Service Users' Satisfaction and Outcomes Survey 2015:

A census of people accessing specialist alcohol and other drug services in the ACT

ATODA
Alcohol Tobacco & Other Drug Association ACT

ATODA Monograph Series

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Service Users' Satisfaction and Outcomes Survey 2015: A census of people accessing specialist alcohol and other drug services in the ACT

October 2016

ATODA

This monograph forms part of the Alcohol Tobacco and Other Drug Association ACT (ATODA) Monograph Series.

ATODA is the peak body for the alcohol, tobacco and other drug sector in the Australian Capital Territory (ACT). This includes both government and non-government services.

ATODA's vision is an ACT community and region with the lowest possible levels of alcohol, tobacco and other drug related harm, as a result of the alcohol, tobacco and other drug (and related) sectors' evidence-informed prevention, treatment and harm reduction policies and services.

ATODA works collaboratively to provide expertise and leadership in the areas of social policy, sector and workforce development, research, coordination, partnerships, communication, education, information and resources. ATODA is an evidence-informed organisation.

The ways ATODA works, and the outcomes it strives to achieve, reflect its commitment to the values of population health, human rights, social justice and reconciliation between Aboriginal and Torres Strait Islander people and other Australians.

ATODA strives to achieve better interaction and integration between alcohol, tobacco and other drug researchers, policy workers, practitioners, consumers and their friends and families in the ACT and region. ATODA hopes this will:

- Improve health and social outcomes for individual service users and their families
- Enhance research utilisation in policy development and its implementation and evaluation
- Mobilise and support knowledge transfer and exchange
- Support demonstration of research and service impact
- Improve the quality of the sector's practice and services
- Improve the health and wellbeing of our community.

ATODA has in-house—and a network of external—expertise in alcohol, tobacco and other drug research, policy, advocacy and capacity building, and a proven track record with engaging collaboratively and producing high-quality evidence-informed reports that provide practical expertise to inform policy and decision-making.

Monographs in the series are:

No 1. Reducing smoking in the ACT among Aboriginal and Torres Strait Islander women who are pregnant or who have young children.

No 2. ACT Alcohol, Tobacco and Other Drug Workforce Qualification and Remuneration Profile 2014.

No 3. Strengthening Specialist Alcohol and Other Drug Treatment and Support: Needs and Priorities for the ACT 2016–2017. An independent expert paper for the ACT Primary Health Network's Baseline Needs Assessment.

We hope this monograph contributes to the sector, and is a useful resource towards our shared goal of a healthy, strong and supported community.

Carrie Fowlie
Chief Executive Officer

Acknowledgements

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

We would like to thank the 469 service users of ACT specialist alcohol and other drug treatment and support services who participated in the 2015 Service Users' Satisfaction and Outcomes Survey (SUSOS), as well as the staff and Executive Directors who facilitated the implementation of the Survey in their services. The organisations that participated were:

- Alcohol and Drug Services (ADS), ACT Health
- Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)
- CatholicCare Canberra & Goulburn
- Directions
- Gugan Gulwan Youth Aboriginal Corporation
- Karralika Programs Inc
- Ted Noffs Foundation ACT
- The Salvation Army
- Toora Women Inc
- Winnunga Nimmityjah Aboriginal Health Service

In 2015, Executive Directors of ACT specialist alcohol and other drug (AOD) treatment and support services committed to working together on a Collective Impact and Evaluation Project (CIEP), and agreed to support the 2015 SUSOS as an activity of this broader project. The SUSOS contributes to the aims of the CIEP by:[a]

- Promoting better understanding of the outcomes and effectiveness of AOD treatment and support.
- Challenging community perceptions of the availability and achievements of AOD services and programs in the ACT.
- Consolidating an understanding by the AOD sector of the specialist and unique roles of these services in assisting and supporting ACT community members with AOD problems.

As a collective impact activity, funding for the implementation of the 2015 SUSOS was through a co-contribution from each ACT specialist AOD service, ACT Health and ATODA. ATODA acknowledges the support and input from the ACT specialist AOD services Executive Directors' Group for the 2015, and previous, Surveys.

ATODA would like to acknowledge the central role of David McDonald from Social Research & Evaluation Pty Ltd in the development, implementation, analysis and writing up of the previous Surveys (2009 and 2012), and in providing expert advice to the 2015 SUSOS implementation and analysis.

The design of this 2015 report is built upon the previous reports of the Service Users' Satisfaction Survey.[1, 2] Many sections of this report replicate and/or update text from the earlier 2009 and 2012 reports, and we acknowledge the original authorship of this text by David McDonald.

ATODA also acknowledges the significant contribution of the ACT peer-based consumer group (CAHMA) at each wave of the Survey, including managing the data collection in 2009. At each subsequent wave, consumer engagement (through CAHMA) has been central to receiving input into the questionnaire content (including the inclusion of new questions about consumer participation), and advice on the appropriate implementation of the Surveys (including setting reimbursement amounts).

[a] Further information about the Collective Impact and Evaluation Project can be found at www.atoda.org/collective-impact-and-evaluation-project/.

The Survey questionnaire was originally developed in 2009 for the first wave of the Service Users' Satisfaction Survey by David McDonald from Social Research & Evaluation Pty Ltd, with extensive support from Nicole Wiggins (CAHMA), Marty Owen (ACT Health), and Adam Winstock and Toby Lea (Sydney South West Area Health Services). The questionnaire incorporates the eight-item Client Satisfaction Questionnaire (CSQ-8)[©3] that has been used under license from the copyright owner, C. Clifford Attkisson PhD; his permission to do so is gratefully acknowledged.

In 2015, the implementation, analysis and write up of the SUSOS was coordinated by Anke van der Sterren, with data entry and analysis provided by Mathieu Leclerc. Other ATODA staff involved with the SUSOS were: Julie Robert, who assisted with the practical implementation of the Survey; and Carrie Fowlie, who provided input and support into all stages of the Survey development and analysis, as well as the dissemination of findings. ATODA also acknowledges the contributions of Amanda Bode and Kathy Sequoia to managing the implementation of the 2012 Survey.

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List of acronyms

ACT	Australian Capital Territory
ADS	Alcohol and Drug Services (ACT Health)
AMS	Aboriginal Medical Service
AOD	Alcohol and other drugs
ATOD	Alcohol, tobacco and other drugs
ATODA	Alcohol Tobacco and Other Drug Association ACT
CAHMA	Canberra Alliance for Harm Minimisation and Advocacy
NSP	Needle and Syringe Program
OTS	Opioid Treatment Services
PBS	Pharmaceutical Benefits Scheme
SUSOS	Service Users' Satisfaction and Outcomes Survey (2015)
SUSS	Service Users' Satisfaction Survey (2009 and 2012)

Executive Summary

A Service Users' Satisfaction and Outcomes Survey (SUSOS) was conducted across the ACT Health-funded and - delivered specialist alcohol and other drug organisations, both government and non-government, on a single day. It largely replicated the ACT Service Users' Satisfaction Surveys conducted in 2009 and 2012. This is a report on the findings of the 2015 Survey. It also provides comparisons between the three survey waves.

The 2015 SUSOS aims to investigate:

- service users' experiences of accessing ACT Health-funded and -delivered specialist AOD services
- service users' perspectives of the quality of these AOD services by assessing their levels and patterns of satisfaction
- self-reported outcomes as a result of utilising these AOD services.

Information from the Survey will inform quality improvement programs in the participating AOD services and broader service planning. The SUSOS also provides a profile of the population of services users accessing AOD treatment and support services in the ACT. Further, the Survey results from the three waves can be compared to investigate changes in satisfaction, service use experiences and outcomes over time.

Nineteen sites at all of the ten AOD specialist organisations in the ACT participated in the 2015 SUSOS, with 469 surveys returned. About 40% of survey participants came from two services— ACT Health's Alcohol and Drug Services (ADS) Opioid Treatment Services (OTS), and the Needle and Syringe Program in Civic (Directions). The high proportion of respondents from these two services should be borne in mind when interpreting the data.

Characteristics of service users

In the 2015 SUSOS, the following characteristics of the service users of AOD treatment services were noted:

- Two-thirds (65.8%) were male.
- The largest 10-year age group was the 30–39 year olds (30.3%), with three-quarters of respondents aged between 20–49 years old.
- About a quarter (25.1%) of respondents indicated that they were of Aboriginal and/or Torres Strait Islander descent; 19.4% of respondents who attended only mainstream AOD services identified as Aboriginal and/or Torres Strait Islander.
- Nearly three-quarters of the respondents (73.5%) stated that they were unemployed.
- Almost half (45.6%) of the surveyed population identified that they were either homeless or at risk of homelessness.
- 38% of respondents indicated that they are parents.

Socio-economic disadvantage is clearly a characteristic of the AOD service user population and has implications for AOD service delivery (particularly for the provision of ancillary services, such as housing support).

Eighty-two per cent of survey respondents reported being a smoker when they first entered or started using the service.

Overall satisfaction levels

The overall level of satisfaction was high, with 90.4% of Survey respondents stating that they were overall 'mostly satisfied' or 'very satisfied' with the service that they had received.

The scores obtained from a composite index of satisfaction, the Client Satisfaction Questionnaire (CSQ-8)©, in which the lowest possible level of satisfaction is scored 8 and the highest possible is scored 32, had a mean of 26.9, well above the mid-point of the scale of 20.

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

All organisations had relatively high satisfaction scores. The differences in these scores reflect, in part, the different types of service users, and the services provided, in the different organisations.

Across the entire surveyed population, high satisfaction scores were related to the following variables:

- Housing status, with respondents with no fixed abode having the lowest levels of satisfaction.
- Length of time attending the service, with new service users showing the lowest levels of satisfaction.
- Waiting times (both between first contact and assessment, and between assessment and commencing treatment), with service users who waited less than a week showing the highest levels of satisfaction, and those who waited for more than 3 months showing the lowest levels of satisfaction.
- The convenience of the services' location.
- The convenience of opening hours.
- Being aware that they had a case manager/key worker.
- Being aware that they had a care plan.
- Being asked to provide feedback on levels of satisfaction with the service or treatment received.
- Perceiving that the service welcomes and acts upon complaints and suggestions.
- Perceptions of being treated with respect by reception staff, doctors, other staff and other service users.
- Positive service user outcomes, with good outcomes on all variables being associated with high levels of satisfaction with the service.

Characteristics of service attendance

Over half of the respondents (56.4%) indicated that they had been attending the service for more than a year, with the frequency of attendance varying, most likely according to the service modality. Of service users attending service types that would be expected to offer a comprehensive assessment, 76% could recall having received one.

Waiting times between first contact with the organisation and completion of the assessment were generally short, with 57.3% of service users receiving their assessment within a week. Fifty-one per cent of respondents were waiting less than a week from assessment to commencing treatment. Of those service users who recalled receiving a comprehensive assessment, more than half reported waiting between two to five weeks between making first contact with the service and commencing treatment.

Accessibility of the services

Some 82% of respondents stated that the location of their service was convenient, and 77% indicated that the opening hours were convenient. Accessibility to information in an understandable form was also high (over 85% for all but one item, 'social media communications').

Case management, care plans and counseling

Over two-thirds of the respondents (67.7%) stated that they had a case manager/key worker and 51.4% stated that they had a care plan. Nearly one-third (28.8%) of respondents stated that they had requested counseling from the AOD service, and of all respondents, 45.8% stated that they had received counseling support from either within the service or by referral to another service.

Ancillary services

Most organisations provide some ancillary services, such as legal advice, debt management, etc.

The most frequently *requested* type of support was with respect to housing (24.1% of respondents), with 16.6% receiving such support within the service and 10.7% being referred out. 'Blood-borne virus information & support' was the most frequently *received* type of support *within the organisation* (29.0%).

Smoking cessation advice had been requested by 19.8% of respondents and 25.4% had received such advice from within the organisation, 7.7% had been referred to another organisation and 3% stated that they had requested smoking cessation advice but not received it.

Outcomes

The Survey assessed the self-reported service outcomes of the participating service users. High levels of positive outcomes (i.e. 'agreed' or 'strongly agreed' with the statements) were reported under each of the accepted primary objectives of AOD treatment:

- To reduce the client's level of substance use
  - Drug use has reduced—85.5%
- To reduce the client's experience of AOD-related harm
  - Less involved in crime—91.3%
  - Improved knowledge of prevention of blood borne virus transmission—84.9%
- To improve the client's health and wellbeing.
  - Improved general health—79.4%
  - Improved mental health—78.2%

Participating service users also reported high levels of positive outcomes (i.e. 'agreed' or 'strongly agreed' with the statements) for ancillary services that are beyond the direct remit of most AOD treatment services:

- Improved parenting and/or other relationships—69.5%
- Improved capacity to manage finances—64.3%
- Improved housing situation—60.9%
- Improved dental health—53.6%
- Improvements in employment situation—47.4%

Predictably, improvements in these and other treatment outcomes were associated with high levels of overall satisfaction.

Over half of the respondents reported having either quit smoking completely (16.2%) or reducing smoking (40.6%) since first entering or starting with the service.

Services' responsiveness and treatment of clients

Sixty per cent of respondents stated that they had been asked at some time to give comments on how satisfied or dissatisfied they were with the service or treatment they received. Overall, 66.5% felt that the service acts on suggestions and complaints.

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

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

Match between service and felt needs

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

Service user input into service operations

About one-third of respondents (33.7%) indicated that they would like a greater say in how the service operates through consumer representation either within or outside the service.

Other comments

Respondents provided a range of additional comments about their satisfaction with services and other services that they believe should be offered in the ACT but are currently unavailable. A large proportion of comments received were positive or neutral. The issues mentioned most often were in relation to opioid maintenance therapy, in particular the need for extended opening hours and for takeaway doses to be more easily available.

Comparisons between the three waves of the Survey (2009, 2012 and 2015)

The total numbers of respondents from all organisations has increased by 36% between 2012 (n=345) to 2015 (n=469); there was a 6% increase between 2009 (n=325) and 2012. The demographic characteristics of the respondents were broadly similar in the three waves of the Surveys (2009, 2012 and 2015) with respect to their age distributions, employment status, housing status and parenting status.

