P. Kehoe & A. Wodak

PATIENT SATISFACTION IN A NSW PUBLIC OPIOID PHARMACOTHERAPY CLINIC: MEASUREMENT AND RESPONSES

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Paul Kehoe and Alex Wodak

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Patients of Rankin Court Treatment Centre
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EXECUTIVE SUMMARY

Patient involvement in service delivery forms a key element of the NSW Methadone Clinic Accreditation Standards (MCAS) (2000). Processes in NSW to engage with opioid dependent patients about pharmacotherapy services are limited however, and differ between clinics.

An opportunity thus existed in NSW to develop a rigorous, effective and affordable quality improvement tool that would engage with patients, and collect evidence to meet the accreditation requirements articulated in the MCAS.

A project to address this issue was completed in 2004 at Rankin Court, the pharmacotherapy clinic for opioid dependent patients at St Vincent's Hospital in Sydney. A Public Health Officer from the NSW Public Health Officer Training Program of the NSW Department of Health undertook this project. Project development and implementation was supported by a reference group which comprised membership from the NSW Department of Health, NSW Users and AIDS Association, NSW Methadone Advice and Complaints Service, St Vincent's Hospital Quality Improvement Unit, and Rankin Court staff.

The project undertook a literature review of consumer satisfaction in health care services (1985 – 2003). At the time of writing, only one instrument had been developed to measure opioid dependent patients' satisfaction with services from methadone clinics: the Verona Service Satisfaction Scale–MT (VSSS-MT)(de los Cobos 2002). This was judged inappropriate for implementation in NSW due to length, textual complexity, and commensurate resource requirements for its implementation.

An eleven-item self-administered questionnaire and survey protocol was developed by the project. Conceptual dimensions underpinning the questionnaire were drawn from the VSSS-MT and other previously validated patient satisfaction instruments, and corroborated against and extended by qualitative research with opioid dependent patients attending local pharmacotherapy clinics. Conceptual domains in the questionnaire comprised professionals' skills and behaviours, information, efficacy, access, patient input to health care and overall satisfaction with service. Likert scale responses were used for the majority of the eleven items, drawing on the same response options as the earlier validated instruments. Open ended questions were put regarding desired changes at the clinic, and seeking general comment. Sex, age category, type of pharmacotherapy medication and length of time as patient at the clinic were also asked; no individually identifying information was collected by the questionnaire. Face validity of the questionnaire was addressed by consultation with relevant stakeholders, and by pre-testing with the target population. Low literacy within the target population was addressed in the questionnaire through the use of simplified language, and the addition of visual cues alongside text.

The survey was implemented over four consecutive days in early 2004. The study population was defined as those opioid dependent patients being prescribed and receiving pharmacotherapy through Rankin Court, and who had presented to Rankin Court for dosing at least once in the three days prior to survey commencement (213 patients).

Members of the study population were provided with the questionnaire in the clinic's waiting room by the project officer, offered the assistance of a consumer representative in completing it, and asked to place it in a sealed box when they advanced to be dosed; clinic staff were separated from data collection, and could not identify respondent by questionnaire – a crucial element in the protocol for data validity with this population.

175 questionnaires were returned by the end of the data collection period, representing an 82% response rate. The average length of time taken to complete the questionnaire was approximately 6 minutes. 108 (61.7%) respondents were male, as were 33 (86.8%) subjects who declined the survey. Age distributions of respondents and those who declined the survey were comparable. 1 (0.6%) respondent and 3(7.9%) subjects who declined the survey were identified as Aboriginal or Torres Strait Islander.

113 (64.6%) of respondents were receiving methadone, 18 (10.3%) buprenorphine, and 44 (25.1%) did not state. 39 (22.3%) of respondents had been a clinic patient for less than one year, while 66 (37.7%) had been a patient for one to five years, 43 (24.6%) had been a patient for longer than five years, and 27 (15.4%) did not state. Concern for anonymity was considered the primary factor for the low compliance with these questions.

Twelve (7%) respondents accepted assistance to answer the questionnaire. Their demographic comparability with that of the overall study population, and high cost per questionnaire, suggest this assistance only be offered in future surveys where there is demonstrated need.

Results generally indicated a high level of patient satisfaction with services. In terms of overall satisfaction, the mean rating of the clinic on a scale from one (terrible) to ten (excellent), was seven. Further, 76% of respondents would either definitely, or with reservations, recommend Rankin Court to a friend who needed treatment. Rankin Court also rated well with respondents in the domains of efficacy, information, and professionals' skills and behaviours (where 68%, 58%, and 83% of respondents respectively considered the clinic's service as mostly satisfactory or excellent). Respondents were less positive when questioned in regard to the clinic's access: only 44% of respondents considered the clinic's physical environment for patients to be mostly satisfactory or excellent, and only 40% of respondents reported the same level of feeling in regard to Rankin Court's response to complaints. Results varied in the domain of patient input to health care: while 63% of patients considered their inclusion in decisions about their treatment was mostly satisfactory or excellent, only 27% reported the same feeling when asked about their inclusion in decisions on how the clinic is run. Thematic analysis of free text responses determined that the most commonly desired changes at the clinic pertained to dosing hours, patients' access to takeaway pharmacotherapy, and clinic staff's attitudes and practices.

By responding to patients' requests, Rankin Court will build patients' trust in the clinic's accountability to consumers, and in the patient satisfaction survey as a meaningful feedback loop to clinic management. The survey, and Rankin Court's response, will significantly contribute to the clinic's accreditation under the MCAS. Annual re-implementation of the survey will support longitudinal assessment of the clinic's performance.

For pharmacotherapy clinics in NSW, the questionnaire and protocol described in this report represent a rigorous, easy to implement, low cost, and effective quality improvement process to engage with patients and meet the accreditation requirements articulated in the MCAS.

RECOMMENDATIONS

1. That the NSW Department of Health encourage members of the NSW Health Drug and Alcohol Council to:
   a. evaluate consumer satisfaction regularly within pharmacotherapy settings, and
   b. consider the contribution that could be made to such evaluation by the satisfaction questionnaire and survey protocol described in this report

2. That the NSW Department of Health consider the promotion of the patient satisfaction questionnaire and survey protocol described in this report to private public pharmacotherapy clinics in NSW, within the context of quality improvement.

3. That the NSW Department of Health, in consultation with other stakeholders, promote the development and implementation of consumer satisfaction evaluative processes within other alcohol and drug treatment and health promotion services, eg. needle and syringe programs, detoxification services, residential rehabilitation services, etc.

4. That relevant Health Department staff, drug user organisations, and other stakeholders in other Australian states, consider the potential of the patient satisfaction questionnaire and protocol described in this report for quality improvement in pharmacotherapy clinics for opioid dependent persons in their jurisdictions.

5. That Rankin Court Treatment Centre reviews its services in light of the results from the patient satisfaction survey described in this report, and where possible, amends services to reflect patients' opinions; further, that Rankin Court Treatment Centre communicates promptly and clearly to patients on the process and outcome of this review.

6. That Rankin Court Treatment Centre embeds the patient satisfaction survey described in this report as an annual feature of its quality improvement framework.

7. That Rankin Court Treatment Centre undertakes further testing and modification of the patient satisfaction questionnaire to improve respondent compliance with its demographic data collection, prior to re-implementation.

1. INTRODUCTION

1.1 Project background and overview

1.1.1 Consumer engagement in health care

The importance of patient involvement in the planning, delivery and evaluation of health care is well recognised, with benefits accrued for consumers, providers, and communities as a result (Hibberd 2003). While the nature and extent of the contribution made by "patient empowerment" in some health care contexts still requires clarification (Grol 2001), the adoption of processes to develop a consumer focused health care system has nonetheless become well embedded in governmental management of health care (Consumer Focus Collaboration 2001).

The worth of consumer participation in health care has been recognised and articulated in NSW by the development of the government report, 'Partners in Health' (NSW Health 2001), which sets out a series of recommendations to achieve ."…equal opportunities [for all NSW residents] to participate in health decision making and to obtain the information they need to improve their own and their community's health." A range of structures and initiatives have been implemented under the recommendations of this report, with impact across a range of health services, including those responding to drug and alcohol health issues.

1.1.2 Consumer engagement in NSW pharmacotherapy clinics for opioid dependent persons

Pharmacotherapy services for opioid dependent people in NSW are available in a range of modalities. These include public and private clinics (which comprise prescription, case management, and dosing within the same facility), GP prescription and/ or dosing, and pharmacist dosing.

Patient involvement in the delivery of services forms a key element of the NSW Methadone Clinic Accreditation Standards (MCAS) (NSW Health 2000). All pharmacotherapy clinics in NSW for opioid dependent people must be accredited against the MCAS at least once every four years in order to continue providing service.

Accreditation of public and private pharmacotherapy clinics in NSW for opioid dependent patients is undertaken by either the Australian Council of Healthcare Standards (ACHS) or Quality Management Systems (QMS). Both organisations have mapped the NSW Methadone Clinic Accreditation Standards (MCAS) (2000) to their individual quality improvement and accreditation frameworks. The MCAS are articulated across six domains of organisational structure and function: continuum of care, leadership and management, human resources management, information management, safe practice and environment, and improving performance.

The integral importance to clinic accreditation of consumer involvement is reflected in the number and variety of standards that make reference to this process, most notably in the domain of leadership and management:

MCAS 2.1.7	The clinic is planned, operated and evaluated in consultation and collaboration with all relevant stakeholders.
MCAS 2.1.9	The clinic's planning involves consultation with management, staff, the community, clients and other relevant health service providers and authorities
MCAS 6.1.7	Feedback from all stakeholders is collected and used to inform problem identification and areas for improvement.

Without substantive evidence that pharmacotherapy patients are involved in service delivery, accreditation of a clinic must thus be considered open to question.

The MCAS are undergoing revision by the NSW Department of Health in 2004. Their articulation with the accreditation frameworks of ACHS and QMS will be impacted on by these organisations' response to 'Partners in Health', the NSW Health Department's position paper on the engagement of consumers in health care. This document states the crucial importance of consumer involvement in the planning, delivery and evaluation of health care, and puts forward a series of recommendations to achieve."…equal opportunities [for all NSW residents] to participate in health decision making and to obtain the information they need to improve their own and their community's health." The importance of consumer engagement in the accreditation of pharmacotherapy clinics for opioid dependent people is expected to be further enhanced by this process.

Significant barriers have existed however in the collection and incorporation of patient feedback in this particular context of healthcare services.

Pharmacotherapy patients' alienation from and disempowerment within health care services has been well described (Woods 2001, Thomson and Morgan 1999); the issue of injurious attitudes towards drug use by clinicians has also been noted (Caplehorn 1996, 1998). These factors, combined with the profound fear of antagonising their prescribing doctor and or/ dosing staff (and thus being denied the substance to which they are physically addicted, and thus entering withdrawal) (Thomson and Morgan 1999, Lord 2003), can place insurmountable obstacles in the way of pharmacotherapy patients engaging directly with services to express dissatisfaction and advocate for change.

In light of these issues, the range of structures and processes in place in NSW to engage pharmacotherapy patients in the planning delivery and evaluation of services are limited.

The Methadone Advice and Complaints Service (MACS) is a staffed, freecall, state-wide telephone service which collects and aggregates complaints and enquiries about pharmacotherapy services for opioid dependent persons. Aggregate data on complaint type is provided to the NSW Department of Health for consideration, but advocacy and/ or mediation on behalf of complainants is rare due both to the limitations on the service provided and the unwillingness of complainants to be identified arising from the concerns identified above.

Pharmacotherapy clinics across NSW have also developed individual mechanisms for engaging with consumers, and attempting to collect and respond to their feedback on services in the context of quality improvement and meeting accreditation requirements. These have ranged from simple measures such as suggestion boxes in patient waiting areas, to detailed questionnaires administered by clinic staff rating specific types and aspects of each service provided.

Problems can arise with a range of these mechanisms however. The introduction of selection and measurement bias into questionnaires that are administered by clinic staff can render the findings open to question – as noted previously, pharmacotherapy patients' fear of prejudicial treatment may prompt them to opt out of such surveys or give responses presumed to be those desired by the interviewer. The resource implications for staff administered questionnaires may also constrain clinics from engaging with appropriate numbers of consumers.

1.1.3 Project development and parameters

An opportunity thus existed in NSW to develop a standardised, affordable and accurate method for the collection of pharmacotherapy clinic patients' views on the nature and delivery of services provided, and that would fulfill the requirements articulated in the MCAS.

A project to address this issue commenced at St Vincent's Hospital in 2001. A Public Health Officer from the NSW Public Health Officer Training Program of the NSW Department of Health undertook this project. A principal part of the project's literature review was completed in that time by the first project officer, Elayne Mitchell. After a hiatus due to staff absence, the project recommenced in late 2003.

The project's focus was localised to the St Vincent's Hospital pharmacotherapy clinic for opioid-dependent patients, Rankin Court Treatment Centre. Despite this local focus, the potential for the project's work to have broader application across NSW was recognised by stakeholders, and noted by the NSW Health Drug and Alcohol Council, the state's peak drug and alcohol services co-ordinating committee.

