Journal of Substance Abuse Treatment 53 (2015) 47–51

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

A Satisfaction Survey of Opioid-Dependent Patients with Methadone Maintenance Treatment

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ARTICLE INFO

Article history:
Received 27 July 2014
Received in revised form 16 December 2014
Accepted 22 December 2014

Keywords:
Opioid dependency
Methadone maintenance treatment services
Satisfaction
Predictors

ABSTRACT

The aim of this study was to examine opioid-dependent patients' satisfaction with the methadone maintenance treatment (MMT) program in Malaysia and identify predictors of satisfaction. We used an interviewer-administered questionnaire developed and validated by Rankin Court, New South Wales, Australia. Of 502 patients approached in 11 MMT centers in Malaysia, 425 agreed to participate giving a response rate of 85%. In terms of overall satisfaction, a high percentage of respondents (85%) were satisfied with the MMT services. A logistic regression analysis showed that only "centres" and marital status were associated with overall satisfaction and that being single (OR 3.31; 95% CI 1.52 to 7.20) or married (OR 4.06; 95% CI 1.76 to 9.38) was associated with higher odds of overall satisfaction compared to being divorced or separated. An analysis of the responses pertaining to the most desired changes required at the center found dosing hours, waiting area and staff shortages to be common. The findings acquired from this survey will be useful to attain a clearer perspective on what aspects of the MMT service need to be reviewed for the improvement of service delivery.

1. Introduction

The aim of methadone maintenance treatment (MMT) in opiate dependency is to reduce the individual and social harm associated with illicit opiate use. MMT does not cure opiate dependence; rather it is a treatment that helps people to manage their opiate dependence. By reducing craving and preventing withdrawal, the addicts' preoccupation with obtaining illicit drugs is reduced sufficiently, thus enabling the users to achieve some stability in their life (Ward, Hall, & Mattick, 1999). From a social perspective MMT has been shown to be cost effective and beneficial for the treatment of opiate dependence (Simoens, Ludbrook, Matheson, & Bond, 2006). Among the benefits seen in individuals and society are reduced numbers of deaths due to drug overdose, improved family stability and employment potential, reduced transmission of diseases such as HIV and sexually transmitted diseases, and reduced criminal activities (Bennett, Holloway, & Williams, 2001; Oppenheimer, Tobutt, Taylor, & Andrew, 1994; Ward et al., 1999; Wells, Calsyn, Clark, Saxon, & Jackson, 1996).

It is estimated that at least one million people in Malaysia are currently addicted to heroin and other opiates (Malaysian Psychiatric Association, 2006). They risk premature death and often suffer from HIV, hepatitis B or C, sexually transmitted diseases, and mental health problems. The MMT program in Malaysia was initiated in October 2005 with 18 facilities (Sangeeth, Hafidah, & Mahmood, 2009) and has now expanded to include 333 centers in 2012 (Ministry of Health Malaysia (MOH), 2012). However, little is known about patients' satisfaction with the delivery of those services. Patients who are dissatisfied with the MMT services may have worse outcomes than others because they may miss appointments or do not follow through on treatment plans (Fitzpatrick, 1991).

The measurement of satisfaction can be difficult because there is no clear definition of satisfaction and a lack of understanding of its underlying factors (Baker, 1997). This has hindered measurement efforts and caused difficulty in the interpretation and comparing of research findings. In spite of the increased emphasis on assessing patients' satisfaction because satisfaction can affect treatment outcome, the literature regarding patients' satisfaction remains limited (Pérez de los Cobos et al., 2004). Even though there is no clear definition of satisfaction, patients' satisfaction can be viewed as patients' expectations and perceptions of how well the services fulfilled their needs. This measure is affected by their prior experiences, individual needs and expectations (Williams, 1994).