Overall satisfaction as measured using the Client Satisfaction Questionnaire (CSQ-8) component of the Survey showed a statistically significant increase in the mean score from 2009 to 2012, but no change between 2012 and 2015; that is, the difference between the CSQ-8 scores in 2012 (27.1) and 2015 (26.9) was not significant.

When asked 'In an overall, general sense, how satisfied are you with the service you have received?', similar proportions between the three waves indicated that they are 'mostly satisfied' or 'very satisfied' with the service they have received. Proportions were also similar from year to year for respondents who stated that they were likely to return to the service in the future if they needed help again. There was a statistically significant decrease between 2012 and 2015 in the proportions of respondents indicating that they had a lot of help sorting out their lives.

Fewer service users reported having received a comprehensive assessment in 2015 (55.3%) than in 2012 (62.4%). Of those having received a comprehensive assessment, waiting times between first contact with the service and assessment were the same for the Surveys in 2012 and 2015. Waiting times from assessment to commencing treatment have increased between these two survey years. Unlike in the 2012 Survey, in 2015 both waiting times periods (first contact to assessment, and assessment to treatment) were associated with satisfaction; those waiting shorter periods of time had higher satisfaction scores.

Similar proportions of respondents in the three waves of the Survey indicated that the locations of the services were satisfactory and that the services' opening hours were convenient to them. Likewise, the differences between the 2012 and 2015 surveys of respondents who indicated that they have a case manager/key worker and care plan were not statistically significant.

The top three most frequently requested and received (within the agency) type of ancillary service in both 2012 and 2015 were 'housing', 'dental health' and 'mental health' (although in differing orders). There were statistically significant increases between 2012 and 2015 for the proportions of respondents requesting smoking cessation advice from their service (from 13.0% to 19.8%), and for respondents being referred out for such support (3.5% in 2012, compared to 7.7% in 2015).

The proportions of respondents reporting improvements on the ten outcome measures decreased between 2012 and 2015 for all but one measure. These changes were not statistically different between 2012 and 2015 for half of the outcomes: involvement in crime; reduced drug use; knowledge of BBV transmission; mental health; and employment situation. Between 2012 and 2015, there was a statistically significant decrease in the proportions reporting improvements for the other outcome measures: general health; parenting and/or other relationships; capacity to manage finances; housing situation; and dental health. Questions about smoking status and changes in smoking behaviour were asked for the first time in 2015, and so can not be compared to the 2012 or 2009 Surveys.

While the proportion of respondents who reported having been asked to give comments on their level of satisfaction with the services they receive decreased between 2012 and 2015, the difference is not statistically significant. Similarly, the proportion agreeing that their service acts on suggestions and complaints decreased between 2012 and 2015, but this is not statistically significant.

The proportions of respondents who indicated being treated with respect by various people with whom they are in contact through their services remained stable across the three Surveys for doctors, other staff and other service users. There was no statistically significant change between 2012 and 2015 for caseworker/key workers, reception staff, pharmacists and other pharmacy staff.

For the ten questions that assessed the match between services delivered and felt needs, the proportions of service users that responded ‘agree’ or ‘strongly agree’ was over 80% for the top five needs for all of the three survey years: ‘the staff here are efficient at doing their job’; ‘you are satisfied with the services you receive here’; ‘this service meets your needs’; ‘you get enough personal support from the staff at this program’; and ‘the service is organised and well run’. The changes for these five needs are not statistically significant between 2012 and 2015.

There was no statistically significant difference between the proportions of respondents indicating that they ‘agree’ or ‘strongly agree’ with the statement ‘you have enough say in decisions about your service or treatment’ between 2012 and 2015. Other questions about service user input were asked for the first time in 2015, and so cannot be compared to previous Surveys.

Conclusions and recommendation

As with the previous satisfaction surveys in 2009 and 2012, the 2015 Service Users’ Satisfaction and Outcomes Survey has provided valuable information demonstrating the high overall level of service user satisfaction at the sector wide level, with significant variations on a service-by-service basis. This information provides opportunities for the participating organisations to review their strengths and build upon them, and to explore opportunities for service quality enhancement in areas where client satisfaction levels are relatively low.

The observation of an across-the-board stability in the level of satisfaction from 2012 to 2015 is encouraging. Despite an increase in demand for their services, AOD treatment organisations in the ACT are managing to provide services that service users rate highly in terms of satisfaction. In general, they are reporting positively on their experiences when accessing these services and on the outcomes achieved while using these services. However, the Survey data also provides information for participating services to further enhance aspects of their service delivery.

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

1. Introduction

The 2015 ACT Alcohol and Other Drug (AOD) Service Users' Satisfaction and Outcomes Survey (SUSOS) was conducted across specialist ACT alcohol and other drug (AOD) agencies, both government and non-government, on a single day. The 2015 Service Users' Satisfaction and Outcomes Survey (SUSOS) aims to investigate:

- service users' experiences of accessing ACT Health-funded and -delivered specialist AOD services
- service users' perspectives of the quality of these AOD services by assessing their levels and patterns of satisfaction
- self-reported outcomes as a result of utilising these AOD services.

Information from the survey will inform quality improvement programs in the participating AOD services and broader service planning.

Furthermore, the SUSOS also provides a profile of the population of services users accessing AOD treatment and support services in the ACT. This information supplements data obtained from other sources such as the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS) to describe the demographics and thereby the potential needs of the AOD treatment population.

The 2015 SUSOS builds on two earlier Service Users' Satisfaction Surveys (SUSS)[b] that were conducted across ACT AOD services, both government and non-government, in 2009 and 2012. The 2015 survey is a slightly revised version of the earlier surveys, incorporating questions that investigate outcomes-related information. However, as most of the questions are the same, the surveys can be compared across these years.

1.1 Background—assessing service users' satisfaction

Lee & Nowell (2015) have identified a number of perspectives for conceptualising performance measurement in non-profit organisations, such as AOD services. They describe two approaches to measuring outcomes: firstly, in terms of whether an organisation has achieved substantial behavioural and environmental changes in their target group; and secondly, through measuring the quality of the service by focusing on client/customer (or 'service user') satisfaction.[4]

The assessment of service user satisfaction is included as a core component of continuous quality improvement systems and standards, for example the Standards Australia ISO 9000 system. That body emphasises the need for service user ('customer') feedback to be 'relevant, reliable and representative' (p.1).[5]

Several national and jurisdictional standards and quality improvement frameworks for alcohol and drug services specifically include consumer participation. The 2004 Health and Community Service Standards, as they apply to alcohol and other drug (AOD) services, for example, include a consumer participation component whereby, "the organisation has strategies to canvass and act on the views of consumers who are currently or potentially involved in or affected by problematic alcohol and/or other drug use".[6]

The NSW Health *Guide to Consumer Participation in NSW Drug and Alcohol Services*[7] provides practical strategies to implement accreditation standards under the *National Safety and Quality in Health Care (NSQHC) Standards*.[8] These standards specify that consumers and/or carers should be involved in governance and quality improvement processes, and the guide proposes

[b] The title of the survey has been changed from the Service Users' Satisfaction Survey (SUSS) in 2009 and 2012 to the Service Users' Satisfaction and Outcomes Survey (SUSOS) in 2015. This change reflects the additional emphasis of the 2015 survey on outcomes from accessing AOD services.

consumer feedback surveys as one strategy to achieve this.

WANADA's *Standard On Culturally Secure Practice (Alcohol and other Drug Sector)*[9] includes service user satisfaction assessment under the heading 'Consumer focussed practice', specifically Standard 3.2: "Development, utilisation and review of a consumer needs and satisfaction survey tool and consultation processes". This is elaborated as: "The agency performs ongoing assessment of consumer needs and satisfaction, utilising feedback to review practice with an aim to improving outcomes". These are the details set out in that standard (p.4):

Essential criteria

a) The agency regularly assesses consumer satisfaction.
b) The agency seeks feedback from consumers on the appropriateness of the method used to assess consumer satisfaction.
c) Staff can describe strategies they implement to maximise consumer feedback.

Good practice criteria

d) Data collected on consumer satisfaction is regularly collated and compared with data previously collected.
e) Collated data sets on consumer satisfaction are used to inform the agency's planning process.
f) The agency provides staff and consumers with the results of collated consumer feedback.

A consortium of international agencies has published a workbook on 'Client Satisfaction Evaluations' in its *Evaluation of psychoactive substance use disorder treatment workbook series*[10]. The Workbook points out that service user satisfaction surveys can address (p.7):

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

Furthermore, organisations can use regular satisfaction assessment to improve outcomes for individual service users as well as to improve the operation of the agency as a whole. As the results of a recent study put it (p.150):[11]

> Treatment programs should consider administering [satisfaction assessment] to their patients at 3 months post-admission to identify patients with low satisfaction scores who may be at risk for prematurely leaving treatment… Measuring patient satisfaction during treatment may help programs meet patients' needs and improve retention.

Service user satisfaction can be used to predict retention in treatment,[12] which, in turn, can be used as a predictor of successful treatment outcomes.[13]

Service user satisfaction surveys have been used in a number of AOD settings throughout Australia. This includes a study of satisfaction levels and patterns among people receiving opioid substitution treatment at NSW community pharmacies[14] and through public clinics in that State.[15] The WA Drug and Alcohol Office conducted service user satisfaction surveys each year from 2007 to 2009 as part of its ongoing monitoring of the outpatient services and inpatient withdrawal treatment services provided through its Next Step Drug and Alcohol Services. The surveys "…offer clients an opportunity to comment on the services they have received and provide valuable feedback to the program areas to maintain and enhance client focused services" (p.i).[16]

While service user satisfaction surveys are utilised as a component of quality improvement processes, they should be interpreted cautiously as an indicator of service quality as these surveys may not necessarily reflect the priorities of service users, and may reflect unrealistic expectations. Service user satisfaction surveys in AOD settings are consistently skewed towards positive and high satisfaction scores.[17] A body of conceptual scholarship and empirical research suggests that "expectations emerge repeatedly as having a fundamental role in expressions of satisfaction" and that "as patient satisfaction is a recognised component of Quality Assurance..., it is therefore tempting to equate "high" levels of reported satisfaction with "high" levels of quality of care". It is, however, important not to use levels of service user satisfaction as a proxy for service quality as it taps a different construct.

NSW researchers have reflected on their experiences in assessing service user satisfaction, drawing attention to the fact that, in discussion, interviewees frequently expressed negative sentiments about their services but nonetheless recorded high satisfaction scores on the survey instrument.[15] The researchers concluded that: "Satisfaction is based on experience and expectation, and if poor service provision is all that a person has experienced then expectation will be low. So when a person then accesses a service that is deemed "better" than past experience it will score higher" (p. 4).

As part of a study of satisfaction among the service users of NSW methadone services, Whitney has documented how service user satisfaction can be conceptualised, and has reformulated thinking in this area.[19] She explains that "...clients are likely to be most satisfied with treatment when they know what to expect from it and it is highly probable or likely that their expectations are realised" (p. 46). Furthermore

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

The behavioural expressions to which Whitney refers include choosing not to participate in satisfaction surveys at all, or withdrawing from the service. This behaviour could reflect people who have low levels of satisfaction with treatment, and the views of people who have done this are, therefore, not captured in this type of service user survey.

By itself, evidence of positive service user satisfaction may not reflect the effectiveness or accessibility of AOD treatment. Service users may be satisfied with the way they are treated at the service even though this treatment is considered ineffective at improving AOD outcomes according to other objective measures. Conversely, a service may achieve positive AOD outcomes for the service user but the service user may report low levels of satisfaction because of the way they feel they have been treated.[10] Studies have also shown that satisfaction survey questions may not reflect, and may be inappropriate to service user experiences thereby eliciting less valid responses.[20, 21]

Other than the factors already discussed, service user responses to satisfaction surveys can also be affected by:

- Limitations derived from the user's dependent position in relation to AOD treatment services.[22]
- Social etiquette—whereby, service users are aware of the need to "maintain constructive social relationships with those caring for them" (p.11),[22] or wish to show appreciation for the efforts of staff doing the best they can with limited resources.[17]
- The positive perception of the service created by the extra attention from the data collection process and an interest in the opinion of the service user.[18]

Some studies have found that service users who are 'highly satisfied' on a basic measure of satisfaction actually report significant problems with their services when their satisfaction is more intensively examined using a mixed-methods approach (e.g. incorporating qualitative and quantitative methods).[17] Whitney has observed that, in satisfaction surveys "...when the context in which clients receive treatment is clarified, which usually occurs through the use of qualitative methods such as in-depth, open-ended interviews, more negative ratings of client satisfaction are often generated".[19] Open-ended questions that elicit responses about the experiences of service users with the service rather than simply the satisfaction rating can probably more accurately measure satisfaction.[17]

Evaluators have suggested that the use of multidimensional instruments, particularly those that incorporate factual measures and open-ended questions, can improve the validity and utility of service user satisfaction surveys. These surveys are more likely to provide information that can be useful in modifying specific elements or processes of the services to improve actual delivery of health care.[17] Multidimensional surveys include several components that correspond to differentiated dimensions of treatment satisfaction, rather than focusing on a single overall satisfaction factor. Factual questions are those that obtain data on objective experiences. For example: how often a treatment experience has occurred?; how long did a particular aspect of service delivery take?; did an aspect of treatment occur?

1.2 Methods

Following a meeting of the Drug Services Forum in September 2015 there was agreement to proceed with the Service Users' Satisfaction and Outcomes Survey (SUSOS) as part of the Collective Impact and Evaluation Project (CIEP).