The project's work was overseen by a reference group comprising representation from stakeholders including:

NSW Department of Health
St Vincent's Hospital Alcohol and Drug Services
St Vincent's Hospital Quality Improvement Unit
Methadone Advice and Complaints Service
NSW Users and AIDS Association (NUAA)

Input to the work of the Reference Group was also sought from the body of patients at Rankin Court. Fliers outlining the purpose and parameters of the project were placed in patient waiting areas in the clinic, and input invited from patients. Patients were also advised that they could contact the injecting drug user's organisation NUAA if they wished ask questions about or provide comment on the project from a source external to the clinic. No contact was received at Rankin Court or NUAA in response to this.

The expertise of senior clinicians in the field and other stakeholders in academia was also drawn on at key milestones throughout the project's development, through an electronic consultation forum.

Advice was also provided by the St Vincent's Ethics Committee (Appendix A) that as the project's development sat within a quality improvement and not a research context, submission of data collection protocols and methods for Ethics Committee approval was neither necessary nor appropriate.

With these structures in place, the following project plan was articulated:

Target population

- Primary target population:
  Patients receiving pharmacotherapy treatment for opioid dependence, who are prescribed their pharmacotherapy at Rankin Court, and use Rankin Court as their dosing clinic
- Potential secondary target population:
  Patients in NSW receiving pharmacotherapy treatment for opioid dependence, at clinics other than Rankin Court

Aim

- To increase the primary target population's satisfaction with pharmacotherapy treatment services at Rankin Court for opioid dependent patients.
- To increase the secondary target population's satisfaction with pharmacotherapy treatment services at clinics in NSW for opioid dependent patients.

Objectives

- To measure the target population's satisfaction with pharmacotherapy treatment services at Rankin Court for opioid dependent patients
- To increase the target population's engagement with and input to quality improvement processes at Rankin Court
- To provide NSW Health with a tested instrument and protocol for the collection of patient satisfaction data in pharmacotherapy treatment services for opioid dependent patients, appropriate for consideration for statewide implementation.

Strategies

- Develop and pilot:
  - a questionnaire for measuring patient satisfaction with pharmacotherapy treatment services as part of an overall quality improvement process
  - a protocol for the administration of this questionnaire as a survey within Rankin Court
- Analyse results from the survey
- Draft a project report for consideration by methadone treatment providers for their own QI purposes.
- Draft paper for peer reviewed journal
- Liaise with relevant NSW health sector entities regarding broader implementation of project outcomes
- Advocate for improved collection and consideration of patient satisfaction information in pharmacotherapy services in NSW

Performance Indicators

- Evidence of patient input collected and considered in quality improvement for pharmacotherapy treatment services at Rankin Court
- Evidence of actions undertaken at Rankin Court in response to this data.

Project Reference Group

The primary functions of the Project Reference Group were to oversee the strategic directions of the Pharmacotherapy Patient Satisfaction Project, and contribute where appropriate to the implementation of its tasks. Its membership comprised:

Dr Alex Wodak	Director, Alcohol and Drug Service, St Vincent's Hospital
Simon Johnston	Policy Officer, Centre for Drugs and Alcohol, NSW Department of Health
Carol Stubley	Nursing Unit Manager, Rankin Court Treatment Centre, St Vincent's Hospital
Ahmed Jamal	Director, Quality Improvement Unit, St Vincent's Hospital
Richard Sulovsky	Program Manager, NSW Users and AIDS Association
Geney Jones	Co ordinator, Methadone Advice and Complaints Service, St Vincent's Hospital
Paul Kehoe	Public Health Officer, NSW Public Health Officer Training Program, NSW Department of Health

Consultation on project direction was undertaken with a network of key stakeholders at regular milestones throughout project implementation. This network comprised:

Prof. Bob Batey	Director, Drug and Alcohol Services, Hunter Area Health Service
Dr John Currie	Director, Drug and Alcohol Services, Western Area Health Service
Dr Andrew Byrne	Private methadone prescriber
Dr Ray Seidler	Private methadone prescriber
Dr Keith Roberts	Private methadone prescriber
Dr Richard Hallinan	Private methadone prescriber
Dr Adam Winstock	Clinical Director, Drug and Alcohol Services, South West Area Health Service
Assoc. Prof. Paul Haber	Senior staff specialist and Head of Department, Drug Health Services, Royal Prince Alfred Hospital
Bronwyn Crosby	Deputy Director, Alcohol and Drug Service, St Vincent's Hospital
Geoff Minards	Counselor, Methadone Advice and Complaints Service, St Vincent's Hospital
Rod McQueen	Private methadone prescriber
Anne O Loughlin	A/g Clinical Operations Manager, Kirketon Road Centre, South Eastern Sydney Area Health Service
Carolyn Day	Doctoral candidate, National Drug and Alcohol Research Centre, University of New South Wales

Project Timeline

Task	Completed by
Establish reference group	December 03
Conclude literature review	December 03
Confirm with reference group: - conceptual dimensions of questionnaire - questionnaire administration method - project directions & parameters	December 03
Thematic analysis of NUAA pharmacotherapy patients' qualitative data	December 03
Consultation with staff on questionnaire design and administration protocols	December 03 / January 04
Assess literacy levels in the population	December 03 / January 04

Pilot of draft questionnaire	January 04
Amend draft questionnaire	January 04
Database design	January 04/ February 04
Questionnaire administration	February 04
Data entry and analysis	February 04/ March 04
Write draft report & article	March 04/ April 04

1.2 Literature review

1.2.1 Introduction

Quality issues in health care have gained increasing interest in the past decade. Quality assurance in health care services has generally incorporated the principle of participation and consultation with the consumers of services as an ideal. These values are considered to be important factors in the changing face of delivery of health care services in the community.

Patients are increasingly recognised as people who have the competence and the desire to be involved in their own treatment and service provision (Thompson 1999). In addition to the ethical reasons for assessing patients' views on health care and the health benefits accrued as a result, information on patient satisfaction can also be used for improving the allocation of resources.

Currie et al, (Department of Human Services, Victoria 2000) developed draft public hospital patient charter principles. Important patient rights outlined in the charter include:

- Treatment and care in a safe environment
- Access to health records and confidentiality of personal information
- Participate in making decisions about treatment and care
- Treatment with respect, dignity and consideration for privacy
- Information about treatment provided
- Information on steps the unit takes to improve quality of care.
- If necessary access to interpreter services.
- Services provided in a culturally sensitive way.
- An opportunity to discuss any questions or complaints concerning the unit
- Ability to make a complaint to an independent complaints body

Some of the above charter principles might be usefully expressed as indicators to measure patient satisfaction.

1.2.2 Relationship between patient satisfaction and treatment outcome and compliance

The relationship between patient satisfaction, and treatment and health outcomes is complex. It is noted that people who are the beneficiaries of good health service delivery processes, and of good health outcomes from their care, are more likely to express satisfaction with the care they have received (Carmel 1985, Hall 1998). However, there is also evidence that the inverse relationship applies – ie. that patient satisfaction is a factor contributing to improved health outcomes (Williams 1994). While the relationship between patient satisfaction and health is thus complex and interactive, patient satisfaction has become recognised as a health outcome measure in itself, and is accepted as an indicator for health (Alazri 2003).

1.2.3 Measurement of patient satisfaction

Collection and measurement of patients' satisfaction with health services provided to them can be conducted in a variety of ways, including surveys, focus groups and interviews. The method/s through which a service facilitates consumer feedback provision should be appropriate, objective, transparent and designed in consultation with consumer representatives. A health service that consults with its patients must also be prepared to acknowledge that responding to the results may require some organisational change.

> *"As a minimum most health systems today recognise the need to hear their patients' opinions about the quality of health care, through the use of satisfaction questionnaires and measures of expectations. However, although this is more participative than simple patient consent, this is still at a fairly minimal level of consultation (Thompson 1999).*

A variety of tools have emerged to monitor hospital care processes and to improve different areas of care. Most studies have focused on medical and economic criteria, but attempts have also been made to include the customer's or patient's judgment about the care that health services provide (Nathorst-Boos et aI, 2001).

Nathorst-Boos et al (2001) conducted an evaluation of two methods for measuring patient satisfaction, the 'Quality Satisfaction Performance' (QSP) and the 'Quality from the Patients' Perspective' (QPP). The quality factors 'treatment by the nurse', participation', information', 'environment' and accessibility' were measured.
Satisfied and well-informed patients find it easier to follow medical instructions.

> *"Measuring patient satisfaction has become increasingly popular. It is important to discuss how these results can be integrated into the health care process in order to increase patient satisfaction. Early in the planning of a study it is therefore important to integrate in what context the results will be used. This should, impossible, include the headings: 'goals~ 'relevant questions', 'interpretation' and 'intervention'.* (Nathorst-Boos et al 2001)

Cross-sectional patient satisfaction surveys have also been used to identify the importance to consumers of attributes of health care and nursing care quality. They have also been used to examine the relationship of consumer perspective to health status and demographic variables in conjunction with the SF36 (Oermnann and Templin, 2000). The SF -36 is a 36-item instrument for measuring health status in eight general areas. In order to determine consumers' perspectives on high-quality health-care, participants completed the Quality Health Care Questionnaire (QHCQ) and the SF-36 Health survey. On the QHCQ, they rated the importance of 27 attributes of health care and nursing care quality, including: medical care; teaching by the nurse; provider competence; choice of provider; nurse-patient interaction; and convenience of appointments. The authors concluded that consumers placed importance on 'teaching by the nurse' particularly among people with less education, low income levels and chronic illnesses.

> *"Learning about what consumers want from their health care and what quality care means to them gives us a better understanding of their expectations. What people expect from their health plans and providers influences their satisfaction with care."* (Oermann & Templin, 2000).

Lawthers et aI, (1999) reported on the feasibility of using patient surveys to measure the quality of outpatient care and to determine indicators for patient satisfaction. They conclude that this method of quality measurement may address several different purposes, including accountability, to demonstrate the value of service delivery to a third party and to identify opportunities for improvement. As measurement is resource-intensive, it is cost-effective if one measurement tool can be used for a variety of purposes.

In a study to determine the overlooked attributes of patient satisfaction with primary care, Concato and Feinstein (1997) used a concise and simple approach to surveying patients. They obtained responses to three open-ended questions asking patients: a) what they liked, b) what they disliked, and c) what they'd like to see changed. This approach was used because of the fundamental belief that patients are the best judges of their satisfaction of care and so that the results would be transparently sensible to clinicians and policy makers.

Concato and Feinstein (1997) developed a taxonomy for classifying patient satisfaction. The taxonomy was divided into five main axes, referring to physician staff, non-physician staff, attributes of the clinic, related services and the institution.

The authors suggest the taxonomy and the corresponding clinimetric approach of asking three open-ended questions to measure patient satisfaction can be applied in at least three different ways:

1. *For administrative (eg quality assurance) purposes*, the open-ended questions can replace more complex surveys of patient satisfaction. If results are organised according to the new taxonomy, repeated surveys can establish trends for specific items of patient satisfaction over time.
2. *For research*, the clinimetric questionnaire used in the study is currently being compared with a published, widely-used psychometric instrument, the Employee Health Care Value survey of the National Committee for Quality Assurance. The comparison will determine whether similar attributes of patient satisfaction are identified by each instrument and whether differences occur in the format of results
3. *For medical education*, can be used directly by students or teachers as a checklist of provider specific aspects of care that are important to patients.

An important use of information about consumer satisfaction with a health service is to inform patients and support quality-based decisions. The Foundation for Accountability (FACCT) is a US based organisation committed to measuring health care quality and communicating results in a way that makes sense to consumers

FACCT's Consumer Information Framework (FACCT, 2002) comprises 5 basic categories for communicating health care quality to consumers:

1. basics of good care - such as access and communication with providers, doctor care, rules for getting care, information and service, satisfaction
2. staying healthy - such as reduction of health risks and early detection. Helping people avoid illness and stay healthy through preventive care, education
3. getting better - helping people recover when they're sick or injured through appropriate treatment and follow-up
4. living with illness - helping people with ongoing, chronic conditions take care of themselves, control symptoms, avoid complications and maintain daily activities
5. changing needs - caring for people and their families when needs change dramatically because of disease or terminal illness - with comprehensive services, care-giver support, hospice care

High satisfaction rates of 75-90% are often found in patient surveys. High levels of patient satisfaction may be due to measurement errors such as social desirability, reluctance to express a negative opinion, the wording of questions and non-specific questions. In order to address these validation problems, Nathorst-Boos et al (2001) communicated with patients to identify the issues that concern them most acutely and to determine how they perceive and interpret the services they receive. Thirty-five individual interviews were conducted, consisting of open ended and adapted follow-up questions covering a range of themes including:

1. issues of importance with regard to the care the patient received
2. what the patient perceived as positive or negative in connection with the care
3. treatment by the nurse
4. participation
5. information
6. environment
7. accessibility.

Literacy issues in data collection
The relationship between literacy and health status is complex due to the association between low literacy and lower socio economic status (which is also a predictor of poorer health status) (Keffalides 1999). Nonetheless, the association between low literacy amongst patients and poorer health status has been seen (American Medical Association 1999); poorer health outcomes can be associated with low literacy through difficulty in reading and comprehending patient education materials, with commensurate decreased access to services or compliance with treatment regimes (Kirsch 1993).

