satisfaction and the promptness of the allocation of a keyworker ($F=8.222$; $p<0.001$). Those who were allocated a keyworker at admission or within a week of admission were more satisfied than those who were allocated a keyworker at a later stage, and particularly more satisfied than those who reported not having a keyworker
- There was also a link between overall satisfaction and the availability to service users of drug workers in the community who were responsible for supporting them and co-ordinating their care after they leave the service ($F=5.035$; $p<0.01$). It is worthwhile noting that those who did not know whether such workers was in place reported the lowest levels of satisfaction
- When looking at the individual elements of this composite score, people reported higher levels of satisfaction with “treatment impact” if their programmes were due to last more than three months ($F=37.708$; $p<0.001$). They also reported higher levels of satisfaction in relation to “treatment support” ($F=8.652$; $p<0.005$). There were no significant differences in relation to “respect”, although those in programmes which were due to last more than three months also reported higher levels of satisfaction.

Conclusions

The NTA's 2007 service user satisfaction survey confirms many of the findings from the previous waves of the study. There was very strong evidence to suggest that service users were satisfied with Tier 4 services, with high levels of satisfaction in terms of treatment impact, respect, support and how services meet diverse needs.

- It is encouraging that individual demographic characteristics were not significant factors in determining satisfaction. Age, gender, sexuality and ethnicity did not have a statistically significant effect, although it should be noted that Asian service users were consistently less satisfied than others across a range of measures. This suggests a trend that could be addressed through the development of more culturally appropriate services
- However, significant differences in levels of satisfaction did exist. A driving force in high levels of satisfaction was that of good clinical practice. Service users with care plans, and those with care plans that had been reviewed recently, had higher levels of satisfaction overall and across all other domains
- Similarly, the prompt allocation of a keyworker soon after admission to a service was linked to better levels of satisfaction, as was the presence of an aftercare co-ordinator

- Residential rehabilitation clients were significantly more likely to have a higher level of overall satisfaction with their treatment than inpatient respondents. These differences must however be interpreted with caution – as previously stated, they may derive from the very different nature of these services and the fact that inpatient clients may be at a different stage of treatment (for example, often undergoing uncomfortable withdrawals) than those undertaking a programme of rehabilitation

The findings also provide some important benchmarks for Tier 4 treatment providers and commissioners. For example, it is good practice for service users in residential rehabilitation to be involved in the selection of their service, to visit it beforehand and to know what it will entail. There was also generally good adherence to key aspects of good practice as identified by Models of Care (NTA, 2006) and other guidance such as Good Practice in Care Planning (NTA, 2007). Keyworker allocation generally took place soon after entry into Tier 4 treatment and treatment was largely care planned and reviewed frequently

- Most respondents also reported having received a range of interventions, including group work, one-to-one keyworking, counselling and psychological therapies and relapse prevention
- There are, however, still opportunities for improvement. Relapse prevention in particular needs to be enhanced as substantial number of respondents – and those in inpatient services in particular – did not report having received this intervention
- The levels of overdose prevention should also be improved – as this is especially important following a period of abstinence when tolerance is low and the risks of overdose are heightened. This is particularly needed in inpatient units where it was reported by only a quarter of inpatient respondents, but also in residential rehabilitation services, where half the respondents did not report having received this intervention
- Similarly, there is a need to improve aftercare co-ordination especially for the users of residential rehabilitation services, suggesting improvements at the level of commissioning integrated treatment pathways. While four in five inpatient service users said that they had an aftercare co-ordinator, fewer than three in five residential rehabilitation service users did
- Finally, as with the Tier 2 and 3 survey, there is also a perceived need to improve levels of family and carer support across all Tier 4 services, a finding consistent to all the NTA user satisfaction surveys carried out over the last three years.

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Reader information

Document purpose	This survey provides an opportunity for Tier 4 drug treatment service users to give their views on quality of treatment. The data will also contribute to the 2007/08 NTA and Healthcare Commission Improvement Reviews, which contributes to the Treatment Effectiveness agenda.	Service user and carer groups. Commissioners of pharmaceutical enhanced services local pharmaceutical committees. Regional government department leads on drugs. Central government department leads on drugs.
Title	The 2007 User Satisfaction Survey of Tier 4 Service Users in England	The third annual England-wide survey of drug users in contact with treatment services, giving users the opportunity to give their views to the NTA.
Lead author	Dima Abdulrahim, Daniel Burn, Angela Campbell, Dawn Gordon and Oswin Baker	
Publication date	May 2008	
Target audience	Primarily providers and commissioners of drug treatment services in England and local authority commissioners, including community care managers. Drug treatment service users.	
Circulation list	Managers and commissioners of treatment services. Local authority commissioners, including community care managers. Co-ordinators and chairs of local partnerships (e.g. drug action teams and crime and disorder reduction partnerships).	
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