All ACT Health-funded and -delivered specialist AOD services that have direct contact with service users agreed to participate in the 2015 SUSOS. ATODA liaised with Executive Directors of each service to nominate survey sites and representatives charged with implementing the SUSOS at each site. A total of 19 sites were identified across all ten ACT Health-funded and -delivered specialist organisations:[c]

- Alcohol and Drug Services, ACT Health
  - Counselling and Treatment Service
  - Opioid Treatment Services
  - Inpatient Withdrawal Unit
- Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)
- Sobering Up Shelter, CatholicCare Canberra & Goulburn
- Directions
  - Woden (Treatment and Support & Althea Wellness Centre)
  - Arcadia House
  - Needle and Syringe Program (NSP): Primary—Civic
- Drug and Alcohol Program, Gugan Gulwan Youth Aboriginal Corporation
- Karralika Programs Inc.
  - Karralika Therapeutic Community Adult Program
  - Nexus Program
- Ted Noffs Foundation ACT
  - Program for Adolescent Life Management (PALM)
  - Community Outreach Outclient Program (COOP) and Continuing Adolescent Life Management (CALM)
- Canberra Recovery Services, The Salvation Army
  - Bridge Program
  - Re-entry/Halfway House

[c] For a description of services available at each site, please see the ACT Alcohol, Tobacco and Other Drug Services Online Directory at www.directory.atoda.org.au.

- Toora Women Inc.
    - Lesley's Place Drug and Alcohol Residential and Outreach Service[d]
    - Marzenna Drug and Alcohol Residential Service[d]
    - WIREDD Day Program
- Alcohol, Tobacco and Other Drug Services, Winnunga Nimmityjah Aboriginal Health Service

In eight organisations, the Survey was conducted on Tuesday 8 December, and in one organisation it was conducted later that same week (as the service was not open on Tuesdays). For one of the Aboriginal and Torres Strait Islander organisations further time was required to negotiate issues around data collection, use and reporting; consequently, the Survey was implemented in this organisation at a later date, although still on a single day.

Questionnaires were delivered to each of the participating services before the Survey date and collected on the day following the Survey being administered. On the day of the Survey, each service user attending at each site was invited to participate in the SUSOS. They completed an anonymous and confidential survey that on completion was sealed in an envelope and placed in a sealed collection box. They were offered $20 in cash as reimbursement, as per the approval received from the ACT Health Human Research Ethics Committee (ETHLR.12.107).

Appendix A provides a detailed description of the methods used to implement the Survey.

ATODA will provide a poster and/or other material, in plain English, summarising the results of the Survey, for distribution through ACT specialist AOD services to their service users, to feed back to them the results of the Survey.

1.2.1 About the Survey instrument

The same core questionnaire was used for the 2009, 2012 and 2015 Surveys, and is based upon the instrument used by the UK National Treatment Agency for Substance Misuse (NTA) in its 2007 User Satisfaction Survey of Tier 2 and 3 Service Users in England and Wales, modified and expanded to meet local needs.[23] The NTA survey instrument includes multidimensional components and factual-type questions to assess various aspects of service experience.

Furthermore, embedded in the SUSOS is a validated instrument called the Client Satisfaction Questionnaire-8 (CSQ-8)©. This instrument, developed by a research team at the University of California San Francisco, produces a composite index of satisfaction derived from eight scale items. The psychometric properties of the CSQ-8 have been validated with a variety of different service user populations, including with people using AOD.[3, 24] As noted in the acknowledgments, the instrument was used under license from the copyright owner.[e]

This 2015 version of the SUSOS questionnaire received further input from Executive Directors (through the Executive Director's Group), and from the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA). Changes and additions to the 2015 questionnaire are listed in Appendix B.

The design of this report is informed, in part, by the NTA's 2007 summary report,[23] and builds upon earlier SUSS reports prepared for ATODA by David McDonald from Social Research & Evaluation Pty Ltd.[1, 2]

The Survey questionnaire received ethics approval from the ACT Health Human Research Ethics Committee (ETHLR.12.107), with amendments approved by the Low-Risk Sub-Committee on 3 December 2015.

[d] Toora Women Inc offers two programs that have both a residential and outreach component (Lesley's Place Drug and Alcohol Residential and Outreach Service, and Mazenna Drug and Alcohol Residential Service). In practice, the SUSOS was administered through the residential site of both of these Services, and separately at the outreach site of both Services.

[e] Because of the copyright and licensing agreement associated with the CSQ-8, the survey tool is not publicly available.

1.3 About the reporting of the data

Each question has been analysed based on the number of people who answered that particular question. That is, if service users did not answer or gave a contradictory or incoherent answer, they were not included in the calculation of that particular data item.

At some points in this report the levels of satisfaction with services as expressed by respondents are presented on an organisation-by-organisation basis. As the sample size at some of the service sites was small (most notably at the Sobering Up Shelter), some data should be interpreted cautiously. Furthermore, the high proportion of representation of service users attending two services—ACT Health's Alcohol and Drug Services, Opioid Treatment Services, and the Needle and Syringe Program in Civic operated by Directions—should also be borne in mind when interpreting the data.

In addition, comparisons should be used with caution owing to the presence of confounders, particularly the differences in types of services and service users in the different organisations. The key point is that the appropriate comparisons are not one organisation with another, but comparing each measure across the Survey years. This highlights the value of repeating the Survey at regular intervals, preferably every three years.

1.3.1 Statistical note

At various points in this report, statistics are provided that may not be familiar to some readers. These statistics tell the reader whether there is a real difference or change between two reported items. When the difference or change is 'not statistically significant', the difference or change can be by chance. A difference or change that is reported as 'statistically significant' has more than a 95% chance of being a real difference or change.

Statistics used include the 'F' statistic, used in one-way analyses of variance (ANOVA), and its related 'p' (or probability) values. The 'p' value indicates the probability of the observed relationships between variables having occurred by chance. 'P' values of less than (shown as <) 0.05 (5%) are conventionally considered to be statistically significant, i.e. the observed relationships are taken not to have occurred simply by chance. Although it is conventional to report both the 'F' and 'p' values (and this is done here), readers cannot directly interpret the 'F' values without recourse to statistical tables.

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

The chi-square test of independence was used to compare frequencies of nominal level data displayed in a cross-tabulation table, and z-tests were used to compare the significance of the difference between two independent proportions.

2. Results from the 2015 Service Users' Satisfaction and Outcomes Survey

2.1 Survey coverage and response

Nineteen different sites at ten organisations participated in the 2015 Service Users' Satisfaction and Outcomes Survey (SUSOS), with the number of questionnaires returned, by organisation and type of service, being shown in Table 1. This represents all of the specialist AOD treatment and support services in the ACT.

In all, 469 service users completed questionnaires. Almost one-quarter of respondents (23.9%) came from one service, ACT Health's Alcohol and Drug Services (ADS) Opioid Treatment Services (OTS), with a further 17% coming from the Needle and Syringe Program in Civic (Directions). In several places in this report, these two services have been singled out for data analysis due to the high proportions of respondents attending these services.

Each service was asked to note the number of service users who refused to participate in the Survey. Across all of the participating services, forty (40) service users were recorded as not wanting to fill out the questionnaire.

Table 1: Number of survey respondents and proportion of all respondents, by organisation and service type within the organisation

Organisation/service	Number of respondents	Proportion of all respondents (%)
Alcohol and Drug Services, ACT Health	**132**	**28.1**
Counselling and Treatment Service	15	3.2
Opioid Treatment Services	112	23.9
Inpatient Withdrawal Unit	5	1.1
CAHMA	**49**	**10.4**
Sobering Up Shelter, CatholicCare	**3**	**0.6**
Directions	**125**	**26.7**
Woden	41	8.7
Arcadia House	4	0.9
Needle and Syringe Program: Primary—Civic	80	17.1
Drug and Alcohol Program, Gugan Gulwan Youth Aboriginal Corporation	**13**	**2.8**
Karralika Programs Inc.	**35**	**7.5**
Karralika Therapeutic Community Adult Program	28	6.0
Nexus Program	7	1.5
Ted Noffs Foundation ACT	**36**	**7.7**
Program for Adolescent Life Management (PALM)	7	1.5
Community Outreach Outclient Program (COOP) and Continuing Adolescent Life Management (CALM)	29	6.2

Canberra Recovery Services, The Salvation Army	**38**	**8.1**
Bridge Program	27	5.8
Re-entry/Halfway House	11	2.3
Toora Women Inc.	**16**	**3.4**
Residential site (Lesley's Place & Marzenna)	8	1.7
Outreach Service site (Lesley's Place & Marzenna)	2	0.4
WIREDD Day Program	6	1.3
ATOD Services, Winnunga Nimmityjah Aboriginal Health Service	**22**	**4.7**
Total	**469**	**100.0**

2.2 Service users' characteristics

2.2.1 Gender and age

Of the 469 service users who completed the questionnaires, 65.8% were male, 34% female and 0.2% 'other'.

The ages of respondents ranged from 12 to 68 years, with a mean age of 36.6 years and a median (the point above and below which half the cases fell) of 37 years. The largest 10–year age group was the 30-39 year olds (30.3% of the total), followed by 40–49 year olds (24.9%), 20-29 year olds (18.7%), 50–59 year olds (14.0%), 12–19 year olds (10.1%) and 60+ year olds (1.9%).

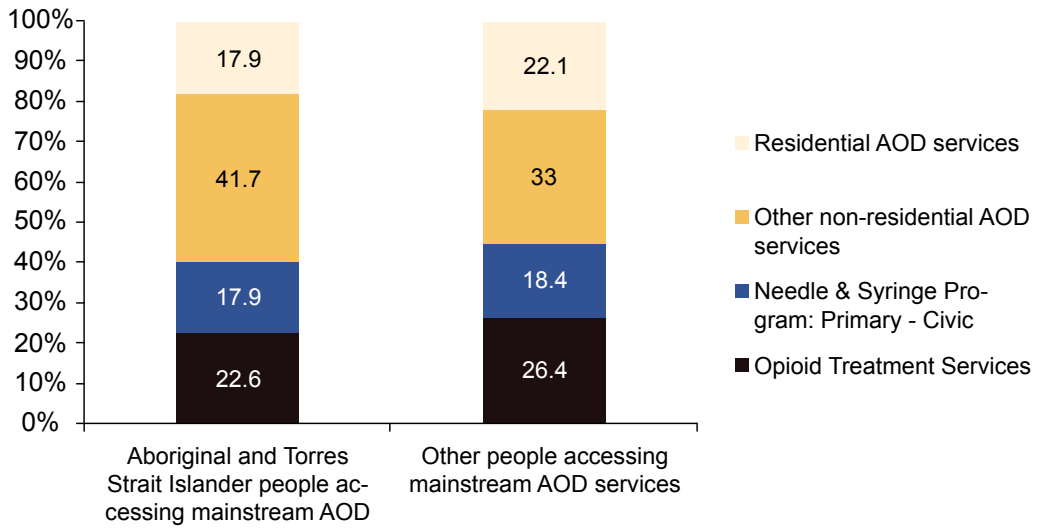
2.2.2 Aboriginal and/or Torres Strait Islander status

The respondents included 117 people (25.1%) who indicated that they were of Aboriginal and/or Torres Strait Islander descent.

When considering only the service users accessing mainstream AOD services[f] on the census date, 19.4% of respondents identified as Aboriginal and/or Torres Strait Islander people. As seen in Figure 1, of Aboriginal and Torres Strait Islander people accessing these mainstream services on the census date, 22.6% were accessing the ADS Opioid Treatment Services, and 17.9% were accessing the Needle and Syringe Program:Primary—Civic. This is comparable to the proportion of other people at mainstream services accessing the Opioid Treatment Services (26.4%) or the Needle and Syringe Program:Primary—Civic (18.4%).

[f] The term 'mainstream services' refers to services that are not Aboriginal and Torres Strait Islander community-controlled organisations, and so do not have Aboriginal and Torres Strait Islander governance structures.

Figure 1: Proportions of respondents attending mainstream specialist AOD treatment and support services in the ACT, by Aboriginal and/or Torres Strait Islander status



2.2.3 Employment

Nearly three-quarters of the respondents (73.5%) stated that they were unemployed, with 11.9% employed full-time and 8.7% employed part-time. An additional 5.8% stated that they engaged in unpaid or voluntary work.

At the time of the Survey, 16.2% were studying—11.2% part-time and 5.0% full-time.

2.2.4 Housing situation

As seen in Table 2, almost half of the respondents (45.6%) had unstable housing, with 15.9% currently living in a residential treatment program, 11.1% being in other types of temporary accommodation, and 18.6% with no fixed place of living. Just over half (54.4%) were in settled, permanent housing.

Table 2: Current housing situation of respondents

Housing situation	Number of respondents	Proportion of respondents (%)
Settled/permanent accommodation	246	54.4
Residential treatment program	72	15.9
Other temporary accommodation	50	11.1
No fixed place of living	84	18.6
Total	**452**	**100.0**

2.2.5 Parental/caring situation

Almost 38% of respondents indicated that they are parents: 17.1% of all respondents were the parent or carer of children under 16 years of age, where the children were living with the respondent; and 27.4% were the parent of a child under 16 years who did not live with the respondent. Some respondents were parents in both categories.

2.3 Overall satisfaction

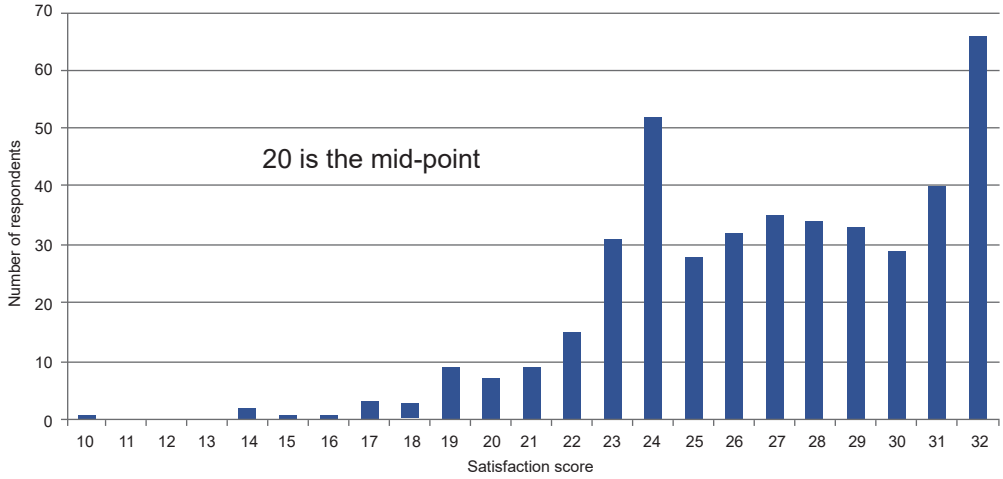
Overall satisfaction was measured using a validated composite index from eight scale items, the Client Satisfaction Questionnaire (CSQ-8)©. The CSQ-8 scores reported here are only for the 431 'valid' responses; that is, people who answered all eight of the questions related to the scale. Furthermore, this means that relationships between CSQ-8 scores (satisfaction levels) and other variables (e.g. characteristics of service attendance, accessibility, etc) only use data from these 431 respondents. Anyone who did not respond to one or more of the eight CSQ-8 questions was excluded from these analyses.