A range of instruments has been developed to assess general literacy (a more basic concept than health literacy, which encompasses the individual's capacity to understand health education material and negotiate the health care system). These include tools such as the Rapid Estimate of Adult Literacy in Medicine (REALM), where the patient reads sixty six common lay or medical words aloud and a score is obtained, and the revised Slosson Oral Reading Test (SORT-R), where the patient reads increasingly difficult lists of words with a score obtained form the number of correctly pronounced words. Both tools have documented reliability and validity (Davis 1991, Slosson 1994).

The clinical impact of low literacy can also manifest by introducing selection bias and measurement error into data collection – individuals with low literacy may self exclude themselves from a study, and not disclose that the reason for this is low literacy due to the stigma associated with it (Baker 1996); alternatively, individuals with low literacy may participate in data collection, but the validity of the tool may be compromised by poor comprehension (Kimble 2001).

1.2.4 Pharmacotherapy treatment services for opioid dependent patients and patient satisfaction

Context
The US National Alliance of Methadone Advocates states that stigma, prejudice and discrimination are the greatest barrier to recovery confronting methadone patients today (Woods, 2001). Most heroin users have experienced invalidation, rejection and punishment, thus exacerbating feelings of alienation from society and possibly entrenching antagonistic behaviour.

Pharmacotherapy treatment is a compromise between heroin users' need to escape the problems associated with the cycle of addiction and the community's reluctance to provide a mood altering and addictive drug as treatment. The universal scarcity of resources distorts treatment provision and many of the deficiencies of methadone treatment are the consequence of community fear and loathing for people who choose to use heroin (Wodak, 2002).

> *"Some of the complaints about methadone by treatment consumers also reflect community contempt of drug use that has been internalised by heroin injectors"... "Is it surprising that many drug users become extremely ambivalent about their drug use and like many members of the community, confuse the proposed solution with the original problem?"* (Wodak, 2002).

Treatment Services Staff

Historically, negative community attitudes toward drug users and pharmacotherapy treatment can impact on staff of pharmacotherapy services, potentially putting them at greater risk of burn out, disillusionment and cynicism. These factors can reduce the effectiveness of treatment and are an unacceptable cost for health workers' health (Bell 1998).

> *"Opioid dependence should not disqualify persons from citizenship, nor is it a reason for their enjoying less than full civil rights. Opioid replacement therapy patients accordingly should enjoy the same rights as any other patients, including an opportunity to comment on the way that treatment is provided, and access to the same procedures as other patients for resolving grievances or addressing complaints. Anything less than this risks making opioid replacement therapy the coercive form of social control that some critics accuse it of being"* (Bell, in Ward et aI, 1998)

The patient's perception of the advantages of treatment affects the efficacy of the treatment. Pharmacotherapy treatment services provide a stable supply of a drug that removes the pressures of maintaining their heroin habit. Treatment represents a safe refuge from the relentless cycle of withdrawal, crime and drug seeking. Heroin users who enter treatment commonly state that they are 'sick of the lifestyle'.

> *"The fact that treatment represents a refuge from the difficulties of addiction does not sit comfortably with most people. Our governing image of addiction is as a form of deviance, and from that moral perspective it does not seem appropriate to protect people from the adverse consequences of deviant behaviour. Thus providing relief from distress resulting from the addicted lifestyle is seen as not only unnecessary, but as counterproductive ".* (Bell, in Ward et aI, 1998)

While there would be a general professional concurrence that monitoring of staff, community and client satisfaction are important quality assurance measures, pharmacotherapy treatment units are unique in that they suffer from negative community attitudes toward opiate dependent people and pharmacotherapy treatment. This may impact on the effective provision of good treatment. Staff behaviour can be affected, increasing anxiety, defensiveness about treatment and cynicism, and in turn contributing to the ambivalence of patients (Bell, 2000).

> *"The goal of delivering structured treatment is to ensure that the treatment space is safe. Safety for patients and staff includes freedom from harassment (by staff and other patients), fairness, and the sense that the treatment constitutes a reliable consistent experience. While punitive responses from staff towards acting out behaviour need to be avoided, maintaining safe limits needs to be enforced a difficult balancing act for which clear rules and expectations need to be spelt out and consistently applied".* (Bell, in Ward et aI, 1998)

Caplehorn and others (1996, 1998) studied the attitudes and beliefs of staff working in methadone maintenance units. Attitudinal scales were developed to measure commitment to abstinence-oriented treatment programs and disapproval of illicit drug use. The findings suggest that staff support for abstinence based treatment modalities is related to their disapproval of drug use and support for punitive sanctions to control drug use. Staff support for a particular policy orientation can thus significantly affect patient outcomes.

Consumers of pharmacotherapy treatment services have the same rights and responsibilities as consumers of any health service. In large methadone clinics it is difficult to provide individualised treatment (even in New South Wales, despite the recent improvements in funding trends). Maintaining high standards of care, protection of marginalised patients, improving staff morale and provision of appropriate services to patients are some aspects of the continuing balancing act demanded of pharmacotherapy treatment services. Finding ways of improving access to pharmacotherapy treatment within limited resources is a problem for services around the world (Ward et aI, 1998).

Retention of patients in pharmacotherapy treatment services was significantly associated with the prevailing attitudes and beliefs of the treatment unit staff, ie. patients were more likely to leave programs where clinic orientation and dosing policy was based on abstinence, than those where the treatment was indefinite maintenance based on harm minimisation principles. There was a shift away from abstinence-oriented policies in the attitudes and beliefs of staff working in Sydney public methadone units in during the 1989-92 period. However staff views on drug addiction were generally unchanged, and scores on a test of basic knowledge about methadone treatment remained poor. The authors conclude that staff attitudes change with time and the process of change can probably be facilitated by education campaigns (Caplehorn, et al, 1998).

Measurement of patient satisfaction in pharmacotherapy treatment services

A recent Canadian study used focus groups to generate questions for a clinical trial of injectable opioids (Fischer et aI, 2002). The groups were made up of 47 treatment experienced and treatment-naive opiate users. The objective was to identify key themes and issues, attitudes and experiences regarding methadone treatment.

Considering the effect of patient satisfaction with services on treatment compliance and outcomes, the reported findings are disturbing. Users in the study stated that the characteristics and procedures inherent to methadone treatment often counteract the treatment objective of 'normalising' people's lives by limiting patients' ability to work, travel, or socialise.

> *"Many users perceive methadone treatment, in its current structure, as unacceptably punitive and controlling, pervasively regimented, and disempowering, and thus demanding too high a price of their self-defined goals and wellbeing for too little benefit. "* (Fischer et aI, 2002)

The importance of counselling was accepted by users in the above study, however they wanted to have choices, options and input into the decision-making about it. Other suggested improvements to treatment services included staff training and implementation of a staff buddy system.

> *"With respect to staff, it was stated that all resource people should be sensitised to working with users in need. Peer support was mentioned as being very important. One suggestion was a 'buddy system' where a user in treatment could call a volunteer when in crisis, to allow the user to "let some steam out, as an outlet"* (Fischer et aI, 2002)

The authors suggest that necessary changes may include modifications of the methadone treatment system toward more 'user friendliness', in terms of choice, flexibility, attitudes, and approaches of staff. However, treatment providers have to accept that no matter what improvements are made, for some heroin users pharmacotherapy treatment is unacceptable:

> *"On the other hand, however, it will have to be accepted that some of methadone treatment's fundamental shortcomings cannot be repaired with the system and that is, and will likely remain, inherently unattractive and unappealing to many opiate users. "* (Fischer et aI, 2002)

De los Cobos and others (2002) report on the previous lack of any validated instrument to measure opioid –dependent patient satisfaction with methadone treatment services. These authors adapted the 32 item Verona Service Satisfaction Scale for specific application in methadone treatment centers, noting the selection of this self administered tool due to its brevity (essential for this study population) and multidimensionality. The adapted instrument (the Verona Service Satisfaction Scale for methadone-treated opioid–dependent patients, or VSSS-MT) contains a mixture of open ended and 5 point Likert scale responses, addressing specific aspects of service delivery and overall quality of service ratings; concept dimensions addressed by this modified questionnaire were:

- overall satisfaction
- professionals' skills and behaviours
- information
- access
- efficacy
- types of interventions

The authors report that the VSSS-MT displays a high level of internal consistency, and a satisfactory level of test-retest reliability.

Consumer input

Consumer organisations representing drug users, the NSW Users and AIDS Association (NUAA) (Morgan, 1993) and the Victorian Drug User Group (VIVAIDS) (Thomson and Morgan 1999) have reported on consumer issues relevant to methadone issues.

The Victorian study (Thomson and Morgan 1999) used focus groups and individual interviews to explore problems and recommend solutions to a number of complaints and grievances common to methadone maintenance treatment patients. Among other important considerations, Thomson discusses: discriminatory treatment from service providers; intolerance of illicit drug use; insufficient service provision; harmful behaviour in reaction to disrespectful or derogatory treatment; denial of an active role in their own treatment; and barriers to resolution of disputes.

In response to the study findings, Thomson and Morgan (1999) developed a draft charter of methadone consumer rights including the following elements:

- To receive quality health care service as promptly as possible
- Considerate care that respects privacy and dignity
- Adequate information on all aspects of services provided or treatment available in terms that can be understood
- To be treated with a non-judgmental attitude, that is unassuming and non-discriminatory

- To be treated in a fair and equitable manner regardless of drug use or medication
- To be kept informed about their treatment and participate in decision making which affects their own health care
- To be given access to information from their medical and pharmaceutical records and be given accurate and honest information in response to any questions relating to their treatment
- To have the confidentiality of medical and pharmaceutical records ensured
- To receive discreet and confidential service
- The right to consent to, or refuse treatment
- The right to make a complaint and receive a fair hearing and have their concerns addressed without any negative repercussions
- The right to purchase clean injecting equipment without it affecting their methadone treatment provided that the pharmacy supplies injecting equipment

IN 1992, NUAA (Morgan 1993) conducted an awareness raising campaign using widely circulated posters and pamphlets asking the question: "are you sick and tired of being treated like you don't count?" and detailing contact details to identify areas of discrimination and gaps in services for injecting drug users. The outcome of the campaign was the funding of a consumer campaign project officer and advisory committee with the aim of establishing and resourcing methadone consumer representative groups at both the clinic and state levels.

Some of the problem areas identified in the NSW report (Morgan 1993) include: lack of consumer information about treatment; various forms of discrimination from a variety of contacts, including health workers; clinic policies, including take-away doses, dosing hours and transfers; problems in receiving adequate pain management when necessary; and breakdown of communication.

In 2003, NUAA sponsored the collection of patient satisfaction data from patients in pharmacotherapy treatment programs in urban Sydney. Patients were administered a 10 item questionnaire while in clinic waiting rooms, addressing a range of aspects of satisfaction. Thirty nine questionnaires were collected and are undergoing analysis at the time of writing.

Quality improvement in NSW pharmacotherapy services

Due to an expansion in availability of pharmacotherapy treatment places in NSW since the NSW Drug Summit in 1999, the number of patients receiving treatment increased by 2,600 between January 2000 and February 2001, to a total of 15,200 people receiving daily methadone doses in NSW (NSW Health, 2001). At December 31 2003, there were 13928 patients receiving methadone in NSW, and a further 2154 patients receiving buprenorphine.

Quality assurance systems in place include strict accreditation standards for clinics, complaints monitoring, treatment agreements, pharmacist training and other professional development and collection of data on health and social outcomes of clients (NSW Health 2001). Consumers have access to the Methadone Advice and Complaints Service (MACS), a telephone service which encompasses the collection and direction of complaints data to the NSW Health Department Accreditation of treatment facilities, assessed through external, independent, clinically experienced agencies is probably the most critical component of quality improvement (Bell, 2000).

All methadone clinics, both public and private, are required to be accredited against the NSW Methadone Clinic Accreditation Standards (MCAS) (NSW Health 2000). These standards are articulated through six groupings: continuum of care, leadership and management, human resources management, information management, safe practice and environment, and improving performance. Consultation with patients, and their involvement in service delivery is an integral part of many of these standards.

Accreditation of methadone clinics in NSW is undertaken by either of two entities, the Australian Council on Healthcare Standards or Quality Management Services, each of whom have articulated where the MCAS are encapsulated within their individual accreditation frameworks (ACHS 2003)

Collection of patient satisfaction data, and its aggregation into useful information for consideration in service planning, should thus be considered an essential plank in methadone clinic accreditation and operation in NSW.

2. METHODS

2.1 Questionnaire development

At this time of writing, the only instrument to measure opioid-dependent patient satisfaction that had been developed and undergone validation testing was that published by de los Cobos et al (2002). The Verona Service Satisfaction Scale for methadone-treated opioid-dependent patients (VSSS-MT) is a self administered 27 item questionnaire, addressing a range of conceptual dimensions including overall satisfaction, professional's skills and behaviours, information, access, and others. The authors report that the VSSS-MT displays satisfactory internal and test-retest reliability, and conclude that the instrument measures opioid dependent patient satisfaction with methadone treatment centres.

Despite these reported findings, the project's stakeholders considered the VSSS-MT too lengthy, complex, and resource-consuming for successful adoption and implementation at Rankin Court, or by extension, at other pharmacotherapy clinics across NSW. Pharmacotherapy patients' willingness to participate in unremunerated surveys - even those with the potential for immediate impact on the services they received - was judged to be insufficient for a questionnaire of this length, and its textual complexity likely to exceed many patients' literacy skills. The protocol by which the VSSS-MT had been administered also required a team of trained research assistants – resources that would be unlikely to be procured on an ongoing basis in NSW. The resources that a clinic would thus have to invest in the administration, collection, and analysis of such large amounts of data would significantly inhibit the instrument's uptake and application at Rankin Court or across NSW.