The CSQ-8 responses are summarised in Table 3. Possible values range from 8 (the lowest possible level of satisfaction) to 32 (the highest possible level of satisfaction). The mid-point of the 8–32 range is 20. The modal (the most frequent) score in the 2015 SUSOS was 32. This is also the highest possible score and was provided by 15.3% of respondents. The lowest score was 10. The mean (average) score was 26.9 and the median was 27; so half of respondents scored below 27 and half above. The distribution of scores is illustrated in Figure 2, below.

Table 3: Overall satisfaction scores (CSQ–8)—numbers and proportions of respondents indicating each satisfaction score (low scores correspond to low satisfaction; high scores correspond to high satisfaction)

Satisfaction score	Number of respondents	Proportion of respondents (%)
10	1	0.2
14	2	0.5
15	1	0.2
16	1	0.2
17	3	0.7
18	3	0.7
19	9	2.1
20	7	1.6
21	9	2.1
22	15	3.5
23	31	7.2
24	52	12.1
25	28	6.5
26	32	7.4
27	35	8.1
28	34	7.9
29	33	7.7
30	29	6.7
31	40	9.3
32	66	15.3

Figure 2: Overall satisfaction scores (CSQ-8) - numbers of respondents indicating each satisfaction score (low scores correspond to low satisfaction; high scores correspond to high satisfaction)



Respondents were asked as part of the CSQ-8 questions, 'In an overall, general sense, how satisfied are you with the service you have received?'. A high level of satisfaction was reported, with 90.4% of those who answered the question stating that they were 'mostly satisfied' or 'very satisfied' (see details in Table 4).

Table 4: Responses by service users to the question: "In an overall, general sense, how satisfied are you with the service you have received?" *

Response	Number of respondents	Proportion of respondents (%)
Very satisfied	193	43.0
Mostly satisfied	213	47.4
Indifferently/mildly dissatisfied	26	5.8
Quite dissatisfied	17	3.8
Total	**449**	**100.0**

*Includes all respondents who answered this question, even if they did not produce a valid CSQ-8 score (i.e. even if they did not answer all eight CSQ-8 questions).

When asked 'If you were to seek help again, would you come back to this service?', 93.1% replied in the affirmative (see Table 5).

Table 5: Responses by service users to the question: "If you were to seek help again, would you come back to this service?"*

Response	Number of respondents	Proportion of respondents (%)
Yes, definitely	245	54.2
Yes, generally	176	38.9
No, not really	26	5.8
No, definitely not	5	1.1
Total	**452**	**100.0**

* Includes all respondents who answered this question, even if they did not produce a valid CSQ-8 score (i.e. even if they did not answer all eight CSQ-8 questions).

When asked to respond to the statement 'You have received a lot of help in sorting out your life'[g], 78.2% of those who felt this question was applicable to them replied that they 'strongly agree' or 'agree' (see Table 6). As one would expect, this variable predicts levels of satisfaction with the service (chi square=101.046, p<0.00).

Table 6: Responses by service users to the statement: "You have received a lot of help in sorting out your life"

Response	Number of respondents	Proportion of respondents (%)
Strongly agre	145	35.1
Agree	178	43.1
Don't know	51	12.3
Disagree	32	7.7
Strongly disagree	7	1.7
Total	**413**	**100.0**

2.3.1 Satisfaction score by organisation and service

There were overall statistically significant differences in CSQ satisfaction scores between the participating organisations (F=2.321, p=0.015). Table 7 reports the mean (average) CSQ-8 scores for each organisation.

[g] This question is not part of the CSQ-8 score.

Table 7: Mean CSQ-8 satisfaction scores, based on valid responses from each organisation

Organisation	Number of valid responses	Mean CSQ-8 Score
Alcohol and Drug Services, ACT Health[h]	123	26.6
CAHMA	43	26.9
Sobering Up Shelter, CatholicCare Canberra & Goulburn[i]	2	22.5
Directions[j]	114	26.8
Drug and Alcohol Program, Gugan Gulwan Youth Aboriginal Corporation	13	25.3
Karralika Programs Inc.	35	28.1
Ted Noffs Foundation ACT	32	25.8
Canberra Recovery Services, The Salvation Army	36	28.0
Toora Women Inc.	14	29.4
ATOD Services, Winnunga Nimmityjah Aboriginal Health Service	19	25.7
All organisations combined	**431**	**26.9**

Since the largest numbers of respondents came from the ADS Opioid Treatment Service and the Needle and Syringe Program (Primary—Civic) (see Table 1), special attention is drawn to their scores as they impact significantly on the overall average, as well as the scores for their organisations (see footnotes h and j). As seen in Table 8, the mean CSQ-8 scores of respondents from the Opioid Treatment Services and Needle and Syringe Program were 26.2 and 26.1 respectively. This compares to a mean score for the other services combined of 27.4. This is a statistically significant difference, although only just. This tells us that service users attending the Opioid Treatment Services or the Needle and Syringe Program (Primary—Civic) have slightly lower levels of satisfaction than the service users of other services, although scores of 26.1 and 26.2 still represent a relatively high level of satisfaction (considering that CSQ-8 scores can range from 8 to 32).

[h] A large proportion of survey participants from the Alcohol and Drug Services (ADS), ACT Health attended the Opioid Treatment Services. Of valid CSQ-8 scores, 106 of 123 (86.2%) respondents from the ADS were attending the Opioid Treatment Services, thereby making up a large proportion of the overall ADS satisfaction score. When these respondents are excluded, the mean combined satisfaction score (CSQ-8) for the other ADS services (Counselling and Treatment Services and Impatient Withdrawal Unit) is 29.1.

[i] The satisfaction score recorded at the Sobering Up Shelter should be interpreted cautiously as it is only based on two responses.

[j] Similar to footnote h, a large number of survey participants from Directions attended the primary Needle and Syringe Program - Civic. Of valid CSQ-8 scores, 72 of 114 (63.2%) respondents from Directions were attending the Needle and Syringe Program - Civic, thereby making up a large proportion of the overall Directions satisfaction score. When these respondents are excluded, the mean combined satisfaction score (CSQ-8) for the other Directions services (Arcadia House and Woden) is 28.1.

Table 8: Comparison of mean CSQ-8 satisfaction scores in the Opioid Treatment Services and the Needle and Syringe Program (Primary—Civic) to all other services combined

Service site	Number of valid responses	Mean CSQ-8 score
Opioid Treatment Services	106	26.2
Needle and Syringe Program (Primary — Civic)	72	26.1
All other services combined	253	27.4
All organisations combined	**431**	**26.9**

2.3.2 Respondents' characteristics and level of satisfaction

Gender was not related to level of satisfaction with services; that is, female and male respondents had similar CSQ-8 satisfaction scores. In addition, Aboriginal and/or Torres Strait Islander status and employment status were not related to satisfaction level.

In contrast, housing status was related to level of satisfaction with respondents having 'no fixed place of living' reporting the lowest satisfaction levels. Respondents in temporary accommodation (including those living in 'residential treatment programs' and those in 'other temporary accommodation') had the highest satisfaction scores, followed by those in 'settled/ permanent accommodation' ($F=4.724$, $p=0.003$).

2.4 Characteristics of service attendance

The Survey asked service users about the length of time that they had been attending their service, the frequency of attending, and the waiting times that they had experienced.

2.4.1 Length of time attending the service

Service users were asked 'How long have you been coming to this service?'. As shown in Table 9, the length of time reported ranged from one week or less (9.4% of respondents) to more than one year (56.4%).

Table 9: Responses by service users to the question: "How long have you been coming to this service?"

Length of time	Number of respondents	Proportion of respondents (%)
1 week or less	44	9.4
1 – 4 weeks	22	4.7
1 – 3 months	49	10.5
4 – 6 months	52	11.2
7 – 12 months	36	7.7
More than 1 year	263	56.4
Total	**466**	**100**

Service users who had been attending for between 7 and 12 months had the highest overall satisfaction scores (mean CSQ-8 of 27.8), though the differences in scores by length of time were not statistically significant. The lowest satisfaction was recorded among the newest service users, i.e. those having attended for one week or less (mean CSQ-8 score of 25.6).

2.4.2 Frequency of attending

The frequency of attending non-residential services, detailed in Table 10, varied markedly, presumably reflecting the service modality. Daily attendance was recorded by 105 respondents (23.4%), but most of these (86 out of the 105 respondents, or 82%) were service users of the Opioid Treatment Services at the ADS. More than half of the service users of the Needle and Syringe Program (Primary—Civic) (56%) were attending either 2–4 times per week or weekly. Of respondents attending non-residential services other than the Opioid Treatment Services or the Needle and Syringe Program, the largest proportion (47.4%) were attending 2–4 times weekly or weekly.

The relationship between this variable and overall satisfaction (CSQ-8 scores) was not statistically significant.

Table 10: Frequency of attending a non-residential service

Frequency	Number of respondents	Proportion of respondents (%)
Daily	105	29.6
5 – 6 times a week	10	2.8
2 – 4 times a week	59	16.6
Weekly	74	20.9
2 – 3 times a month	39	11.0
Monthly	28	7.9
Less than monthly	40	11.3
Total	**355**	**100.0**

2.4.3 Waiting times

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

As shown in Table 11, more than half of the respondents (55.3%) stated that they had received a comprehensive assessment from the service for their alcohol and other drug-related needs. A substantial proportion (18.1%) did not know if this had happened or not. It should be noted that not all service types need to provide a comprehensive assessment as part of their service, which could explain the large number of 'No' answers to this question. When services that would not be expected to offer a comprehensive assessment were excluded from the analysis (for example, harm reduction services), the proportion of respondents stating that they had not received a comprehensive assessment was 10.4%, and the proportion stating that they 'don't know' was 13.7%. Therefore, of service users attending service types that would be expected to offer a comprehensive assessment, 76% could recall having received one.

Table 11: Service users receiving a comprehensive assessment at all ACT specialist AOD treatment and support services

Received a comprehensive assessment	Number of respondents	Proportion of respondents (%)
Yes	257	55.3
No	124	26.7
Don't know	84	18.1
Total	**465**	**100**

Of those who had received a comprehensive assessment (n=257) and who felt the question applied to them, waiting times between first contact with the organisation and completion of the assessment were generally short, with 57.3% of service users to whom this applied receiving their assessment within a week, and 91.1% within a month.

The waiting times from assessment to commencing treatment were slightly longer, with 51.1% waiting less than a week and 81.9% less than one month; around 18% of respondents had waited more than one month between assessment and commencing treatment.

About one-third (33.1%) of those who had received a comprehensive assessment (n=257) waited less than two weeks between making first contact and commencing treatment. A further 26% waited between 2–5 weeks.

Waiting times were related to level of satisfaction measured by the CSQ-8. The CSQ-8 scores yielded were significantly different in relation to the length of time waited until both receiving an assessment ($F=5.186$; $p=0.002$) and the beginning of the treatment ($F=3.904$; $p=0.010$). In both cases, the individuals who waited less than a week showed the highest CSQ-8 scores while the individuals who waited more than 3 months showed the lowest scores.

2.5 Accessibility

Service accessibility can be operationalised in terms of the location of services, their opening hours and respondents' access to information. All three were assessed in the 2015 SUSOS.

2.5.1 Location

Service users were presented with the statement, 'This service location is convenient for you', and were asked to indicate their level of agreement or disagreement with the statement. As seen in Table 12, 82.0% 'agreed' or 'strongly agreed' that the service location was convenient. As one would expect, this variable was a predictor of the satisfaction scores, with respondents stating that they 'strongly agree' that the location is convenient having the highest satisfaction scores. Those who answered 'don't know' to the question had the lowest scores ($F=28.489$, $p<0.00$).

Table 12: Responses by service users to the statement “Service location is convenient”

Service location is convenient	Number of respondents	Proportion of respondents (%)
Strongly agree	154	36.0
Agree	197	46.0
Don't know	31	7.2
Disagree	41	9.6
Strongly disagree	5	1.2
Total	**428**	**100**

2.5.2 Convenience of opening hours

Participants were asked ‘Does this organisation provide the services you want at hours that are convenient to you?’, and 77.0% responded in the affirmative.

Differences existed on an organisation-by-organisation basis, as shown in Table 13. The opening hours were more likely to be identified as inconvenient at the ADS (27.3%), with the majority of these being service users of the Opioid Treatment Services. Of service users attending the Opioid Treatment Services 30.6% identified the opening hours as inconvenient. Of those attending the Needle and Syringe Program, only 6.6% felt that the opening hours were inconvenient.

The perceptions of the convenience of organisations’ opening hours did not differ significantly between service users who were employed full-time, employed part-time, unemployed or doing unpaid/voluntary work (Chi-square = 10.128, df 6, p=0.119).

Across all services, the convenience of opening hours predicted significantly higher CSQ-8 satisfaction scores (F=41.587, p<0.00).