A shorter, eleven-item questionnaire was thus developed by the project.

Conceptual dimensions underpinning the eleven items referenced those of the original Verona Service Satisfaction Scale (VSSS-32) (Ruggieri et al 1996) and the Client Satisfaction Questionnaire (CSQ-8) (Larsen et al 1979), These conceptual dimensions included professionals' skills and behaviours, access, efficacy, information, and overall satisfaction. The local applicability of these conceptual dimensions were corroborated against and extended by analysis of data from qualitative research undertaken by the NSW Users and AIDS Association (NUAA) with opioid dependent patients attending local pharmacotherapy clinics in 2003. For this research, a project officer had undertaken semi-structured interviews with thirty nine patients from three inner city Sydney pharmacotherapy clinics. Thematic analysis of the data identified similar conceptual dimensions to those from the above literature as being the important aspects of service on which to measure patient satisfaction with service in pharmacotherapy clinics for opioid dependent persons, with the inclusion of one additional theme: patients' input to decision making in health care.

Likert scale response categories were used for eight of the eleven items, and drew upon the same response options as the two earlier questionnaires. Thus for the conceptual dimensions of professionals' skills and behaviours, access, efficacy, and information, the response options were (1) terrible; (2) mostly dissatisfied; (3) neither good nor bad; (4) mostly satisfactory; (5) excellent. For the two items addressing the conceptual dimension of overall satisfaction, the response options for the first also used a Likert scale (response options: (1) no, definitely not; (2) no, but with reservations; (3) wouldn't matter either way; (4) yes, but with reservations; (5) yes, definitely) while the second asked for a summative rating of the clinic from one to ten. The remaining two items were open ended questions, asking respondents to identify what would be the one thing they would most like to see changed at the clinic, and for any other comments on the clinic.

Face validity of the questionnaire was addressed through consultation with senior clinicians working in the field of pharmacotherapy for opioid dependent patients, and by two rounds of pre-testing with a total of twenty subjects from inner urban Sydney pharmacotherapy clinics. Subjects who completed the draft questionnaire for this purpose were interviewed following the pre test, and asked if the instrument excited any discomfort, if any questions were difficult to understand, and if any questions constrained them from saying more than they would have wished (Converse and Prosser 1986). Subjects were also asked to rephrase the questions in their own words (Nuckols 1953), with their responses coded as fully correct, generally correct (no more than one part altered or omitted), partially wrong (general subject still correct), or completely wrong/ no response. Specific terms that had been referred to with multiple meanings in the qualitative data and were used in the questionnaire (dose, treatment, services), were checked for repeatability during the pretest. One of the twenty subjects required the questionnaire to be read to him due to illiteracy. Nine items from across all of the conceptual dimensions were discarded from the questionnaire as a result of this pretesting, due both to the requirements for brevity and to the pre-test subjects' comments.

Low literacy issues amongst the target population were addressed in the instrument through the use of simplified text, and the incorporation of visual cues to signify response choices. These visual cues took the form of small faces, from frowning and very displeased (attached to the response option 'terrible') to widely smiling (attached to the response option 'excellent').

2.2 Survey implementation

The survey to measure patient satisfaction with services at Rankin Court, the St Vincent's Hospital pharmacotherapy clinic for opioid dependent persons, was implemented over a four-day period in early February 2004.

Commencement of survey implementation was preceded by a fortnight of promotional strategies to advise patients of its purpose and imminent start, and thus enhance the survey's response rate. Promotional fliers advertising the survey's commencement and its potential benefit for patients were displayed in prominent places in patient waiting areas (see Appendix D), and clinic staff verbally briefed patients about the survey as they were dosed. Mechanisms in place to protect respondent anonymity in the survey process were also emphasised to patients

The target population for the project was defined as those opioid dependent patients being prescribed and receiving pharmacotherapy through Rankin Court. For the survey, the study population was defined as those patients who had presented to the Rankin Court clinic for their pharmacotherapy at least once in the three days prior to survey implementation (and thus deemed 'active' on the Rankin Court patient database). This definition of the study population was adopted due to the characteristics of the Rankin Court pharmacotherapy patient population, where many patients may have dual diagnosis and/or be homeless and thus not infrequently be absent from dosing for potentially extended periods of time.

The following protocol was followed for the survey's implementation:

Upon a patient's entry to the clinic waiting area, the Project Officer invited their participation in the survey to measure their satisfaction with the services provided by the clinic. The potential for this data to influence the nature and delivery of the clinic's services – and thus the immediate benefit for patients - was also advised to the patient, and the measures in place to ensure respondent anonymity were noted. Patients were also advised that their decision on whether or not to participate in the survey would in no way prejudice their treatment in the clinic. This verbal briefing reiterated the information displayed on the questionnaire's cover sheet (see Appendix C)

The Project Officer noted the patient's response to this invitation on a list of patient names (that the questionnaire had been taken, that the questionnaire had been refused, or that the patient elected to do the questionnaire on another day), and a questionnaire and pen provided to the patient if consent to participate in the survey was given.

Patients who consented to participate were directed to a representative of the drug users advocacy organisation, the NSW Users and AIDS Association (NUAA), for assistance in reading and responding to the questionnaire should such assistance be required; due to the recognised stigma associated with low literacy (Baker et al 1996; Parikh et al 1996), such directions were phrased in such terms as, "..if you do not have your reading glasses with you" or, "…if the lighting in here is too poor for you to see clearly..". A NUAA representative was present in the clinic waiting area during dosing hours for the four day period over which the survey was implemented. The benefit accrued for the survey by NUAA fulfilling this function was the removal of bias for patients to provide socially desired responses to the questionnaire. – something that might not have been possible if a clinic staff member had been acting in this role.

Patients were invited to complete the questionnaire while waiting to receive their dose.

Upon the patient's entry to the clinic's separate dosing area, they were asked by the attendant clinic dosing staff if they had consented to participate in the survey. The patient's response was noted against the patient notes held by the dosing staff. If the patient had consented to participate, dosing staff asked the patient if they had completed the questionnaire to their satisfaction. If so, the patient was asked to place the completed questionnaire in a return box, which had been placed in the client section of the dosing area (clearly away from dosing staff). The patient notes then recorded that the patient had completed and returned the questionnaire. If the patient indicated that they had accepted but not yet completed the questionnaire to their satisfaction, they were asked to take the questionnaire away to complete it and return the following day; this also would then have been noted on the patient notes by the dosing staff.

Completed questionnaires were removed from the return box on a daily basis by the Project Officer, and the list of patient names that had accepted a questionnaire reconciled with the patient notes held by the dosing staff. Patients who had completed and returned the questionnaire were marked off on the list of names held by the Project Officer, thus avoiding unnecessary requests for participation in the survey and possible duplication of responses.

Patients who refused to participate in the survey were not approached again for recruitment. Those patients who had accepted a questionnaire but who were not recorded by clinic staff as returning a completed one, were invited to participate in the survey on a maximum of two further occasions. If the questionnaire had not been completed and returned after the third approach, no further attempts at recruitment were made.

2.3 Analysis

Data were housed and manipulated in Access 2000 and Excel 2000.

Free text answers were thematically analysed independently by researchers, and a coding structure devised and applied collaboratively.

Basic descriptive statistics were presented for responses to each item.

3. RESULTS

3.1 Demographic profile

Age and indigenous status of the pharmacotherapy patient population at Rankin Court are routinely collected in compliance with reporting requirements for the Minimum Data Set on Alcohol and Other Drug Treatment Services (MDS). The MDS does not capture transgender status. These data are available for comparison between survey respondents and non-participants through the survey protocol, which recorded which patients did and did not participate in the survey. Other demographic characteristics were not reportable at the time of writing. Available demographic characteristics for the study population are set out below in Table 1.

Table 1. Demographic characteristics of the opioid-dependent pharmacotherapy patient study population, Rankin Court, 2004 (n= 213)

Characteristic	Participated in Survey n(%)	Refused Survey n(%)
Sex		
Male	108 (61.7)	33 (86.8)
Female	67 (38.3)	5 (11.2)
Age		
≤ 25 years	8 (4.6)	1 (2.6)
26 – 35 years	57 (32.6)	14 (36.8)
36 – 45 years	62 (35.4)	11 (28.9)
46 - 55 years	44 (25.1)	10 (26.4)
> 55 years	4 (2.3)	2 (5.3)
Indigenous status		
Aboriginal/TSI	1 (0.6%)	3 (7.9%)
Non Aboriginal/ TSI	174 (99.4%)	35 (92.1%)

Basic treatment characteristics collected from survey respondents are displayed below.

Table 2. Treatment characteristics, Patient Satisfaction Survey respondents, Rankin Court 2004 (n=175)

	n (%)
Pharmacotherapy type	
Methadone	113 (64.6)
Buprenorphine	18 (10.3)
Not stated	44 (25.1)
Length of time as patient at clinic	
< 1 year	39 (22.3)
1-5 years	66 (37.7)
> 5 years	43 (24.6)
Not stated	27 (15.4)

3.2 Response rate

175 completed questionnaires were received at the end of the four-day data collection period, representing a response rate of 82%.

Excluded from the study population denominator were:

- patients being prescribed at Rankin Court but being dosed elsewhere (seventy patients at the time of data collection), and
- those patients being recorded as being prescribed and dosed at Rankin Court, but who had not presented in the three days prior to the survey and were thus deemed 'inactive' (ten patients at the time of data collection).

There was a variable response rate to the four demographic questions on the questionnaire: seventeen (9.7%) respondents did not state their sex, eighteen (10.3%) respondents did not nominate their age category, twenty-seven (15.4%) respondents did not nominate how long they had been a patient at the clinic, and forty-four (25.1%) respondents did not state which form of pharmacotherapy they were receiving. Ten (5.7%) of all respondents answered none of these questions.

Comparisons between respondents according to demographic characteristics reflect these response rates: for example, only fifty-nine respondents (33.7%) identified their sex as female, and ninety-three respondents (53.1%) as male. Of the remainder, six (3.4%) identified as transgender, and the remaining seventeen (9.7%) did not state their sex.

3.3 Questionnaire administration

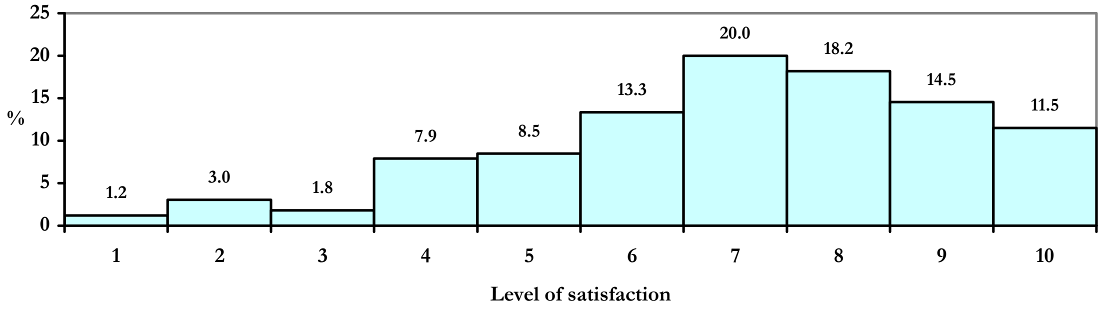
A total of 12 (6.9%) of all respondents accepted the offer of assistance to complete the survey by the NUAA representative. All respondents who accepted assistance were male.

Of the twelve assisted respondents, two (17%) were receiving buprenorphine, the remainder methadone. one (8.3%) did not state their age, one (8.3%) was 25 years or less, four (33.4%) were aged between 36 and 45 years, and six (50%) were aged between 46 and 55 years. Five (41.7%) respondents who accepted assistance to complete the questionnaire had been patients at Rankin Court for less than one year

3.4 Overall quality of service

Respondents were asked to reflect on all their experiences at Rankin Court, and give an overall rating of the service from 1 (terrible) to 10 (excellent). Ten (5.7%) respondents did not answer. The mean rating of the service from those who did respond was a score of 7, with a standard deviation of 2.1. No substantive differences were apparent between male (mean 6.9) or female (mean 6.7) respondents, nor between respondents receiving methadone (mean 6.9) or buprenorphine (mean 6.6). The distribution of responses for the entire population of respondents is displayed below in Figure 1.

Figure 1. Overall rating of clinic from 1(terrible) to 10 (excellent), Patient Satisfaction Survey respondents, Rankin Court, 2004 (n=165)



Respondents were also asked if they would recommend this clinic to a friend who needed treatment. Six (3.4%) of all respondents did not answer. No substantive differences were apparent in the distributions of responses according to sex or type of medication: 50% of male respondents, and 49.1% of females would "definitely" recommend this clinic to a friend who needed treatment, while 50.4% of patients receiving methadone, and 55.5% of those receiving buprenorphine would do the same. The distribution of responses for the entire population of respondents is displayed below in Figure 2.

Figure 2. "Would you recommend this clinic to a friend who needed treatment?", Patient Satisfaction Survey respondents, Rankin Court, 2004 (n=175)

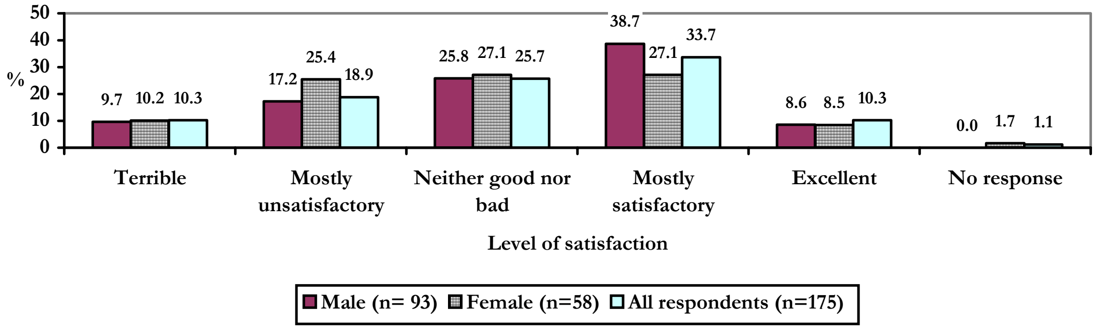
3.5 Access

Respondents were asked for their overall feeling about how the clinic responds to complaints from patients. Five (2.9%) of all respondents did not answer. Females were more likely to rate the clinic as responding poorly to complaints than males: 30.5% of females considered the clinic's response to complaints as terrible or mostly unsatisfactory, compared to 22.6% of males. Patients receiving buprenorphine were less likely to consider the clinic's response to complaints as mostly satisfactory or excellent (17.6%), compared to those receiving methadone (42.2%), but this proportional disparity is emphasised by the comparatively small number of patients receiving the former medication. The distribution of responses for male, female and the entire population of respondents are displayed below.

Figure 3. “What is your overall feeling about the way this clinic responds to complaints from patients?”, Patient Satisfaction Survey respondents, Rankin Court, 2004

Respondents were also asked for their overall feeling about the physical environment for patients. Two (1.2%) of all respondents did not answer this question. More females (35.6%) than males (26.8) reported feeling that the physical environment for patients is either terrible or mostly unsatisfactory. No substantive differences were apparent in the distributions of responses between those patients receiving methadone and those receiving buprenorphine. The distribution of responses for male, female and the entire population of respondents are displayed below in Figure 4.

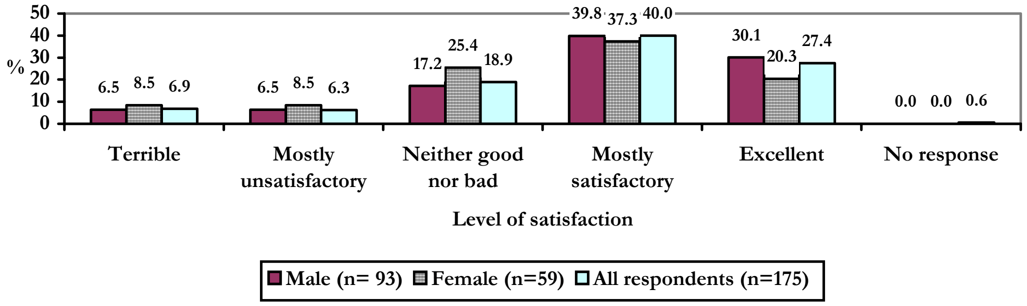
Figure 4. “What is your overall feeling about the physical environment for patients at this clinic?”, Patient Satisfaction Survey respondents, Rankin Court, 2004



3.6 Efficacy

Respondents were asked for their overall feeling on how effective this clinic has been in helping them with their problems. One (0.6%) of all respondents did not answer this question. Females were less likely than males to report that the clinic helps them with their problems: 57.6% of females considered that the clinic was mostly satisfactory or excellent in helping them with their problems, compared to 69.9% of males. No substantive differences were apparent in the distribution of responses between those patients receiving methadone or buprenorphine. The distribution of responses for male, female, and the entire population of respondents are displayed below in Figure 5.

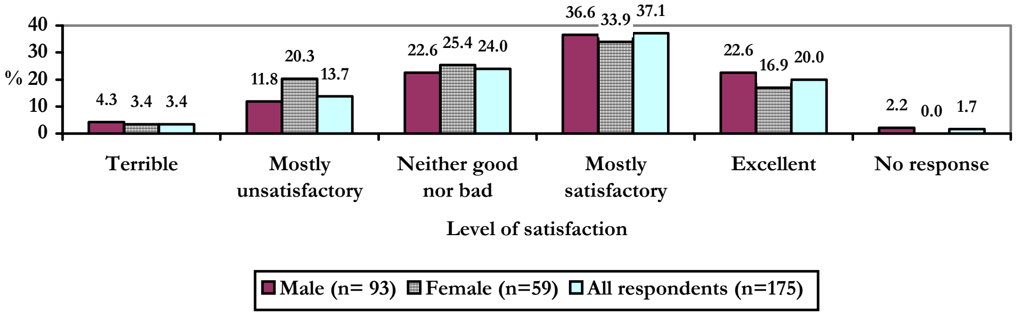
Figure 5. "What is your overall feeling about how effective this clinic has been helping you with your problems?", Patient Satisfaction Survey respondents, Rankin Court, 2004



3.7 Information

Respondents were asked for their overall feeling about the amount of information this clinic gives them about their treatment. Three (1.7%) of all respondents did not reply to this question. A larger proportion of females (23.7%) than males (16.2%) reported feeling that the amount of information given to them by the clinic about their treatment was terrible or mostly unsatisfactory. No substantive differences were apparent in the distribution of responses between those patients receiving methadone or buprenorphine. The distribution of responses for male, female, and the entire population of respondents are displayed below in Figure 6

Figure 6. "What is your overall feeling about the amount of information this clinic has given you about your treatment?", Patient Satisfaction Survey respondents, Rankin Court, 2004



3.8 Professional's skills and behaviours

Respondents were asked for their overall feeling about how staff at this clinic treats them. One (0.6%) of all respondents did not answer this question. No substantive differences were apparent in the distribution of responses according to either sex or type of medication received: 78% of females and 83.8% of males reported feeling that staff's treatment of them was either mostly satisfactory or excellent, while 83.1% of patients receiving methadone and 83.2% of patients receiving buprenorphine reported the same. The distribution of responses for the entire population is displayed below in Figure 7.

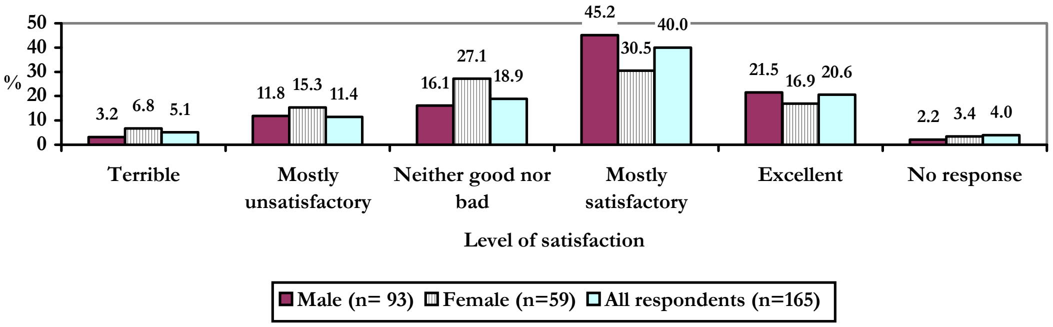
Figure 7. “What is your overall feeling about how staff at this clinic treat you?”, Patient Satisfaction Survey respondents, Rankin Court, 2004 (n=175)

3.9 Patient input to health care

Respondents were asked for their overall feeling on the way they’re included in decisions on their treatment, and also for their overall feeling on the way they’re included in decisions on how the clinic is run.

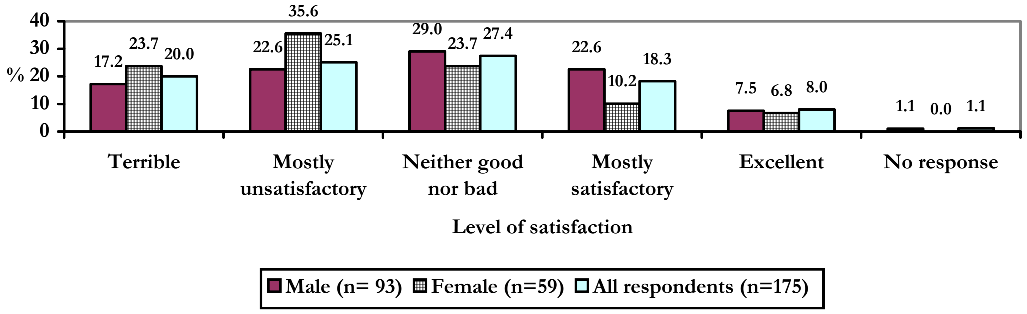
7(4%) of respondents did not answer the first of these questions. Fewer females (47.4%) than males (66.7%) reported feeling that the way they were included in decisions about their treatment was either mostly satisfactory or excellent.. No substantive differences were apparent in the distribution of responses according to whether patients received methadone or buprenorphine. The distribution of responses for male, female, and the entire population of respondents are displayed below in Figure 8.

Figure 8. “What is your overall feeling about the way you’re included in decisions on your treatment?”, Patient Satisfaction Survey respondents, Rankin Court, 2004



2 (1.1%) of respondents did not answer the question regarding their overall feeling on the way in which they’re included in decisions on how the clinic is run. Fewer females (16.8%) than males (30.1%) reported feeling that the way in which they were included in decisions about how the clinic was run was mostly satisfactory or excellent. No substantive differences were apparent in the distribution of responses according to those patients receiving methadone or buprenorphine. The distribution of responses for male, female, and the entire population of respondents are displayed below in Figure 9.

Figure 9. "What is your overall feeling about the way you're included in decisions on how this clinic is run?", Patient Satisfaction Survey respondents, Rankin Court, 2004



3.10 Patient-directed change in clinic service delivery

Respondents were asked to nominate what one thing they would most like to see changed at this clinic. Nine (5.1%) of all respondents did not nominate anything. Of the remaining 166 respondents, twenty-seven respondents nominated two things they would like to see changed, and five respondents nominated three things they would like to see changed. Multiple responses have not been excluded; respondents did not indicate priority to multiple answers.

The most frequently nominated desired change at the clinic pertained to its hours of dosing. Respondents who raised this issue consistently noted a desire for longer hours of dosing, with earlier starting times.

Access to takeaway doses of pharmacotherapy was also frequently raised by respondents, with those raising this issue noting takeaway medication's contribution to normalising lifestyles: "Take away policies: should have takeaways to maintain normal life"

Changes in staff attitudes and/ or practices were nominated by a large proportion of respondents, with some noting that, "..some staff look down their noses at us" and requesting that staff be more "tolerant".

A large proportion of respondents also stated they wished to see changes to the dosing process, either by increasing its speed or the means by which people queue for dosing. A ticket or numbering system was proposed by a number of respondents for improving the queuing process.

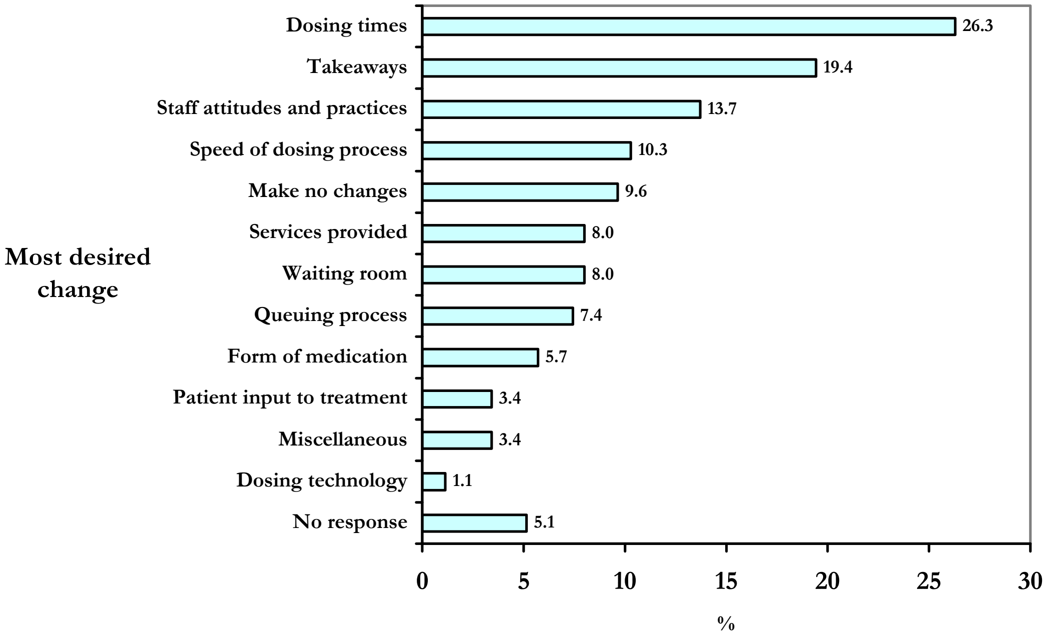
Changes to the services provided by the clinic were proposed by a number of respondents. These included consolidation of those services already in place – such as expansion of counselling – as well as the addition of new services, such as group therapy and living skills classes.