Table 13: Convenience of opening hours by organisation

Organisation	Opening hours are convenient				
	Yes (%)	No (%)	Don’t know (%)	Total (number)	Total (%)
Alcohol and Drug Services, ACT Health	68.8	27.3	3.9	128	100.0
CAHMA	85.4	2.1	12.5	48	100.0
Sobering Up Shelter, CatholicCare Canberra & Goulburn	100.0	0	0	3	100.0
Directions	78.5	5.8	15.7	121	100.0
Drug and Alcohol Program, Gugan Gulwan Youth Aboriginal Corporation	84.6	7.7	7.7	13	100.0
Karralika Programs Inc.	82.9	8.6	8.6	35	100.0

Ted Noffs Foundation ACT	62.9	2.9	34.3	35	100.0
Canberra Recovery Services, The Salvation Army	86.8	2.6	10.5	38	100.0
Toora Women Inc.	93.3	0	6.7	15	100.0
ATOD Services, Winnunga Nimmityjah Aboriginal Health Service	76.2	9.5	14.3	21	100.0
Total	**77.0**	**11.2**	**11.8**	**457**	**100.0**

2.5.3 Accessibility to information

The availability of information in an understandable form is another component of service accessibility. Overall, the Survey respondents largely agreed with the statement that 'I understand what is being said to me in this service'. They stated that they understood most of what was being said to them by their caseworkers/key workers (93.4%), by the reception staff at their organisations (92.7%), and thirdly by doctors (88.4%). With regard to written sources of information, 85.9% agreed that they understood the information in leaflets and flyers, and 85.8% in letters. Regarding communication via social media, 78.7% agreed that they understood the information but a large proportion of the total sample (22.1%) reported that this form of communication is irrelevant to them. Table 14 has details.

Table 14: Level of agreement with the statement, "I understand what is being said to me in this service", by information source

Information source	Strongly agree	Agree	Don't know	Disagree	Strongly disagree	Total
By my caseworker/key worker	51.1	42.2	5.3	1.0	0.3	100.0
By reception staff	44.5	48.2	6.1	0.7	0.5	100.0
By doctors	44.1	44.3	7.4	4.0	0.3	100.0
In leaflets or flyers	41.4	44.5	10.5	3.3	0.3	100.0
In letters	42.0	43.8	10.0	3.1	1.0	100.0
In social media communications	39.5	39.2	15.6	4.3	1.4	100.0

2.6 Case managers, care plans and counselling

2.6.1 Case managers

When asked the question, 'Do you have a case manager/key worker assisting you to receive your drug and alcohol related services?', about one-fifth (20.6%) of the total respondents answered that this was not applicable to them. Of the remaining respondents (n=368), two-thirds (67.7%) stated that they had a case manager/key worker, and 11.1% did not know. Table 15 has details. Having a case manager/key worker was related to high satisfaction scores ($F=15.090$, $p<0.000$).

Table 15: Service users reporting that they have a case manager/key worker

Have a case manager/key worker	Number of respondents	Proportion of respondents (%)
Yes	249	67.7
No	78	21.2
Don't know	41	11.1
Total	**368**	**100**

2.6.2 Care plans

When asked 'Do you have a care plan for your drug or alcohol needs?' about one-fifth (22.1%) of the total respondents answered that this was not applicable to them. Of the remaining respondents who felt that this question was applicable to them (n=364), 51.4% stated that they had a care plan, 25.8% said they did not, and 22.8% said that they did not know, as shown in Table 16. Having a care plan was also related to level of satisfaction ($F=16.9$, $p<0.00$).

Table 16: Service users reporting that they have a care plan

Received a care plan	Number of respondents	Proportion of respondents (%)
Yes	187	51.4
No	94	25.8
Don't know	83	22.8
Total	**364**	**100.0**

2.6.3 Counselling

Respondents were asked whether they had requested or received 'counselling' (either within the service or referred to another service). The question did not specify what type of counselling was requested or received (i.e. was it specialist AOD counselling, or some other type of counselling, e.g. trauma counselling).

Nearly thirty per cent (28.8%) of all respondents stated that they had requested counselling from the AOD service they were accessing. Of *all* respondents, 35.4% stated that they had received counselling from within the agency, and 10.4% responded that they had been referred out to another service for counselling.

2.7 Ancillary services

Most organisations provide some services that are ancillary to their core services, such as referral to legal advice, debt management, etc. Information on fifteen ancillary services are reported from the Survey; Table 17 has details. Respondents were asked:

- If they had *requested* the particular type of support from the service.
- If they had *received* it within the service.
- If they had been *referred* to another service for the support.
- If they had requested the particular type of support from their service but *had not received* it.

It is important to note that these categories are not mutually exclusive; multiple responses are possible, so the percentages for each ancillary service do not add up to 100%.

The most frequently *requested* type of support was with respect to housing (24.1% of respondents), with 16.6% receiving such support within the service and 10.7% being referred out. 'Blood-borne virus information & support' was the most frequently *received* type of support *within the organisation* (29.0%), followed by 'smoking cessation advice or support' (25.4%). Among *referrals* out to other services, mental health support was most frequent (11.7% of respondents). Only small proportions reported *requesting services but not receiving them*. In this category, support with housing had the highest frequency (4.5%). It should be noted that, for most types of ancillary services, the proportion of respondents receiving the service within their organisation was higher than the proportion requesting it.

Table 17: Ancillary services requested and received (proportion of all respondents, n=469; multiple responses possible)

Type of service/support	Requested	Received within agency	Referred out	Requested but not received
Housing	24.1	16.6	10.7	4.5
Dental Health	22.0	21.5	11.3	3.8
Mental Health	21.7	23.2	11.7	2.1
Centrelink or related payments	21.7	22.8	9.2	2.8
Other general health services	20.5	23.0	11.3	2.3
Smoking cessation advice or support	19.8	25.4	7.7	3.0
BBV information & support	17.7	29.0	7.5	2.6
Employment/skills training	17.7	15.4	9.2	1.9
BBV screening	17.5	20.5	9.4	2.8
Education	14.9	17.3	6.6	3.2
Parenting/relationships	14.7	18.8	7.7	3.2
Legal advice	14.3	14.1	11.1	2.8
Family concerns, incl. family violence	12.4	17.3	7.7	3.2
Debt management	12.2	12.2	8.3	4.1
Sexual health	11.1	14.3	6.4	3.2

It is now generally accepted that organisations providing AOD treatment and harm reduction services should actively promote smoking cessation among their service users and staff[25]. In this survey, 19.8% of respondents stated that they had requested smoking cessation advice, 25.4% had received it within their organisation, 7.7% had been referred to another organisation for such advice, and 3% stated that they had requested it but not received it (see also Section 2.8.1).

2.8 Outcomes

Outcomes were assessed in 10 domains, as detailed in Table 18. The table excludes responses where the service users classified the question as not being applicable to them, e.g. NSP service users would not necessarily expect to have reduced their drug use since commencing use of the service.

The most frequently reported positive outcome was with respect to involvement in crime, with 91.3% of service users to whom the question applied stating that they 'agree' or 'strongly agree' with the statement that, 'since starting to receive this service, I am less involved in crime'.

This was followed in frequency by: reduced levels of drug use (85.5%); improved knowledge of BBV transmission prevention (84.9%); improved general health (79.4%); improved mental health (78.2%); improved parenting/relationships (69.5%); improved capacity to manage finances (64.3%); improved housing (60.9%); improved dental health (53.6%); and finally improvements in their employment situation (47.4%).

Table 18: Self-reported outcomes of treatment at their AOD service ('not applicable' responses removed)

Outcomes: "Since starting to receive this service..."	Strongly agree	Agree	Don't know	Disagree	Strongly disagree	Total
You are less involved in crime	58.4	32.9	3.5	3.8	1.4	100.0
Your drug use has reduced	48.5	37.0	6.8	6.0	1.8	100.0
Your knowledge of preventing transmission of blood borne viruses has improved	44.1	40.8	8.3	4.7	2.2	100.0
Your general health has improved	39.6	39.8	12.5	6.2	1.9	100.0
Your mental health has improved	36.7	41.5	14.8	5.3	1.7	100.0
Your family parenting and/or other relationships have improved	30.0	39.5	15.1	10.9	4.5	100.0
Your capacity to manage your finances has improved	29.2	35.1	20.4	11.2	4.1	100.0
Your housing situation has improved	27.9	33.0	11.8	17.9	9.4	100.0
Your dental health has improved	27.5	26.1	19.2	19.4	7.8	100.0
Your employment situation has improved	19.6	27.8	19.6	24.7	8.2	100.0

On all of these outcome variables, the level of agreement with the statements is positively associated with CSQ-8 satisfaction scores, i.e. reported good outcomes are associated with high levels of satisfaction with the service.

2.8.1 Smoking status and outcomes

Service users were asked about their smoking status when they first entered or started using this service. Of those who responded to the question, 81.9% identified themselves as 'a smoker', and 14.5% responded 'no'. Of those who responded that they were smokers when they started

using the service, two-thirds (66.1%) were male, one-third (33.1%) were aged between 30–39 years old, and three-quarters (73.4%) were unemployed.

Service users were asked about their change in smoking behaviour. Of those who felt this question was relevant to them, 16.2% responded that "I have quit smoking completely" and 40.6% responded that they smoke less; other responses are reported in Table 19.

Table 19: Change in smoking behaviour since first entering or starting to use the service

Change in smoking behaviour	Number of respondents	Proportion of respondents (%)
I have quit smoking completely	63	16.2
I smoke *less* now than when I first entered or started using this service	158	40.6
I smoke *about the same* amount now as when I first entered or started using this service	136	35.0
I smoke *more* now than when I first entered or started using this service	32	8.2
Total	**464**	**100**

2.9 Services' responsiveness

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

2.9.1 Asked to give comments

Service users were asked, 'Have you ever been asked by this service to give comments on how satisfied or dissatisfied you are with the service or treatment you receive?'. Of those who knew whether they had been asked or not (i.e. excluding the 'don't know' responses), more than half (59.6%) responded that they had been asked to give comments, while 40.4% responded negatively (see Table 20). Respondents who indicated that they had been asked to comment were significantly more likely to be satisfied with the service ($F=13.359$, $p<0.00$).

Table 20: Service users reporting that they have been asked to give comments on how satisfied or dissatisfied they are with the service or treatment they receive

Asked to give comments	Number of respondents	Proportion of respondents (%)
Yes	215	47.3
No	146	32.1
Don't know	94	20.7
Total	**455**	**100.0**

2.9.2 The service acts on suggestions and complaints

When presented with the statement that the 'Service acts on suggestions and complaints', 66.5% of those who felt that this question was applicable to them indicated that they 'strongly agree' or 'agree' with the statement. Only 6.5% felt that their service does not act on suggestions and complaints. Table 21 has details.

Table 21: Service users reporting that the service acts on suggestions and complaints

Service acts on suggestions and complaints	Number of respondents	Proportion of respondents (%)
Strongly agree	93	23.4
Agree	171	43.1
Don't know	107	27.0
Disagree	22	5.5
Strongly disagree	4	1.0
Total	**397**	**100.0**

Again, a statistically significant relationship exists between this variable and service satisfaction ($F=36.803$, $p<0.00$). The distribution of responses between organisations was broadly similar.

2.10 How the service users feel they are treated

The Survey ascertained service users' perceptions of how they are treated by the various people they are in contact with at their services, including staff and other service users. Details are in Table 22. High proportions reported being treated with respect by all categories of personnel. The highest proportions stating that they 'agree' or 'strongly agree' that they are treated with respect relate to: reception staff (95.8%); caseworkers/key workers (93.8%); other staff (89.9%); doctors (86.4%); and other service users (84.1%). The lowest proportions referred to pharmacists (82.2%) and pharmacy staff other than pharmacists (78.7%), but it should be noted that these proportions are still over 75%.

This variable is closely related to levels of overall satisfaction in relation to being treated with respect by reception staff, doctors, other staff and other service users.

Table 22: Service users reporting that they feel they are treated with respect

You are treated with respect by...	Strongly agree	Agree	Don't know	Disagree	Strongly Disagree	Total
Reception staff	54.0	41.8	3.1	0.5	0.7	100.0
Your caseworker/key worker	59.2	34.5	4.9	0.8	0.5	100.0
Staff other than those separately listed	47.4	42.5	6.3	2.6	1.2	100.0

Doctors	47.3	39.1	7.7	4.4	1.5	100.0
Other users at this service	37.7	46.4	10.6	4.3	1.0	100.0
Pharmacists	43.4	38.8	11.1	4.1	2.6	100.0
Other pharmacy staff	39.9	38.8	13.7	6.1	1.5	100.0

2.11 Match between service and felt needs

Additional questions were asked to assess the extent to which a variety of needs were seen as being met; Table 23 has details. Some of these questions have been covered elsewhere in this report. They are repeated here so that the responses can be seen in context.

There was a high level of agreement with statements matching services with felt needs of service users. In the cases of nine of the statements listed in Table 23, more than 77% of service users 'agreed' or 'strongly agreed' with the statements. The highest ranking statement on this measure was 'The staff here are efficient at doing their job' (91.1%), followed closely by 'You are satisfied with the services you receive here' (90.9%), and 'This service meets your needs' (86.1%).

The two negatively expressed statement 'Family members/partners do not get enough support' and 'You only use this service because there is nothing better available' warrant attention. About one-third (32.5%) of respondents 'agreed' or 'strongly agreed' that 'Family members/partners *do not* get enough support', with 37.0% responding affirmatively to 'You only use this service because there is nothing better available'.

Table 23: Service users reporting a match between service and felt needs

Type of need	Strongly agree	Agree	Don't know	Disagree	Strongly disagree	Total
The staff here are efficient at doing their job	42.0	49.1	6.6	1.9	0.5	100.0
You are satisfied with the services you receive here	39.7	51.2	5.9	2.8	0.5	100.0
This service meets your needs	40.5	45.6	8.7	4.7	0.5	100.0
You get enough personal support from the staff at the program	40.6	45.3	9.8	3.3	1.0	100.0
The service is organised and well run	33.6	50.4	10.8	3.8	1.4	100.0
This service location is convenient for you	36.0	46.0	7.2	9.6	1.2	100.0
You have enough say in decisions about your service or treatment	30.8	50.6	12.9	4.5	1.2	100.0
You are usually able to get appointments at this service at the times you want them	24.3	53.8	11.7	8.3	1.9	100.0

You only use this service because there is nothing better available	12.9	24.1	15.9	32.6	14.5	100.0
Family members/partners do not get enough support	11.4	21.1	30.5	29.4	7.8	100.0

2.12 Service user input into service operations

As reported in Table 23, when respondents were asked to rate their level of agreement with the statement 'you have enough say in decisions about your service or treatment', 81.4% responded that they 'agree' or 'strongly agree'.