The physical environment for patients while they wait to be dosed was also nominated by respondents as requiring change. The waiting room was not considered clean by patients ("The waiting room is a terrible situation; smells, oppressive."), and was described as "overcrowded".

A number of patients stated they desired to change the form in which they received their methadone (from the present form of biodone back to syrup), or to have a choice of being able to do so.

The distribution of responses for the entire population of respondents is displayed below in Figure 10.

Figure 10. "What is the one thing you would most like to see changed at this clinic?", Patient Satisfaction Survey respondents, multiple responses allowed, Rankin Court, 2004 (n=175)



An opportunity was also made available in the questionnaire for respondents to make any other comments that they wished about the clinic. Seventy-six (43.4%) of all respondents did not make any comment. Of the remaining ninety-nine respondents, eighty-five respondents made one comment, twelve respondents made two comments, and two respondents made three.

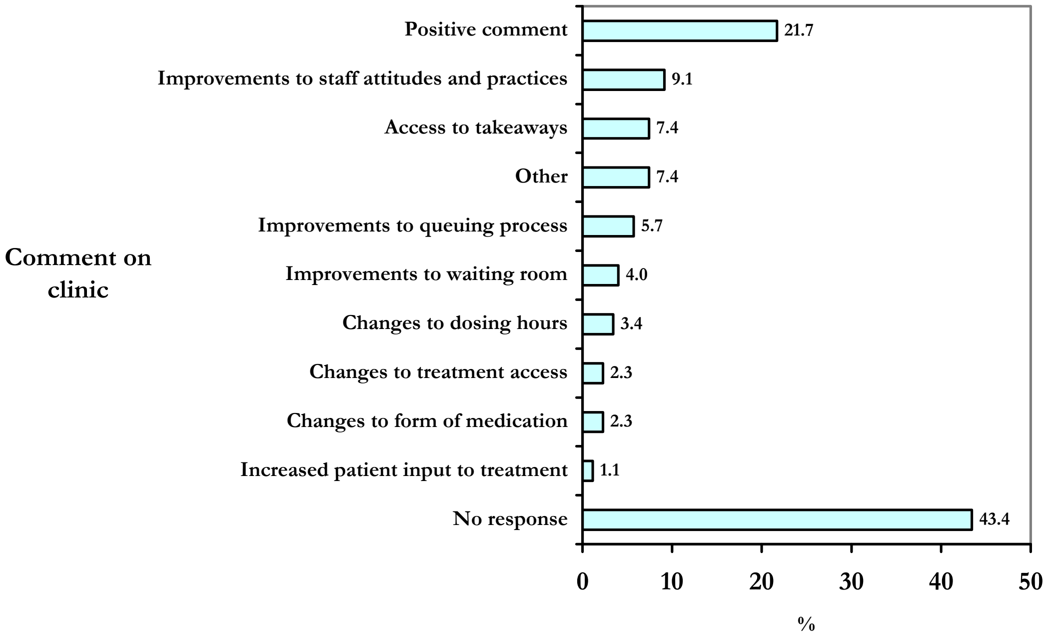
The most frequent comment made by respondents was a positive statement on the clinic's staff and/ or service delivery. This was commonly referenced to the value of the service to the client ("It's working for me"), or to recognition of the context in which staff operate ("I think the nurses and doctors are a great example of grace under pressure").

Other comments reiterated issues that had already been nominated by respondents as aspects of the clinic they would like to see changed; these included improving staff attitudes and practices, increasing patient access to takeaway of medication, and changes to the system by which patients queue to get dosed.

A small number of respondents commented on the eligibility criteria for accessing the clinic's services, suggesting that those who work, or had been accessing the clinic for a long time, no longer be eligible for treatment.

The distribution of responses for the entire population of respondents is displayed below in Figure 11.

Figure 11. “Is there anything else you would like to say about this clinic?”, Patient Satisfaction Survey respondents, Rankin Court, 2004 (n = 175)



4. DISCUSSION

4.1 Questionnaire and protocol

4.1.1 Response rate

The overall response rate of 82% achieved by the survey indicated a generally robust questionnaire and survey protocol.

Nonetheless certain issues that arose in the response to the questionnaire, and in its implementation, deserve analysis and potential revision prior to future replication.

While the available demographic characteristics of the respondents are generally comparable to those who declined to participate in the survey, it is still important to note that the proportion of males, and the proportion of those identified as Aboriginal or Torres Strait Islander was higher amongst the latter group. Future implementation of this survey must monitor these participation trends, and respond appropriately

It is also worthy of note that 10 (5.1%) respondents answered none of the four demographic questions at the beginning of the questionnaire (about sex, age category, medication type, and length of time as patient at Rankin Court); 9.1%, 10.2%, 25.1% and 15.4% of respondents respectively did not respond to each of these same questions.

While the issue had not presented in pretesting, it must be considered that the layout of the questionnaire (which labeled the demographic questions from A – D, and the remaining questions from 1–11) may have confused some respondents, prompting them to start their responses underneath the demographic questions. This may have applied to a proportion of the respondents who answered none of the demographic questions. .

It is also reasonable to postulate that some of the above respondents, as well as those who answered only some of the demographic questions, chose to withhold this particular information about themselves deliberately, and not by misunderstanding the questionnaire. Considerable emphasis is placed in the literature on opioid dependent patients' alienation in general health and pharmacotherapy services, and their fear of alienating their prescriber or dosing staff - and thus losing access to their pharmacotherapy. In this context, immediate assurances of anonymity may not be accorded sufficient strength; disclosure of information perceived as having the potential for matching individuals to data could thus be too threatening for some respondent, with the outcome that questions are left unanswered.

Such concerns are not without substance. 195 (92%) of the study population receive methadone, and 18 (8%) buprenorphine. Further sub setting by sex and/ or age category has the potential in this study population to increase the perceived possibility of individual response identification. Nonetheless, these questions inclusion in the instrument is necessary for appropriate analysis.

Testing of a reformatted version of the questionnaire (in regard to the demographic questions) with opioid dependent persons receiving pharmacotherapy would be recommended prior to any future implementation. Further emphasis on anonymity may also act to improve response to these items.

4.1.2 Protocol

Some difficulties were also experienced in the logistical implementation of the survey. While the queuing time of patients waiting to be dosed at times well exceeded the approximate 6 minutes it took to complete the questionnaire, this was not always the case – on many occasions, the patient was able to proceed immediately to be dosed upon their entry to the clinic. Not unreasonably, this situation impacted on a patient's ability or willingness to complete and return a questionnaire. 18 (8%) patients were given the questionnaire on more than one occasion before returning it. The protocol did accommodate for this situation by conducting data collection over several days; nonetheless, the urgency which many patients feel about receiving their dose, and their wish to progress through the clinic as quickly as possible, are powerful factors which will consistently inhibit participation in an remunerated survey which relies on completion during a dosing visit.

The survey protocol used for the survey involved two staff external to the usual clinic staff: the project officer (who approached patients and invited participation in the survey) and the NUAA representative (who was available to assist patients with completing the questionnaire if they requested it). These two staff was present in the patients' waiting area of the clinic for all dosing hours over the four day data collection period – a total of twenty three hours and forty five minutes.

A total of 12 (6.9%) of all respondents had the survey administered to them by the NUAA representative. With the limitations of such a small subset, their demographic characteristics approximated to that of the entire study population: all of these twelve were males; two (17%) were receiving buprenorphine; and their age was distributed commensurately to that of the overall study population. Responses were generally comparable to other respondents, though trending to more positive in their opinions of the service than the overall mean: the average rating of the clinic by these respondents was 8.1, higher than the entire population's average (7), but still within one standard deviation.

At a wage of $28/ hour for the NUAA representative, the provision of assistance to complete the questionnaire is thus calculated at a cost of $55.40 for each administered questionnaire. While the importance of achieving a maximum response rate by the study population is unarguable, the marginal cost of each of these questionnaires is high, and presents a notable opportunity cost for the agency bearing it. The use of dedicated staff to assist patients in responding to this questionnaire in future implementation must thus be considered open to question. The importance of accessing patient satisfaction data from patients with low literacy, and the issues of equity this raises, must be considered by those stakeholders with budgetary decision making authority. It is possible that this cost could be reduced through such strategies as the use of consumer volunteers, or the employment of a casual clerk, but it is arguable whether skills to communicate with the study population are easily located in the casual employment market. As 92% of responses came from the first offer of a questionnaire to a patient, it is arguable that the data collection period could be reduced to two instead of four days, thus further reducing costs.

The value of the functions undertaken by the project officer is difficult to estimate. Anecdotally, patients' attention was poor for any matters other than their position in the dosing queue, and the likelihood of patients picking up a survey of their own volition was questionable. It is considered that the verbal prompting of patients to undertake the survey was the principal factor behind it's the level of response, and would thus be important to retain in any future implementation. That this role be undertaken by non clinic staff is considered crucial for data integrity.

In summation, the questionnaire and protocol performed well in collecting data from patients on their satisfaction with service provided at Rankin Court. They represent a rigorous and effective quality improvement process to engage with opioid dependent pharmacotherapy patients and meet the accreditation requirements articulated in the MCAS.

The questionnaire and protocol offer considerable potential for quality improvement and accreditation fulfillment within other pharmacotherapy clinics in NSW. Their low cost of implementation would also facilitate their adoption. Consideration of their broader application across NSW pharmacotherapy clinics is thus recommended to stakeholders

4.2 Review of results

The results generated by the survey are of considerable value to the quality improvement cycle at Rankin Court. While affirming of the clinics overall direction and quality of service, areas of service that could be improved were also highlighted.

Overall satisfaction with the clinic was high amongst patients, as evidenced in the high average rating of the clinic, and the overwhelming proportions of patients who would be prepared to recommend the clinic to a friend who needed treatment. On a scale form 1(terrible) to 10 (excellent), the mean rating of the clinic was 7, and with responses clustered in the top half of the scale (standard deviation of 2.1). Concurring with this rating was that 76.9% of respondents reported that they would recommend this clinic to a friend who needed treatment

Similarly positive feedback on the clinic's performance was received from respondents in the domains of efficacy, information, and professional's skills and behaviours, where 68% 58%, and 83% of respondents respectively considered the clinic's service as mostly satisfactory or excellent. This level of commendation from patients on staff behaviour is welcome.

It is important to note however that for the questions in the domains of efficacy and of information, considerable proportions of respondents opted for the central response choice "neither good nor bad": 25% of respondents reported this opinion in response to both, "What is your overall feeling about how effective this clinic has been helping you with your problems?" and "What is your overall opinion about the amount of information this clinic has given you about your treatment?" Review of clinic service in these aspects of care would be appropriate, and annual assessment of the clinic's improvement against these questions a useful evaluative mechanism.

Respondent opinion was mixed in the domain of patients' input to health care: while 63% of patients considered their inclusion in decisions about their treatment was mostly satisfactory or excellent, only 27% reported the same feeling when asked about their inclusion in decisions on how the clinic is run. It is important to note that considerably fewer females than males reported positive opinion in regard to these questions, where only 49% and 17% respectively considered service in these areas to be mostly satisfactory or excellent. Women's poorer opinion of these aspects of the clinic's service is of importance and deserves further investigation. Consultation with female patients is advised. Expectations of communication and the nature of involvement in health care decision-making may be gender correlated, with commensurate implications for case management protocols, and consumer involvement structures.

Patients' dissatisfaction with their involvement in decisions on how the clinic is run is apparent. 46% of respondents felt their involvement in this area of service provision was either terrible or mostly dissatisfactory. It is arguable over which clinic operational decisions should involve patients, and then what weight should be accorded to patients' views if so. Examples of previous operational decisions put to patients include the change from methadone syrup to biodone in 2001, where extensive consultation was undertaken with patients, and the majority view determining the outcome. Examples of operational decisions not put to patients include the later start of dosing hours instituted in late 2003 in response to the introduction of computerised dosing. While it is reasonable to assume that differences of opinion will always exist between stakeholders in regard to the breadth and nature of patient involvement in clinic operational decisions, the development and communication of a clinic mission statement and protocol on this topic may reduce differences of understanding and increase patient satisfaction.

The clinic's quality of service in regard to accessibility was not considered positively by the majority of respondents: 30.5% of female patients considered that the clinic's response to complaints was mostly unsatisfactory or terrible, and a further 37.3% considered it neither good nor bad. Satisfaction with complaint handling is a principal indicator of a service's accessibility, and the limited proportion of patients who expressed positive regard for Rankin Court's capacity in this area of service provision is of concern. Clearer identification of patients' concerns with how complaints are responded to would be a valuable step for the clinic to improve this rating, along with communication to patients both of the available complaints process, and the limitations on services incumbent on publicly funded clinics.

Of similar concern in regard to accessibility was the large proportion of women (36.2%) reporting the physical environment for patients to be either terrible or mostly unsatisfactory. A larger proportion of respondents (30%) reported dissatisfaction in response to this question than any other except from that relating to patient involvement in how the clinic is run. A clinic review of odour management and cleaning systems for the patient waiting area would be welcome, and in accordance with the suggestions put forward by respondents. Management of the information displayed to patients on the waiting area walls would also benefit from inclusion in this review.

Patient nominated changes to the clinic highlight this population's priorities for quality improvement in service provision.

The three issues most frequently nominated by respondents to the question, "What is the one thing you would most like to see changed at this clinic?" pertained to dosing times (28%), takeaways (21%), and staff attitudes and practices (15%).

Hours of service are a major indicator of a service's accessibility. At the time of writing, Rankin Court provides methadone dosing between 8am and 1pm, and 3pm and 3.45pm from Monday to Friday, and from 8am to 1pm on Saturday and Sunday. Dosing for buprenorphine is provided between 11am and 1pm from Monday to Friday, and 10am and 12pm on Saturday and Sunday. Respondents frequently expressed their desire for longer dosing hours, with many specifying that changes in dosing hours should include an earlier start time. The desired extension to dosing hours, or an earlier start time, was often referenced to patients' needs to get to work or on to other commitments.

The logistical aspect of attending the clinic to receive their pharmacotherapy dose is a core part of patients' experience of and satisfaction with a clinic, and as such, it is reasonable that decisions on dosing hours must within reason and resource limitations, accommodate patient desires. However, Rankin Court is a public clinic, with pharmacotherapy provided free to a limited number of patients targeting those most at need. It is arguable that those patients who are stable enough to be employed should thus be paying for and receiving their pharmacotherapy through chemists, freeing up public places for less resourced opioid-dependent persons – and thus negating the relevance of working hours for the clinic's dosing hours. The contextual difficulty with this situation is the ongoing deficit in NSW of methadone prescribers and/ or pharmacies, which can hamper patients moving from public to private settings. In summary, it is important that Rankin Court review its dosing hours in light of patients' feedback expressed in this survey, but that its eligibility criteria for inclusion and continuance on the Rankin Court program (and commensurate service limitations) also be explicitly communicated with all patients.

Access to takeaway doses of pharmacotherapy is highly valued amongst opioid- dependent patients, and their provision strictly regulated by NSW Department of Health due to their potential for diversion and subsequent harm within the community. Rankin Court restricts access to take away doses of pharmacotherapy to:

- Christmas Day (all patients)
- homebound patients
- patients experiencing extenuating circumstances

Extenuating circumstances could include such events as court appearances, funerals, or post natal recovery, and are only available after a patient has been stable on the Rankin Court program for over three months; patients seeking a take away dose due to extenuating circumstances are required to submit a written application stating their case to the clinic, with only the Director of Drug and Alcohol Services able to grant approval for such requests. Approvals of takeaways are in accordance with the NSW guidelines.

The basis for these restrictions to take away doses lies in Rankin Court's parameters as a public pharmacotherapy clinic, the main therapeutic aim of which is stabilisation: as a free service targeting the most vulnerable and chaotic opioid-dependent persons, it is considered that individuals stable enough to be seeking routine take away doses of pharmacotherapy are likely to be of questionable eligibility as a Rankin Court patient.

Greater communication is recommended between the clinic and its patients on the application process and eligibility criteria for take away pharmacotherapy, along with the reasoning behind their restrictions at Rankin Court. Along with briefing patients on these issues during assessment and case management, the permanent display of this information in client waiting areas may also be of benefit. Further investigation of patients current understanding of Rankin Court's take away policy is recommended as a precursor to these interventions.

In light of the large majority of respondents (83%) who reported feeling staff treatment of them was mostly satisfactory or excellent, it is of interest that the third most frequently requested change at Rankin Court pertained to staff attitudes and practices. In part this can be attributed to the nature of the Likert scale response question, which asked respondents for their "overall" feeling – thus allowing respondents to give a positive rating to clinic staff overall, but still contribute a suggestion on how staff behaviour could be improved; for example, eleven of the twenty four respondents who nominated staff behaviour as the most desired change in the clinic, also rated staff treatment of patients as either mostly satisfactory or excellent.

Examples of respondent concern with staff behaviour included perceived breaches of confidentiality, and negative staff attitudes towards patients.

Ongoing review and support for staff development, especially in regard to attitudes towards opioid dependent persons, is recommended in light of this response from patients. Measures undertaken to support staff development in this regard should be communicated to patients as evidence of management's commitment to respond to the patient satisfaction survey.

Despite these concerns, it should also be noted that when offered the opportunity to give comment of any kind about the clinic, the largest proportion of respondents who did so (38.4%) made positive statements about the service received. These predominantly referred to the skills and behaviours of staff ("I think the nurses and doctors are a great example of grace under pressure." "Good job Rankin Court staff thank you."), but also referenced the perceived effectiveness of the clinic for the respondent ("It's working for me.").

In summation, the results from the 2004 patient satisfaction survey with pharmacotherapy patients at Rankin Court offer both affirmation for the quality of service provided by management and staff, but also offer considerable guidance on aspects of service which can be reviewed to better align with patients' needs.

REFERENCES

Alazri, M. H. & Neal, R. D. (2003), "The association between satisfaction with service provided in primary care and outcomes in Type 2 diabetes mellitus." *Diabetic Medicine,* vol. 20 no. 6 pp 486 – 490.

American Medical Association (1999), "Health literacy: report of the Council on Scientific Affairs. Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs." *Journal of the American Medical Association,* vol. 281 no. 6 pp552 –557.

Australian Council on Healthcare Standards (May draft 2003), "Resource tool for methadone clinics, 1st edition ", Australian Council on Healthcare Standards, Ultimo NSW.

Bell (1998), Delivering effective methadone treatment, in: Ward, J. & Mattick, R. P. & Hall, W (eds) *Methadone Maintenance Treatment and Other Opioid Replacement Therapies* Harwood Academic Publishers, Australia.

Bell, J. (2000), "Quality improvement for methadone maintenance treatment." *Substance Use and Misuse,* vol. 35 no.12-14 pp1735-56.

Caplehorn, J. R. & Irwig, L & Saunders, J. B. (1996), "Attitudes and beliefs of staff working in methadone clinics." *Substance Use and Misuse,* vol. 31 no. 4, pp 437 - 452

Caplehorn, J. R. & Lumley, T. S. & Irwig, L & Saunders, J.B. (1998), "Changing attitudes and beliefs of staff working in methadone maintenance programs." *Australian and New Zealand Journal of Public Health,* vol. 22 no.4 pp 505 - 508

Carmel, S. (1985), "Satisfaction with hospitilisation: a comparative analysis of three types of services." *Social Science and Medicine* vol. 21 no.11 pp1243 – 1249.

Consumer Focus Collaboration (2001), *The Evidence Supporting Consumer Participation in Health*, Department of Health and Aged Care, Canberra

Concato, J & Feinstein, A. (2001), "Asking patients what they like: overlooked attributes of patient satisfaction with primary care." *American Journal of Medicine.* vol. 102 no. 4 pp 399-406.

Converse and Prosser (1986), *Survey questions: handcrafting the standardised questionnaire.* Sage University Press, Series on Quantitative Applications in the Social Sciences, Series No 07 – 063, Newbury Park

Currie, K. & Spink, J. & Rajendran M. (2000) *Well-written Health Information - A Guide. Public Hospital Patient Charter Principles.* Victorian Department of Human Services, Melbourne,

Davis, T. C. & Crouch, M. A. & Long, S. W. & Jackson, R. H. & Bates, P. & George R. & Murphy, P & Crouch, M (1993). "Rapid estimate of adult literacy in medicine: a shortened screening instrument." *Family Medicine.* vol. 25 no. 6 pp391 - 396

De los Cobos, J. & Valero, S. & Haro, H. & Fidel, G. & Escuder, G. & Trujols, J. & Valderrama, J.C. (2002) "Development and psychometric properties of the Verona Service Satisfaction Scale for methadone-treated opioid-dependent patients." *Drug and Alcohol Dependence.* vol. 68 pp209-214.

Foundation for Accountabilty (FACCT) (2002) “Quality Measures”, http://www.facct.org/facct/site/facct/facct/Measures

Fischer, B. & Chin, A. T. & Kuo, I. & Kirst, M. & Vlahov, D. (2002) “Canadian illicit opiate user's views on methadone and other opiate prescription treatment: An exploratory qualitative study.” *Substance Use and Misuse.* vol. 37 no.4, pp495-522.

Grol R. (2001) “Improving the quality of medical care: building bridges among professional pride, payer profit, and patient satisfaction.” *Journal of the American Medical Association.* vol. 286 no.4 pp2578 - 2585

Hall, J. A. & Milburn, M. A. & Roter, D. L. & Daltroy, L. H. (1998), “Why are sicker patients less satisfied with their medical care? Tests of two explanatory models.” *Health Psychology.* vol. 28 pp 261 – 270

Hibbard, J (2003) “Engaging health care consumers to improve the quality of care.” *Medical Care.* vol. 41 no.1 ppI61 – I70

Kefalides, P. T. (1999) “Illiteracy: The silent barrier to health care.” *Annals of Internal Medicine* vol. 103 (Part 1) pp 333-336.

Kimble, L. P. & Dunbar, S. B. & McGuire, D. B. & De, A. & Fazio, S. & Strickland O. (2001) “Cardiac instrument development in a low literacy population: The revised Chest Discomfort Diary.” *Heart and Lung.* vol. 30 no.4 pp312-320

Kirsch, I & Jungeblut, A & Jenkins, L. & Kolstad, A. (1993) *Adult literacy in America: a first look at the results of the National Adult Literacy Survey.* Washington DC: National Centre for Education Statistics, US Department of Education

Larsen, D. L. & Attkission, C. C. & Hargreaves, W. A. & Nguyen, T. D. (1979) “Assessment of client/ patient satisfaction: development of a general scale.” *Evaluation Program Planning.* vol. 2 pp 197-207.

Lawthers, A. G. & Rosanski, B. S. & Nizankowski, R. & Rys, A. (1999) “Using patient surveys to measure the quality of outpatient care in Krakow, Poland.” *Journal for Quality in Health Care.* vol. 11 no. 6 pp. 497-506.

Lord, S. (2003) “Opioid treatment in practice: a consumer perspective”, *Proceedings of the APSAD 2003 Conference on Alcohol and Drugs*, 17-20 November 2003, Australian Professional Society on Alcohol and other Drugs, Randwick NSW

Morgan S. (1993) *Report on the methadone consumers campaign.* NSW Users and AIDS Association Inc. (NUAA), Surry Hills, NSW (Unpublished report).

Nathorst-Boos, J. & Munck, I. & Eckerlund, I. & Ekfeldt-Sandberg, C. (2001) “An evaluation of the QSP and the QPP: two methods for measuring patient satisfaction.” *International Journal for Quality in Health Care.* vol. 13 no. 3 pp257-264.

NSW Health Department (2000), *NSW Methadone Clinic Accreditation Standards*, State Health Publication, Sydney.

NSW Health Department (2001), *Partners in Health: Sharing information and making decisions together. Report of the Consumer and Community Participation Implementation Group*, NSW Government Action Plan, Sydney.

Nuckols (1953) “A note on pre testing public opinion questions.” *Journal of Applied Psychology*, vol. 37 pp119-120

Oermann, M. H. & Templin, T (2000), “Important attributes of quality health care: consumer perspectives.” *Journal of Nursing Scholarship.* vol. 32 no. 2 pp167172.

Qatari, G. A. & Haran, D. (1999), “Determinants of users' satisfaction with primary health care settings and services in Saudi Arabia.” *International Journal for Quality in Health Care.* vol.11 no.6 pp 523-531

Ruggeri, M. & Dall’Agnola, R. & Agostini, C & Bistoffi, G. (1996) “Factor analysis of the Verona Service Satisfaction Scale–82 and development of reduced versions.” *International Journal of Psychiatric Research Methods.* vol. 6 pp23-38

Slosson, R. L. (1994) *Slosson oral reading test SRT-R manual.* Slosson Education Publications, East Aurora, New York

Thompson, A.G.H. (1999) “New millennium, new values: citizen participation as the democratic ideal in health care”, *International Journal for Quality in Health Care.* vol. 11 no. 6 pp.461 - 464

Thomson, N. & Morgan K. (1999) *The Victorian Community Methadone Program. An investigation into consumer complaints and grievances.* Victorian Drug User Group (VIV AIDS) project (unpublished report), Melbourne.

Williams, B. (1994) “Patient satisfaction: A valid concept? *Social Science & Medicine.* vol. 38 pp509 - 516

Wodak, A (2002) “Methadone and heroin prescription: babies and bath water. It's the context stupid: methadone treatment in an unsympathetic environment.” *Substance Use and Misuse.* vol. 37 no.4 pp523-530.

Woods, M. A. (2001) “Methadone advocacy: the voice of the patient.” *Mount Sinai Journal of Medicine.* vol. 68 no.1 pp 75-8.

APPENDIX A:

St Vincent’s Hospital Research Office advice

1. From Dr Alex Wodak, Director, Alcohol and Drug Services St Vincent's Hospital, to Rodney Eccleston, Research Office St Vincent's Hospital, October 2003:

Dear Rodney,

I am starting a project soon with a Public Health Officer Trainee (Paul Kehoe) from the NSW Health Department whose job will be to design and test a consumer satisfaction survey for the methadone/buprenorphine punters. The question is whether or not that will be regarded as a quality instrument and therefore exempt from the HREC process. We want this instrument ultimately to be used state-wide. We may also want to publish something about this in a refereed journal to maximise impact beyond NSW and maybe also to maximise impact beyond this specific application.