Service users were also asked, 'would you like to have a greater say in how this service operates?', and 'if yes, how would you prefer to make this input?'. Of those service users who answered the question, 33.7% indicated that they would like greater say in how the service operates (37.6% responded 'no', and 28.7% responded 'don't know'). Table 24 shows the responses of those who answered 'yes' (multiple responses were possible).

Table 24: Service users' indications on how they would prefer to have a greater say in how this service operates (multiple responses are possible)

How service users would prefer to have a greater say	Number of respondents
Through a consumer representative	70
As a consumer representative on a committee run by this service	52
As a consumer representative on a committee run by an outside organisation	33
Other	16

2.13 Written comments from respondents

Service users were asked to provide written comments to three questions:

- 'If you could change one thing about your treatment at this service, what would it be?' (250 responses)
- 'Are there any drug or alcohol services or programs that should be offered in the ACT that are not being offered at present? If so, what are they?' (113 responses)
- Any other comments (73 responses)

Of all the respondents, 285 (61%) wrote some type of specific comment in answer to one or more of these questions, including positive comments such as "all good", "everything's OK", etc. For ease of reporting and to avoid repetition, the answers to these questions were pooled and grouped into themes as detailed in Table 25. Some responses include more than one concept and so were grouped into more than one theme; the total 'numbers of mentions' for each question is therefore greater than the number of people who responded to the questions.

As shown in Table 25, there were many respondents who specifically wrote positive comments about either the services or the staff at the services. This included, for example, two respondents who wrote:

> *I have been treated with respect and provided with lots of help. I currently receive help in employment and referral to [service]. These people are guardian angels.*
>
> and
>
> *Help, care and support on offer here will be very valuable to myself and health. Case workers, counsellors are great and can talk to anyone anytime which is what I need. I speak highly of [service] and workers.*

The issues mentioned most often by respondents were related to opioid maintenance therapy (n=83), in particular the need for extended opening hours and for takeaway doses to be more easily available. Within this category, a large number of people also listed heroin assisted treatment (sometimes characterised as a 'heroin trial') as a service that is needed but that is not currently available. The large number of responses for these items was, of course, partly related to the high proportion of Survey respondents accessing the Opioid Treatment Services at the ADS.

Staffing was also listed as an issue of importance to service users. Mostly, these were positive comments specifically praising the commitment and skills of staff. Comments about the need for additional staff or for different types of staff were often voiced in the context of noticing that staff are overloaded and working with limited resourcing.

Of the remaining items listed, most were to do with specific suggestions around treatment and program delivery, including access issues, service amenity, program design and program structure. There were a large number of single-response items, examples of which have been included in Table 25.

Table 25: Service users' responses to the three open-ended questions, arranged by theme (multiple responses were possible)

Comments by theme	Number of mentions
General positive e.g. • "all good", "an excellent service", "staff are lovely"	**53**
Positive comments about staff	**19**
General negative	**1**
Opioid Maintenance Therapy (OMT) e.g. • Need for extended opening hours • Takeaway doses to be more easily available • Need for OMT dosing clinic on the northside • General dosing issues • Medication issues—availability of specific medications • Lack of availability of heroin assisted treatment	**83**

- Improved access to mobile dosing
- OMT reduction programs/wanting to stop OMT

Staffing **29**

e.g.

- Positive comments about staff
- Staff overworked/overloaded
- Additional staff (types and/or increase in numbers)
- Improved communication between staff
- Need for change in attitude or behaviour of staff

Access **28**

e.g.

- Need for extended opening hours (not specifically related to OMT)
- Reduce waiting times
- Access problems due to location
- Need to enable / improve access

Service amenity **20**

e.g.

- More active space
- Improved food
- More fun activities and outings

Information and education **19**

e.g.

- Don't know what the service options are
- More information about programs / services
- Increase information / support to family and community
- More overdose prevention education

Improved support to address ancillary issues **15**

e.g.

- Housing
- Transport
- Dental care

Rules **15**

e.g.

- Enforce rules consistently
- Issues with other service users
- Want to be allowed to smoke at the service
- Rules don't make sense

Rehabilitation **14**

e.g.

- More rehabilitation and/or improved choice of rehabilitation programs/providers
- Specific types of rehabilitation (e.g. family-orientated, for people on medication)

Increase funding / governement support to services **10**

Programs design **9**

e.g.

- Change length of program or components
- Provision of increased "freedom" earlier in the program

More services / support for specific groups **9**

e.g.

- Aboriginal and Torres Strait Islander specific services (including a meeting place)
- Youth services
- Men
- Pregnant women

Counselling **7**

e.g.

- More counselling
- Provision of specific types

Withdrawal **7**

e.g.

- More withdrawal services
- Medicated withdrawal
- Couples withdrawal services

Improved support / programs for people using crystal methamphetamine **7**

Improved access to sterile injecting equipment **6**

e.g.

- No limits on equipment
- Needle and Syringe Program in prison
- Free fit-pack dispensers
- Additional primary NSP with ancillary services
- Mobile Needle and Syringe Program

Improved service users-centred support and consumer involvement **6**

Supervised injecting facility **4**

Other: additional services **5**

e.g.

- Smoking cessation support
- Drug law reform
- General drop in and chill out service

Other: program structure **56**

e.g.

- Reduce AA/NA within the programs
- Expand access to groups (e.g. Smart Recovery)
- More one-on-one components
- More free time / more laid back
- Increase / expand other program types

About the survey **6**

e.g.

- Appreciate being given the opportunity to do the survey, this survey is too long

3. Comparisons between the 2009, 2012 and 2015 waves of the Satisfaction Surveys

The service user satisfaction surveys were started in 2009, with one of the aims being to track changes in levels and patterns of service user satisfaction across the ACT AOD services over time. This section compares the data from the three time points in 2009, 2012 and 2015.

3.1 Survey coverage and response

Table 26 shows survey coverage and response data from each of the three Surveys in 2009, 2012 and 2015. As in 2012, ten organisations participated in the 2015 Survey, one more than in 2009. Gugan Gulwan Youth Aboriginal Corporation joined the participating organisations after the 2009 Survey.

The total numbers of respondents from all organisations has increased by 36% between 2012 (n=345) to 2015 (n=469); there was a 6% increase between 2009 (n=325) and 2012 (see Table 26).

In each survey year, the service that contributed the highest proportion of respondents was the Alcohol and Drug Service Opioid Treatment Service[k] —31% in 2009, 30% in 2012, and 24% in 2015. Unlike the previous Survey (2012), there was also a high proportion of respondents from the Needle and Syringe Program in Civic in 2015 (17% in 2015, compared to 4% in 2012 and 12% in 2009).

Table 26: Survey coverage and response in each year of the SUSS (2009, 2012) and SUSOS (2015)

Survey coverage & response (measure)	Year of Survey 2015	2012	2009
Organisations participating (number)	10	10	9
Total respondents (number)	469	345	325
Respondents from Opioid Treatment Services (%)	24%	30%	31%
Respondents from Needle and Syringe Program Civic (%)	17%	4%	12%

3.2 Service users' characteristics

As seen in Table 27, there were a higher proportion of males participating in the 2015 survey when compared to the earlier surveys, but the proportion of people who identified as Aboriginal and/or Torres Strait Islander was the same as 2012. As noted in the report of the 2012 SUSS, there was an increase in Aboriginal and/or Torres Strait Islander respondents between 2009 (15%) and 2012 (25%). This is likely to be due to the inclusion of Gugan Gulwan Youth Aboriginal Corporation as a participating service and the doubling of the number of respondents from Winnunga Nimmityjah Aboriginal Health Service in 2012. The proportion of Aboriginal and Torres Strait Islander people accessing all AOD services has remained the same in 2015 (25%).

[k] This was referred to as the 'Alcohol & Drug Program (ADP) Building 7, TCH' in the 2009 report.

The demographic characteristics of the respondents were broadly similar in the three waves of the Surveys (2009, 2012 and 2015) with respect to their age distributions, employment status, housing status and parenting status. However, it is noted that in 2015 a higher proportion of participants had no fixed place of living compared to previous years, and that a lower proportion of respondents were parents with children who were living with them (28% in 2012 compared to 17% in 2015). The proportions of Aboriginal and Torres Strait Islander people accessing mainstream AOD services has increased slightly between 2012 (18.3%) and 2015 (19.4%).

Table 27: Service users characteristics in each year of the SUSS (2009, 2012) and SUSOS (2015)

Service user characteristics (measure)	Year of Survey		
	2015	2012	2009
Gender			
Male (%)	66%	56%	62%
Female (%)	34%	43%	38%
Age			
Range (years)	12-68	14-65	15-70
Mean (years)	37	36	36
Median (years)	37	35	35
12–19 years old (%)	10%	9%	5%
20–29 years old (%)	19%	24%	25%
30–39 years old (%)	30%	30%	36%
40–49 years old (%)	25%	24%	22%
50–59 years old (%)	14%	10%	12%
60+ years old (%)	2%	3%	1%
Aboriginal and/or Torres Strait Islander status (%)	25%	25%	15%
Employment status			
Unemployed (%)	74%	67%	70%
Full-time employment (%)	12%	13%	11%
Part-time employment (%)	9%	14%	10%
Unpaid/voluntary work (%)	6%	7%	8%
Studying (%)	16%	20%	17%
Housing			
Temporary (%)*	27%	27%	28%
No fixed place (%)	19%	12%	14%
Settled accommodation (%)	54%	61%	58%
Parenting			
Child/ren living with them (%)	17%	28%	21%
Child/ren not living with them (%)	27%	30%	31%

* For the 2015 SUSOS, 'temporary' combines 'residential treatment program' and 'other temporary accommodation' to enable comparison with previous years

3.3 Overall satisfaction

Overall satisfaction as measured using the Client Satisfaction Questionnaire (CSQ-8) component of the Survey showed a statistically significant increase in the mean score from 26.2 in 2009 to 27.1 in 2012 ($t=-2.48$, $df=611$, $p<0.01$). The slight decrease between 2012 (27.1) and 2015 (26.9) is not statistically significant ($t=-148$, $df=749$, $p=0.882$).

When asked 'In an overall, general sense, how satisfied are you with the service you have received?', similar proportions between the three waves indicated that they are 'mostly satisfied' or 'very satisfied': 90.0% in 2009; 91.9% in 2012; and 90.4% in 2015.

Similar proportions also indicated that they were likely to return to their service in the future if they needed help again: 90.8% in 2009; 94.5% in 2012; and 93.1 in 2015. The difference between 2012 and 2015 is not statistically significant.

The proportions indicating that they had 'received a lot of help in sorting out your life' increased from 77.2% in 2009 to 85.7% in 2012, a statistically significant difference ($z=2.66$, $p<0.01$). In 2015, 78.2 of the respondents answered that they 'strongly agree' or 'agree' that they had a lot of help sorting out their lives, which represents a statistically significant decrease from 2012 ($z=-2.602$, $p=0.009$).

3.4 Characteristics of service attendance

Fewer service users reported having received a comprehensive assessment in 2015 (55.3%) than in 2012 (62.4%). Of those having received a comprehensive assessment, waiting times between first contact with the service and assessment were the same for the Surveys in 2012 and 2015.

However, waiting times from assessment to commencing treatment have increased; in 2012, 90% of respondents waited less than one month to commence treatment, while in 2015, this proportion was 82% (i.e. in 2015, 18% were waiting for longer than one month between assessment and treatment, compared to 10% in 2012).

Unlike in 2012, the respondents to the 2015 Survey indicated that waiting times were related to levels of satisfaction, with those waiting less than a week having the highest satisfaction scores and those waiting more than 3 months having the lowest satisfaction scores (this was the case for both waiting periods—first contact to assessment, and assessment to treatment).

3.5 Accessibility

Similar proportions of respondents in the three waves of the Survey indicated that the locations of the services were satisfactory: 82% in 2009; 82.7% in 2012; and 82.0% in 2015. The differences are not statistically significant.

Respondents' perceptions that the services' opening hours were convenient to them increased, from 73% in 2009 to 78.2% in 2012, and then decreased slightly to 77.0% in 2015. These differences are, however, not statistically significant.

3.6 Case manager and care plans

The proportion of respondents who indicated that they have a case manager/key worker increased from 51.4% in 2009 to 63.4% in 2012, a statistically significant difference (z=-3.07, p<0.00). In 2015, the proportion reached 67.7%, but the difference compared to 2012 is not statistically significant (z=-1.214, p=0.225).

Similarly, the proportion that indicated that they had a care plan increased from 44.6% in 2009 to 54.2% in 2012, a statistically significant difference (z=-2.249, p<0.02). The proportion of respondents who indicated that they had a care plan decreased slightly in 2015 to 51.4%, but the difference between 2012 and 2015 is not statistically significant.

3.7 Ancillary services

The top three most frequently requested and received (within the agency) type of ancillary service in both 2012 and 2015 were 'housing', 'dental health' and 'mental health' (although in differing orders). In 2012, support for 'dental health' was the most requested ancillary service (24%), while in 2015 the most requested ancillary service was 'housing' (24.1%). In regards to ancillary services received within the agency, 'mental health', 'Centrelink or related payments', 'other general health services' and 'blood borne virus information and support' were prominent in both survey years.

There were statistically significant differences between 2012 and 2015 for the proportions of respondents requesting smoking cessation advice from their service (from 13.0% to 19.8%), and for respondents being referred out for such support (3.5% in 2012, compared to 7.7% in 2015). While there was also an increase from 2012 to 2015 in the proportions of respondents receiving smoking cessation support or advice within the service, this was not a statistically significant increase (21.7% in 2012 and 25.4% in 2015).

3.8 Outcomes

The proportions of respondents reporting improvements in all ten of the outcomes covered in the Survey increased from 2009 to 2012, as shown in Table 28. In all but three, the changes were statistically significant.

The proportions of respondents reporting improvements on these outcome measures decreased between 2012 and 2015 for all but one measure. These changes were not statistically different between 2012 and 2015 for half of the outcomes: involvement in crime; reduced drug use; knowledge of BBV transmission; mental health; and employment situation. There was a statistically significant decrease in the proportions reporting improvements for the other outcome measures: general health; parenting and/or other relationships; capacity to manage finances; housing situation; and dental health.

Questions about smoking status and changes in smoking behaviour were asked for the first time in 2015, and so can not be compared to the 2012 or 2009 Surveys.

Table 28: Outcomes: 'Since starting to receive this service…'. Proportions agreeing or strongly agreeing—comparisons between survey waves, 2009, 2012 and 2015

Outcome domain	2009	2012	2015	Statistical significance of change 2009–2012*	Statistical significance of change 2012–2015*
You are less involved in crime	86.5	93.1	91.3	sig.	NS
Your drug use has reduced	83.7	88.7	85.5	sig.	NS
Your general health has improved	78.2	86.0	79.4	sig.	sig.
Your knowledge of preventing transmission of blood borne viruses has improved	78.3	83.3	84.9	NS	NS
Your parenting and/or other relationships have improved	64.8	82.3	69.5	sig.	sig.
Your mental health has improved	71.5	78.7	78.2	sig.	NS
Your capacity to manage your finances has improved	67.3	78.4	64.3	sig.	sig.
Your housing situation has improved	59.2	72.2	60.9	sig.	sig.
Your dental health has improved	52.5	60.3	53.6	NS	sig.
Your employment situation has improved	48.2	56.0	47.4	NS	NS

* These columns indicate whether or not the changes observed from 2009 to 2012 and 2012 to 2015 are statistically significant at p = 0.05. 'sig.' = statistically significant. 'NS' = not statistically significant.

3.9 Services' responsiveness

The proportion of respondents who reported having been asked to give comments on their level of satisfaction with the services they receive increased from 41.9% in 2009 to 49.9% in 2012, a statistically significant difference ($z=-2.038$, $p<0.04$). The proportion then decreased between 2012 and 2015 to 47.3%, but the difference is not statistically significant.

The proportion reporting they 'agree' or 'strongly agree' that their service acts on suggestions and complaints increased from 60.9% to 72.5%, a statistically significant difference ($z=-4.163$, $p<0.00$). In 2015, the proportion decreased to 66.5%, but the difference between 2012 and 2015 is not statistically significant.

3.10 How the service users feel they are treated

The proportions of respondents who indicated being treated with respect by various people with whom they are in contact with through their services remained stable across the three Surveys for: 'doctors' (83.8 in 2009, 87.4% in 2012, 86.4% in 2015); 'other staff' (89.9% cf. 89.7% cf. 89.9%); and 'other service users' (84.5% cf. 87.2% cf. 84.1%).

While there was a statistically significant increase between 2009 and 2012 in the proportions of respondents who agreed or strongly agreed that they were treated well by their 'case worker/key worker' and 'reception staff', there was a small but insignificant decrease in these proportions between 2012 and 2015—96.3% to 93.8% for 'caseworker/key workers', and 96.1% to 95.8% for 'reception staff'.

Responses for how service users felt they were treated by 'pharmacists' and 'other pharmacy staff' was higher (although not statistically significant) in 2015 compared to 2012 (for 'pharmacists', 82.2% cf. 76.9%, and for 'other pharmacy staff', 78.7% cf. 73.9%).

3.11 Match between service and felt needs

For the ten questions that assessed the match between services delivered and felt needs, the proportions of service users that responded 'agree' or 'strongly agree' was over 80% for the top five needs for all of the three survey years: 'the staff here are efficient at doing their job'; 'you are satisfied with the services you receive here'; 'this service meets your needs'; 'you get enough personal support from the staff at this program'; and 'the service is organised and well run'. While these proportions have increased over time for these five measures, these differences are not statistically significant between 2012 and 2015.

3.12 Service user input into service operations

The proportions of respondents indicating that they 'agree' or 'strongly agree' with the statement 'you have enough say in decisions about your service or treatment' increased between 2009 (73.7%) and 2012 (82.05%), and decreased only slightly to 81.4% in 2015 (not statistically significant). Other questions about service user input were asked for the first time in 2015, and so cannot be compared to previous Surveys.

4. Discussion and conclusion

The overall aim of the 2015 Service Users' Satisfaction and Outcomes Survey (SUSOS) has been to gain insight into service users' perspectives on the nature and quality of the AOD services they access by assessing their levels and patterns of satisfaction. In addition, the SUSOS builds a picture of the self-reported experiences of using AOD services, and of the outcomes as a result of utilising these services.

While not a primary intention of the Survey, the SUSOS has nonetheless also provided a snapshot of the characteristics of service users of ACT Health-funded and -delivered specialist AOD services. This data complements information from other sources[I] to build a profile of the service users of AOD organisations that is useful in the planning and provision of service delivery.

4.1 Service users of AOD specialist services

4.1.1 Survey response—utilisation of AOD specialist services

A total of 469 people attending AOD treatment and support services in the ACT participated in the 2015 SUSOS, compared to 345 who participated in 2012. The increase in the number of respondents between the Survey years is likely to reflect an increase in demand for AOD specialist services in the ACT. The 36% increase in respondents between 2012 and 2015 corresponds to data from the ACT Minimum Data Set that shows a 36% increase in service demand between 2010 and 2014 at non-government specialist AOD treatment and support services.[26]

It is also possible that the increase in respondents may partly reflect increased participation rates over time by AOD service users in surveys such as this. However, while an estimate of service users who refused to fill out the survey was collected in 2015 (n=40), this data is not available for previous years, so it is not possible to know this for certain.

The data shows that between 400 and 500 people access specialist AOD treatment and support services on any single day in the ACT. This estimate takes into account: the number of respondents (469); the number of service users who refused to participate (40); that some people may have attended specifically on the census date knowing that the Survey was being held; that a small number of specialist AOD programs in the ACT were out of scope of the SUSOS; and that a small number of respondents may have completed the survey twice (see Section 4.5).

All specialist AOD treatment and support services in the ACT took part in the SUSOS. Forty per cent of respondents were attending either the Opioid Treatment Services (Alcohol and Drug Services, ACT Health) or the Primary Needle and Syringe Program—Civic (Directions).

[I] Such as from the Alcohol and Other Drug Treatment Services National Minimum Data Set - AODTS-NMDS.

4.1.2 Characteristics of service users

The gender and age breakdown of the survey population is broadly consistent with the population described in the ACT Health reporting of closed episodes of care to the 2014–15 Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS).[m, 27, 28] For both sets of data, two-thirds of the service user population are male, and most are in the 30–39 year old age group, with about three-quarters in the 20–49 year old age bracket.

The proportion of service users reporting that they were of Aboriginal and/or Torres Strait Islander descent was higher in the SUSOS than reported through the 2014–15 AODTS–NMDS. About one-quarter (25.1%) of all SUSOS respondents indicated that they identify as Aboriginal and/or Torres Strait Islander. When services that do not report to the NMDS (see footnote m) are excluded from the analysis of the SUSOS data, 20.5% of respondents identified as Aboriginal and/or Torres Strait Islander. This can be broadly compared to the figures reported to the NMDS (2014–2015): 9.1% of service users identified as Aboriginal and/or Torres Strait Islander, with 5.1% 'not stated' (although the methodology used to collect data was different for each data set).

The data shows that a significant number of Aboriginal and Torres Strait people are seeking help for AOD issues, including through mainstream AOD services. This emphasises the importance of building and maintaining capacity within the AOD sector to provide culturally safe AOD treatment and support services.

Socio-economic disadvantage is clearly a characteristic of the AOD service user population and has implications for AOD service delivery (particularly of ancillary services, such as housing support). Three-quarters of the respondents indicated that they are unemployed. The data also shows that there is a high proportion of people who are accessing specialist alcohol and other drug services in the ACT who are either homeless or at risk of homelessness. Almost half (45.6%) of the surveyed population identified that they had no fixed place of living, were in an AOD residential service, or in other temporary accommodation.

Nearly 40% of respondents indicated that they are parents of a child/children under 16 years old. This may influence the ways in which individuals can access particular types of AOD services, and has implications for the types of ancillary services and support that AOD services provide (for example, providing family-oriented residential services, child care for parents attending day programs, or support around child protection).

The 2015 SUSOS is the first survey to systematically collect data on smoking status across all AOD treatment and support services. Of those service users who answered the question, 81.9% reported being a smoker when they first entered or started using the service. This is consistent with other surveys and studies of smoking prevalence in AOD treatment services and with other disadvantaged groups.[29]

4.2 Overall satisfaction levels and patterns

As is usual with service user satisfaction surveys, especially those covering treatment service users, high overall levels of satisfaction were reported. As discussed in section 1.1, satisfaction scores are not necessarily indicative of the exact level of satisfaction with the service, nor with service quality. Nevertheless, satisfaction scores are helpful to organisational quality improvement processes, particularly when compared over time. In the 2015 SUSOS, the mean CSQ-8 score was 26.9 and the median 27, both well above 20 that is the midpoint of the range of possible scores. Furthermore, although there was a slight decrease in the service user satisfaction score between 2012 and 2015, this change was not significant.

[m] The National Minimum Data Set reported by the Australian Institute of Health and Welfare does not include data from Winnunga Nimmityjah Aboriginal Health Service, Gugan Gulwan Youth Aboriginal Corporation, the Sobering Up Shelter, the Opioid Treatment Services, and the Needle and Syringe Program (Primary-Civic). Most of these services do, however, report their data to ACT Health.

This level of satisfaction is further supported by the proportions of respondents who indicated that they were satisfied in an overall general sense with the service they have received (90.4%) and that they were likely to return to their service in the future (93.1%). These proportions have remained stable over time. However, there was a significant reduction between 2012 and 2015 in the proportion of service users who felt that they had received help in sorting out their life.

The results section reported a lower level of satisfaction among service users of the Opioid Treatment Service (OTS) when compared to the overall level of satisfaction (26.2 cf. 27.1). However, as already noted, the difference was only just significant, and the score reported for the OTS is still high (considering the possible range of CSQ-8 scores from 8 to 32). While not definitive, a clue to this slightly lower CSQ-8 figure may be found in the qualitative responses, where a large number of comments related to the availability of methadone dosing, particularly the need for extended opening hours and the availability of takeaway doses.

High satisfaction scores were related to the following variables:

- Housing status, with respondents with no fixed abode having the lowest levels of satisfaction.
- Length of time attending the service, with new service users showing the lowest levels of satisfaction.
- Waiting times (both between first contact and assessment, and between assessment and commencing treatment), with service users who waited less than a week showing the highest levels of satisfaction, and those who waited for more than 3 months showing the lowest levels of satisfaction.
- The convenience of the services' location.
- The convenience of opening hours.
- Being aware that they had a case manager/key worker.
- Being aware that they had a care plan.
- Being asked to provide feedback on levels of satisfaction with the service or treatment received.
- Perceiving that the service welcomes and acts upon complaints and suggestions.
- Perceptions of being treated with respect by reception staff, doctors, other staff and other service users.
- Positive service user outcomes, with good outcomes on all variables being associated with high levels of satisfaction with the service.

Satisfaction levels were not different between men and women, or whether respondents were of Aboriginal and/or Torres Strait Islander descent or not. Likewise, frequency of attending was not clearly related to levels of satisfaction.

4.3 Experiences of using AOD services

4.3.1 Characteristics of service attendance

The characteristics of service attendance measured in this Survey (e.g. length of time attending the service, frequency of attending, and waiting times) reflected the service types accessed. The skew towards long associations with their services reflects the relatively large proportions of Survey respondents accessing non-residential AOD services such as harm reduction, needle and syringe programs, Aboriginal and Torres Strait Islander services and opioid maintenance treatment. Similarly the high proportion of respondents from the Opioid Treatment Services, and the nature of service delivery through this service (i.e. service users must attend daily for methadone dosing), is reflected in the high frequency of respondents who indicated that they were attending a non-residential service 'daily'.

A large proportion of all respondents (44.8%) indicated that they had either not received or did not know if they had received a comprehensive assessment. When the analysis included only service users attending services that would be expected to provide a comprehensive assessment, the proportion of those who did not know if they had received a comprehensive assessment fell to 24.1%. This means that in services where service users would be expected to have received a comprehensive assessment, three-quarters recalled having received one.

Of those service users who recalled receiving a comprehensive assessment, more than half reported waiting between two to five weeks between making first contact with the service and commencing treatment. Since the implementation of the SUSOS, AOD treatment and support services have rolled out various initiatives under specific methamphetamine-related funding targeted to better management of service users at the front-end of service delivery. As such, a future Survey may include additional and more nuanced questions that not only measure waiting times, but also the quality of the waiting list management (e.g. what sort of support did service users receive from the service while waiting to commence the treatment they were ultimately expecting).

For most items to do with service delivery (e.g. location, opening hours, having a case manager, having a care plan), the proportions of respondents answering favourably have not changed significantly between the two Surveys in 2012 and 2015. The following items recorded a significant change between 2012 and 2015. In 2015:

- Fewer service users indicated that they had received a comprehensive assessment
- More service users reported waiting for longer periods of time between assessment and commencing treatment.

While there was not a significant difference between the 2012 and 2015 Surveys of people who requested counselling, there was a significant decline in those receiving within-agency counselling (while the proportions of those referred out for counselling stayed about the same). This is consistent with data from the 2013–14 AODTS–NMDS that shows a decline in counselling being offered through AOD services in the ACT over the past five years.[30]

4.3.2 Service accessibility

High proportions of service users either ‘agreed’ or ‘strongly agreed’ that the locations of their services were convenient and that they understood the information they had received through these services (through workers or various forms of written information). Satisfaction with opening hours, while generally identified as convenient, varied across service delivery types. For example, one-third of service users attending the Opioid Treatment Services identified the opening hours as being inconvenient. This was also illustrated through the open-ended Survey questions where 23 respondents identified the need for extended opening hours as an issue.

4.3.3 Provision of ancillary services

As mentioned above, the high levels of socio-economic disadvantage of service users of AOD treatment and support services points to the necessity to provide access to a range of ancillary services either within the organisation or through referral to an outside service (e.g. housing support, access to mental health services, Centrelink payments, general health services). In the 2015 SUSOS, the most frequently *requested* type of support was with respect to housing (24.1% of respondents). This is consistent with the high proportion of respondents identified in this population who are either homeless or at risk of homelessness (see section 4.1.2).