Since it involves developing and testing a survey, rather than simply administering a standard instrument, it might get called research but the other view is that this is basically quality assurance and therefore does not need hauling over the coals.

I would welcome your thoughts on the matter.

best wishes,

Alex

Dr. Alex Wodak,
Director, Alcohol and Drug Service,
St. Vincent's Hospital,
Darlinghurst, NSW, 2010,
Australia

2. From Rodney Eccleston, Research Office St Vincent's Hospital to Dr Alex Wodak, Director, Alcohol and Drug Services St Vincent's Hospital, October 2003:

Hi Alex

Thanks for passing this by the office.

The NHMRC have created yet another rule book concerning this very issue and I have attached it for your reference. Take a quick look at page 6. With regard to the Privacy Principles, you should not be in any breach as this activity relates directly to the primary reason this group is coming to clinic.

I would suggest we do the following.

1. I will bring your e-mail to the attention of the ethics sub-committee this Thursday and suggest we issue you with a quality assurance reference number for this activity.

2. In order to establish some level of consent (see point 1 under consent page 6) for the folk this tool will be tested on, I would suggest one of two approaches. Firstly, draft a public notice
(poster) for the clinic, informing people that QA activity is taking place. It should assure them of confidentiality/ anonymity, a right to refuse taking part without impacting on treatment/care and provide some background to the reason the tool is being developed. Alternatively you could consent (written) people individually. I believe the first option would be more than suffice.

3. You should forward a proposed poster as outlined above for our files.

With this approach I do not think you will have problems when this project moves toward publication.

I hope this helps. Best of luck with it.

Rodney
Rodney Ecclestone

Research Office
St. Vincent's Hospital,
Darlinghurst, NSW, 2010,
Australia

3. From Dr Alex Wodak, Director, Alcohol and Drug Services St Vincent's Hospital, to Rodney Eccleston, Research Office St Vincent's Hospital, May 2004:

Dear Rodney

We ran a consumer satisfaction survey with our methadone patients for quality improvement and accreditation purposes at Rankin Court in February 2004. I wrote to you seeking your advice in October last year (attached).

I write now to seek Research Office endorsement of our intention for the survey materials and results to be put into the public domain through monograph and peer review journal publication.

Consistent with your October advice, the attached poster about was displayed in Rankin Court's patient waiting area in the month preceding the survey implementation. The survey instrument (attached) also addressed these issues on its cover sheet.

I regret that these materials were not received sooner by the Research Office, and appreciate your assistance with this matter.

Please contact Paul Kehoe on 9391 9447 if you require any further information in regard to this query.

best wishes

Alex

Dr. Alex Wodak,
Director, Alcohol and Drug Service,
St. Vincent's Hospital
Darlinghurst, NSW, 2010,
Australia

4. From Helen Fraser, Research Office St Vincent's Hospital to Dr Alex Wodak, Director, Alcohol and Drug Services St Vincent's Hospital, June 2004:

Dear Dr Wodak

Thank you for your email with attachments dated May 31 2004 to the Human Research Ethics Committee seeking approval to publish results from an advertisement and a quality improvement form that were utilised at Rankin Court.

I'm happy to inform that the HREC executive approved such publications.

Yours sincerely

Helen Fraser
Acting Executive Director
Human Research Ethics Committee

APPENDIX B:

Terms of Reference, Project Reference Group

St Vincent’s Hospital Alcohol and Drug Service
Rankin Court Treatment Centre

Pharmacotherapy Patient Satisfaction Project Reference Group
Terms of Reference

Introduction

As a facility of St Vincent’s Hospital, Rankin Court participates in and reports against the Evaluation and Quality Improvement Program (EQuIP) indicators of the Australian Council of Health Care Standards (ACHS). This accreditation framework encompasses and reflects the Methadone Clinic Accreditation Standards produced by the NSW Department of Health (2000).

The implementation and outcomes of this patient satisfaction project will contribute directly to the fulfillment of EQuIP responsibilities.

Function

The key functions of the Reference Group are to oversee the strategic directions of the Pharmacotherapy Patient Satisfaction Project, and contribute where appropriate to the implementation of its tasks.

Responsibilities

The Reference Group will be responsible for contributing to the development, implementation, and evaluation of the Pharmacotherapy Patient Satisfaction Project across the areas of:

- Development of project goals and parameters
- Design of patient satisfaction questionnaire and survey protocols
- Stakeholder input and liaison, including consumers, St Vincent’s Hospital, Department of Health, other service providers
- Project advocacy

Reporting Relationships

The Reference Group has no line reporting relationship within St Vincent’s Hospital, and convenes solely to contribute to the Pharmacotherapy Patient Satisfaction Project.

Membership

Simon Johnston	Drug Programs Bureau, NSW Health
Alex Wodak	Director, Alcohol and Drug Service, St Vincent's Hospital
Carol Stubley	Rankin Court Treatment Centre, St Vincent's Hospital
Ahmed Jamal	Quality Improvement Unit, St Vincent's Hospital
Richard Sulovsky	NSW Users and AIDS Association
Geney Jones	Methadone Advice and Complaints Service
Paul Kehoe	NSW Health (Project Officer & secretariat)

Frequency of meetings
The Reference Group will convene on a 6 weekly basis; communication between Reference Group members may occur more frequently reflecting project tasks and priorities.

Secretariat
The Project Officer will provide secretariat support to the Reference Group. This support will comprise agenda papers, minutes and follow up actions arising.

APPENDIX C:

Patient Satisfaction Survey protocol and instrument

Rankin Court Treatment Centre
St Vincent's Hospital
Patient Satisfaction Survey
February 2004

Survey Protocol

Promotion

1. Promotion of patient satisfaction questionnaire in 2 weeks prior to implementation – clients advised by clinic staff of dates and purpose of data collection, protection of respondent anonymity, etc

Administration

1. Project officer invites patients' participation in the survey upon their entry to the clinic. Patients are advised on purpose of data collection and of respondent anonymity.

2. Patients' response to invitation noted on the recruitment master list of patients (held by the Project Officer), and an unmarked questionnaire provided if the individual consents to participate.

3. Patients who consent to participate will be directed to the NUAA representative for assistance in reading and responding to the questionnaire should such assistance be required (nb. stigma of low literacy to be avoided in this process - eg. patients can be prompted for assistance "..if patient does not have their reading glasses with them" , "lighting conditions are poor" etc)

4. Upon entry to dosing room, patients will be asked by clinic staff if they consented to participate in the survey. Their response will be noted against copy of the recruitment master list. If the patient consented to participate, clinic staff will ask the patient if they have completed the questionnaire to their satisfaction. If they have, the patient will be asked to place the completed questionnaire in a return box. The copy of the Master List will record that the patient has completed and returned the questionnaire. If the patient indicates that they have not completed the questionnaire to their satisfaction, they will be asked to take the questionnaire away to complete it and return the following day.

5. Completed questionnaires are removed from the return box on a daily basis, and the recruitment master list reconciled with the copy held in the dosing room. Patients who have completed and returned the questionnaire will be marked off on the Recruitment Master List to avoid future requests for participation.

6. Patients who consented to participate, were given questionnaires and not completed and returned them, will be followed up by recruitment staff on two more subsequent occasions. If the questionnaire has not been completed and returned after the third provision of a questionnaire, no further attempts at recruitment will be made. Data collection will be undertaken over a four day period.

Rankin Court Treatment Centre
St Vincent's Hospital
Patient Satisfaction Survey
February 2004

What's this survey all about??

Rankin Court wants to provide the best services to people on methadone and bupe.

Answering the following short questions will mean **YOUR VOICE IS HEARD**, and may change how this clinic is run.

Your answers are **ANONYMOUS.** No clinic staff will know which answers came from which person, so **YOU CAN BE COMPLETELY HONEST.**

Speaking up will make services better for you, and for other people at this clinic.

The results, and how the clinic will respond to them, will be displayed for you to see in the waiting room as soon as possible.

If you have any questions, you can:

- ring Richard at NUAA on 1800 644 413
- ring Paul at Rankin Court on 9361 8024
- ask for Paul at Rankin Court reception

Interviewer administered: ☐

(INSTRUCTIONS: For questions A – D, please tick ONE BOX for EACH question)

A. **Sex** ☐ male ☐ female ☐ transgender
B. **Age (years)** ☐ 25 and less ☐ 26 – 35 ☐ 36 – 45 ☐ 46 – 55 ☐ 55 and over
C. **Treatment** ☐ methadone/ Biodone ☐ bupe/ Subutex
D. **Total time as patient at this clinic (years)** ☐ less than 1 ☐ 1 - 5 ☐ greater than 5

*(INSTRUCTIONS: For each of questions 1-8, place an **X** over the **ONE** face that best describes your recent experiences at this clinic **within the last 6 months or less**)*

WHAT IS YOUR OVERALL FEELING ABOUT ….

	Terrible	Mostly unsatisfactory	Neither good nor bad	Mostly satisfactory	Excellent
1. …how staff at this clinic treat you?	😠	☹	😐	🙂	😁
2. …the way you're included in decisions on your treatment? *(eg. your dose, your case management, etc)*	😠	☹	😐	🙂	😁
3. …the way you're included in decisions on how the clinic is run? *(eg. its opening hours, takeaway policy, etc)*	😠	☹	😐	🙂	😁
4. …the physical environment for patients at this clinic? *(eg. its appearance, comfort, space, etc)*	😠	☹	😐	🙂	😁
5. …the way this clinic responds to complaints from patients?	😠	☹	😐	🙂	😁
6. …how effective this clinic has been helping you with your problems?	😠	☹	😐	🙂	😁
7. …the amount of information this clinic gives you about your treatment?	😠	☹	😐	🙂	😁

	No, definitely not	No, but with reservations	Wouldn't matter either way	Yes, but with reservations	Yes, definitely
8. Would you recommend this clinic to a friend who needed treatment?	😠	☹	😐	🙂	😁

9. What is the one thing you would most like to see changed at this clinic?

____

____

____***(Turn over to add more comments)***.

10. Is there anything else you would like to say about this clinic?

____

____

____***(Turn over to add more comments)***.

11. Thinking about ALL your experiences at this clinic, please give this clinic an OVERALL rating by circling one of the numbers below.

1 2 3 4 5 6 7 8 9 10
(Terrible) (Excellent)

THANK YOU FOR YOUR HELP!!

SPECIAL THANKS TO NUAA FOR ASSISTANCE AND SUPPORT WITH THIS SURVEY

Further comments:

APPENDIX D:

Patient Satisfaction Survey promotion and recruitment materials

Rankin Court wants to know
what you want!

Early this year, Rankin Court will be asking
YOUR OPINION on the best ways to provide services to people on methadone and bupe.

Your opinions will be anonymous, and it will entirely up to you if you want to have a say – your treatment here will not be affected if you do or don’t.

The survey is being written **NOW**.

Do you want to get involved in deciding what questions will be asked?

Speaking up make can make services at Rankin Court better for you, and for other people here too!

If you want to get involved, or have any other questions about this, you can..

- ring Paul at Rankin Court on 9361 8024
- ask for Paul at Rankin Court reception
- ring Richard at NUAA on 1800 644 413

Tell us what you think of us!

From

Tuesday Feb 9 – Friday Feb 13,

Rankin Court will run an anonymous survey to ask

WHAT YOU THINK

of the services provided here to people on
methadone and bupe.

Your cooperation and support for the survey will be greatly appreciated. Speak up, and help make services at Rankin Court better for you, and for other people here too!

If you have any other questions about the survey, you can…

- ring Paul at Rankin Court on 9361 8024
- ask for Paul at Rankin Court reception
- ring Richard at NUAA on 1800 644 413

APPENDIX E:

Implementation issues for other agencies

Patient Satisfaction Survey: Implementation issues

1. Objectives

   Is there a commitment to quality improvement on behalf of the agency, and responding to survey findings? If not, then survey implementation should be reconsidered.

2. Permission

   Has permission been granted by agency management?
   Has exemption been secured from the local ethics committee (if relevant)?

2. Consultation

   Have all relevant stakeholders been consulted? Eg. staff, patients, users' groups (if available), quality improvement staff (if available)? Has their input to implementation been structured appropriately? Eg. reference/ advisory groups.

3. Local appropriateness

   Have the items on the questionnaire been assessed for local suitability?
   Are there questions or information that need to be omitted or added?

4. Survey protocol requirements

   Are there sufficient resources to carry out the survey according to the original protocol? Consider the implications of deviating from the protocol, and the potential introduction of bias. Visible/ active involvement of clinic staff in data collection is strongly advised against due to the potential bias on responses.

5. Analysis

   What resources are available to respond to qualitative data collected in the questionnaire? Does a new coding schema need to be developed for the data?

6. Feedback & response

   How quickly and through what mean will results be communicated back to patients & other stakeholders? This is an urgent priority. What actions will be taken to respond to the survey findings?

Patient Satisfaction Survey: Database

An Access 2000 database has been developed by the Information Services Technology Centre at St Vincent's Hospital, in consultation with that hospital's Alcohol and Drug Services, to house and manipulate data from the latter's 2004 patient satisfaction survey.

It is anticipated that a copy of this database, and FAQ text file, will be available from St Vincent's Hospital Alcohol and Drug Services by the end of 2004, for agencies interested in repeating this survey with their own patient populations

Support for this database will not be supplied by St Vincent's Hospital