The proportion of respondents receiving ancillary services within their organisation was often higher than the proportion requesting it. This may reflect the practice of staff proactively raising particular issues and/or providing relevant services for service users.

The proportions of service users who requested and received (both within agency and out of agency) smoking cessation advice and support increased between the 2012 and 2015 Surveys. This is likely to reflect the increased project activity and capacity within AOD services in the ACT to provide smoking cessation advice and support (see Section 4.4.1).

4.3.4 Service user input into their treatment and service responsiveness

The 2015 SUSOS data continues to show that AOD services are responsive to service users. The proportion of respondents who could recall that they had been asked to give comments on their level of satisfaction with the services they receive and who felt that their organisation acts on suggestions and complaints has remained high (59.6% and 66.5% respectively). Furthermore, 81.4% of service users stated that they 'agree' or 'strongly' agree that they have enough to say in decisions about their service or treatment.

Service user participation in decision-making about their own treatment has been acknowledged to improve experiences within AOD organisations for service users and their families.[31] One study has found, for instance, that giving service users the opportunity to participate in their drug treatment is associated with their greater satisfaction with drug treatment and a greater sense of achievement of their treatment goals.[32]

These findings are consistent with the data from the 2015 SUSOS that show that being asked to comment on their level of satisfaction with the service and perceiving that the service acts on suggestions and complaints are associated with being more satisfied with the service (as measured by the CSQ-8).

About one-third of service users indicated that they would like to have a greater say in how the service operates through consumer representation either within or outside the service.

4.3.5 Experiences with staff

On the whole, service users were very positive about their experiences with staff at the services. They reported being treated well by various types of staff within the service (reception staff, case worker/key worker, doctors and other staff); for each category, over 85% of service users reported that they 'agreed' or 'strongly agreed' that they were treated with respect by these staff members.

Furthermore, high proportions of service users reported that: 'staff here are efficient at doing their job' (91.1% agreed or strongly agreed); and, 'you get enough personal support from the staff at this program' (85.9%). A large number of service users also specifically complimented staff in their written responses to the open-ended questions. Many respondents commented that staff were overworked and overloaded, and that additional numbers and types of staff were needed to enhance service delivery. A small number of negative comments reflected on improving communications between staff, and changing the attitudes or behaviours of some staff.

4.4 Outcomes

The SUSOS assesses the self-reported service outcomes of the participating service users. High levels of positive outcomes (i.e. 'agreed' or 'strongly agreed' with the statements) were reported under each of the accepted primary objectives of AOD treatment:[33]

- To reduce the client's level of substance use
  - Drug use has reduced—85.5%
- To reduce the client's experience of AOD-related harm
  - Less involved in crime—91.3%
  - Improved knowledge of prevention of blood borne virus transmission—84.9%
- To improve the client's health and wellbeing.
  - Improved general health—79.4%
  - Improved mental health—78.2%

It should be noted that these objectives form a general statement of shared primary objectives of AOD treatment and do not necessarily reflect the objectives of individual services or service users. These objectives will vary according to the specific interventions being provided at each service. So, for example, the primary objective of the Needle and Syringe Program is to 'reduce the client's experience of AOD-related harm' (particularly through reducing the transmission of blood borne viruses); the service does not have the objective of necessarily 'reducing the client's level of substance use'.

While 'improved mental health' is accepted as an outcome of AOD treatment, this is conceived of as a general improvement in social and emotional health and wellbeing resulting from AOD treatment. 'Improved mental health' in this context is, therefore, not necessarily an objective measurement of mental health status according to official criteria (e.g. according to the DSM–5, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition). Some AOD treatment and support services may attempt to specifically improve mental health (according to an objective standard) through the direct provision of, or referral to, particular mental health interventions. However, not all AOD services will necessarily have this objective (e.g. the Needle and Syringe Program or the Opioid Treatment Services).

Similarly, while AOD treatment services may attempt to support service users with a number of ancillary activities, they are not within the primary remit of many of these services, nor are most services funded to comprehensively provide ancillary activities. Nevertheless, many services are able to provide some level of ancillary support, even if it is by referring service users to outside services (e.g. legal services, housing services, Centrelink)—see section 4.3.3. Considering these activities are beyond the primary remit of AOD services, service users reported reasonable levels of positive self-reported outcomes for a number of these 'ancillary' activities (i.e. 'agreed' or 'strongly agreed' with the statements):

- Improved parenting and/or other relationships—69.5%
- Improved capacity to manage finances—64.3%
- Improved housing situation—60.9%
- Improved dental health—53.6%
- Improvements in employment situation—47.4%

For *all* of these outcome measures, improvements were associated with high levels of overall satisfaction

4.4.1 Smoking cessation outcomes

'Smokers' were asked about their change in smoking behaviour while accessing the AOD service. Over half reported having either quit smoking completely (16.2%) or reducing their smoking (40.6%) since first entering or starting with the service. This is likely to be related to the increased focus on smoking cessation support within AOD services over the past five years or so, including:[n]

- The development of tobacco management policies—e.g. smokefree services and smoking areas, with supporting policies and signage.
- Formally embedding smoking status assessment and smoking cessation support into existing standard practices at AOD services.
- Smoking cessation training for staff to provide high quality smoking cessation support according to best practice.
- Provision of smoking cessation supports, such as subsidised nicotine replacement therapy for staff and service users.

4.5 Survey strengths and limitations

A clear strength of the 2015 SUSOS is that all of the specialist AOD treatment and support services in the ACT participated in collecting data. This enabled the collection of data to provide a reliable profile of people attending AOD specialist treatment and support services in the ACT. Implementation of the Survey is a clear example of ACT AOD services working together towards a collective goal of promoting better understanding of the outcomes and effectiveness of drug treatment and support. It is a credit to the AOD sector that organisations and workers were able to mobilise quickly to implement this Survey effectively and efficiently, and to facilitate such a high participation rate.

There are clearly a number of limitations that should be considered when reflecting on the findings of the Survey. Some limitations to satisfaction surveys have already been discussed in section 1.1.

It is theoretically possible that a small number of service users participated in the Survey more than once, particularly in a small number of non-residential services that are located close together. While there were one or two (unconfirmed) instances where staff reported that they suspected that a service user may have already filled out the questionnaire elsewhere, this was not reported as a widespread problem. Conducting the Survey (in most services) on a single day militated against the impact of this. In the two services where the Survey was conducted on a later (single) day, there was unlikely to be a large overlap with service users of the other services.

Survey responses could be compromised in part by the fact that dissatisfied service users tend to withdraw from the service, leaving the more satisfied service users occupying the service places. In the case of AOD service users, however, this is not as marked as in some other settings because some survey respondents are involuntary service users, and some have no other source of services available (e.g. many opioid maintenance therapy service users).

As a written questionnaire, some service users with more limited literacy may have had trouble understanding and filling out the questionnaire. While staff were on hand to assist service users, some (particularly where staff were very busy) may not have asked for or received assistance. Furthermore, where staff did assist service users in filling out the questionnaire, this may have compromised the answers to the questions. Staff were asked to limit this possible impact by not monitoring the responses of service users.

[n] For further information on these smoking cessation activities, see for example: 'Workplace Tobacco Management' (www.atoda.org.au/projects/tobacco/); 'Under 10% Project' (under10percent.org.au); and 'We CAN Project—Communities Accessing all types of Nicotine replacement therapy' (www.atoda.org.au/activities/we-can-project-communities-accessing-all-types-of-nicotine-replacement-therapy/).

Similarly, survey responses may have been affected by a concern by some service users that their responses could potentially influence the on-going availability of services (e.g. concern that the service may cease to be funded if responses are not favourable). This is particularly relevant for this disadvantaged client group that relies heavily on these services for treatment and support.

4.6 Conclusions

For the most part there have not been significant changes in the trends between the 2012 and 2015 waves of the Survey program. While the overall levels of satisfaction have decreased slightly for several measures, these are mostly not significant, and are still at high levels. The 2015 Service Users' Satisfaction and Outcomes Survey has provided valuable information demonstrating the high overall level of service user satisfaction at the sector wide level, as well as some areas that may need improvement.

The 2015 SUSOS has also provided valuable data on the profile of service users of AOD specialist treatment and support services in the ACT, as well as information about self-reported experiences and outcomes from attending these services. High levels of positive outcomes were reported under each of the accepted primary objectives of AOD treatment—i.e. reduced levels of substance use, reduced experiences of AOD-related harm and improved health and wellbeing.

Appendix A: Methods—how the 2015 Survey was implemented

After services agreed to participate in the 2015 SUSOS, ATODA liaised with Executive Officers of each service to nominate their survey sites and representatives charged with implementing the SUSOS at each site. A total of 19 sites were identified across the ten organisations.

Each service representative was provided with an Information Package that included:

- 'Guidelines for implementing the Survey at your site'

  This provided instructions for activities in the lead-up to the Survey implementation, on the Survey day, and following the Survey. Representatives were asked to hold a briefing for staff who would be administering the Survey.

- An information sheet: 'Implementing the Survey. Guide for Staff'

  This provided a 'how-to' guide for staff responsible for administering the Survey on the day. Among the information covered was how to appropriately support people with low literacy without compromising the quality of the information, and emphasising the importance of privacy and confidentiality.

- A poster to promote the Survey at their sites prior to implementation.

ATODA communicated with each service representative (by phone and/or email) to talk through and/or clarify the instructions. As part of these communications, service representatives were asked to estimate the number of service users anticipated to attend on the Survey day. This guided the number of questionnaires that were issued to each site.

On the day before the Survey, ATODA delivered a package of documents to the representatives at each organisation or site that included:

- The information sheet: 'Implementing the Survey. Guide for Staff'.
- Participant Information Sheet and Consent Forms with information about the Survey, including the (minimal) risks of participating.
- Questionnaires and coded envelopes for the completed questionnaires.
- Cash reimbursements in individual envelopes and a reimbursement record sheet to acknowledge receipt of the cash reimbursement.

In addition, each service was provided with a data sheet to record the number of people who refused the offer to participate in the Survey.

In eight organisations, the Survey was conducted on Tuesday 8 December 2015, and in one organisation it was conducted later that same week (as the service was not open on Tuesdays). For one of the Aboriginal and Torres Strait Islander organisations further time was required to negotiate issues around data collection, use and reporting; consequently, the Survey was implemented in this organisation at a later date, although still on a single day (Friday 12 February 2016).

On the day of the Survey, each service user attending at each site was invited to participate in the SUSOS. The service user was given a 'Participant Information Sheet and Consent Form' to explain the Survey, including who would be involved in the Survey and the purpose and use of the results, along with information on the approval process through the ACT Health Human Research Ethics Committee (ETHLR.12.107).

This Information Sheet also explained how service users would be able to access the Survey results, and that participation was entirely voluntary, with no impact on the services they receive. Consent was implied by completing the questionnaire and placing it in the collection box.

Participants were offered $20 in cash as recompense for their out-of-pocket expenses and their contribution of time in completing the questionnaire, as per the approval received from the ACT Health Human Research Ethics Committee. This amount is consistent with reimbursements offered for participation in other similar questionnaires, and was considered to be an appropriate balance between being fair while not being an inducement to participate.

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

- Handed a copy of the questionnaire to fill out in a 'pen-and-paper' question-and-answer format, and a coded envelope into which to seal the completed form.
- Encouraged to complete the questionnaire in private.
- Asked to seal the questionnaire in an envelope provided for that purpose, and place it in the sealed collection box.
- Staff were on hand to assist any respondent who had trouble understanding any of the questions, owing to the relatively low literacy levels of some respondents. Steps were taken to ensure that, in these cases and all others, the responses remained confidential.
- Given $20.00 in cash and asked to indicate on the reimbursement record sheet that they had received the money.

The questionnaires were collected by ATODA following the Survey date. The forms were removed from the envelopes, coded to identify the service from which they came, and the data entered into a database for analysis.

The resulting data files were analysed and this report prepared. Quantitative data analysis used PASW Statistics version 18. Qualitative data analysis was undertaken by hand using a thematic analysis of the responses.

ATODA will prepare a poster and/or other material, in plain English, summarising the results of the Survey, for distribution through ACT specialist AOD services to their service users, to feed back to them the results of the Survey.

Appendix B: Changes made to the questionnaire between the 2012 SUSS and the 2015 SUSOS

The following questions were changed or added to the 2015 Service Users' Satisfaction and Outcomes Survey from the previous survey in 2012.

Question		Change or addition
2	Gender	Box labelled 'Transgender' was changed to 'Other'
5	If this is not a residential service, how often do you come to this service?	Box added labelled: 'N/A (this is a residential service)'
9	Do you have a case manager/ key worker assisting you to receive your drug and alcohol related services?	Box added labelled: 'N/A'
11	If you have a care plan, when was it last reviewed?	Box added labelled: 'N/A'
14	Have you requested help in any of the following areas?	'Type of support' item wording changed from: 'Smoking cessation advice' to 'Smoking cessation advice or support'
15	How much do you agree with the following statements? (related to outcomes)	Item wording changed from: 'Your parenting and/or other relationships have improved', to 'Your family, parenting and/or other relationships have improved'
16		Added question: 'When you first entered, or started using this service, were you a smoker?' Response options: 'Yes'; 'No'; 'Don't know'
17		Added question: 'If yes, which of the following statements fits you best?' Response options: 'I have quit smoking completely'; 'I smoke *less* now than when I first entered or started using this service'; 'I smoke *about the same* now than when I first entered or started using this service'; 'I smoke *more* now than when I first entered or started using this service'; 'N/A'
23	I understand what is being said to me in this service	Added item: 'In social media communications'
26	What is your current housing situation?	Added option of 'Residential treatment program'; changed option of 'Temporary accommodation', to 'Other temporary accommodation'

30		Added question: ‘If you could change one thing about your treatment at this service, what would it be?’
31		Added question: ‘Would you like to have a greater say in how this service operates?’ Response options: ‘Yes’; ‘No’; ‘Don’t know’ ‘If yes, how would you prefer to make this input?’ Response options: ‘Through a consumer representative’; ‘As a consumer representative on a committee run by this service’; ‘As a consumer representative on a committee run by an outside organisation’; ‘Other (please specify)’; ‘N/A’

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