A major limitation in assessing patient's satisfaction with MMT services is the limited availability of instruments designed to measure satisfaction specific to MMT service delivery. Given the lack of such a tool, satisfaction with MMT program has been assessed using other satisfaction instruments designed for other purposes such as the Client Satisfaction Questionnaire (CSQ-8) (Larsen, Attkisson, Hargreaves, & Nguyen, 1979), the Service Satisfaction Scale (SSS-30) (Attkisson & Greenfield, 1996) and the Verona Service Satisfaction Scale (VSSS-32) (Ruggeri, DallAgnola, Bisoffi, & Greenfield, 1996). The SSS-30 has several

Abbreviations: CSQ-8, Client Satisfaction Questionnaire; MMT, Methadone Maintenance Treatment; SSS-30, Service Satisfaction Scale; VSSS-32, Verona Service Satisfaction Scale; VSSS-MT, Verona Service Satisfaction Scale for methadone-treated opioid-dependent patients.

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http://dx.doi.org/10.1016/j.jsat.2014.12.008
0740-5472/

features that greatly limit its usefulness in assessing patients' satisfaction with MMT. The most important of these is that SSS-30 appears appropriate for use only in health or mental health outpatient services (Attkisson & Greenfield, 1994). For example, it contains items that ask patients about their satisfaction with prescription (or non-prescription) medication in helping to relieve symptoms. de los Cobos et al. (2002) adapted the VSSS-32 specifically for application in methadone treatment centers. The adapted instrument (the Verona Service Satisfaction Scale for methadone-treated opioid-dependent patients, or VSSS-MT) has 27 items and contains a mixture of open ended and 5 point Likert scale responses, addressing specific aspects of service delivery and overall quality of service ratings. The authors reported that the VSSS-MT displays a high level of internal consistency, and a satisfactory level of test–retest reliability. Despite its usability, the Rankin Court Centre, New South Wales, Australia (Kehoe, Wodak, Degenhardt, & National Drug Alcohol Research Centre, 2004) considered VSSS-MT as too long and complex for most patients' literacy skills. The Rankin Centre thus developed a validated shorter, eleven items questionnaire which we used in this study.

Assessing patients' satisfaction with the MMT services is crucial because at present the trend is for health care services to be more patient oriented. Given that patients' satisfaction evaluation is important and that WHO has recommended it for improving the quality of services at MMT centers (World Health Organization, United Nations International Drug Control Programme, & European Monitoring Center on Drugs Drug Addiction, 2000), we wanted to determine patients' satisfaction with the MMT services they were receiving. Thus, the main objective of our study was to examine patients' satisfaction with the MMT services offered by MMT centers in Malaysia. We also identified factors which predicted overall satisfaction.

2. Methods

2.1. Survey centers and participants

This cross-sectional study was conducted in 11 centers from four regions in Peninsular Malaysia (central, north, south and east). Eligible centers were methadone-dispensing centers that had been in operation for at least 3 months. The centers were selected based on simple random sampling while participants from each selected center were based on convenient sampling. The researchers approached potential participants in order to recruit and inform them of the purpose of the research. Potential respondents were assured of their anonymity, and oral informed consent was obtained. Subjects who showed clear signs of substance intoxication were excluded from the study. Two trained interviewers administered the questionnaires via face-to-face interview. The survey was carried out over a 2-month period. Only participants who received MMT in the month prior to the survey were included.

We made one change to the questionnaire before the study. Since we intended to dichotomize the response of overall satisfaction to “satisfied” and “dissatisfied”, we changed the wording for item 11 of the original questionnaire to “Thinking about all your experiences at this centre, are you satisfied with the service?” This version of the questionnaire was piloted with a representative sample of 40 participants to assess the items for local suitability before the study began. Data from this pilot testing were not included in the analysis.

2.2. Instrument

Except for item 11, we used all the items in the questionnaire developed by Rankin Court, Australia. Permission to use the questionnaire was obtained from the questionnaire developer. According to the questionnaire developer, the items in the questionnaire addressed a range of conceptual dimensions including professionals' skills and behaviors, physical environment, the amount of information provided, and overall satisfaction. Face validity of the questionnaire has also been addressed (Kehoe et al., 2004).

Eight of the eleven items explored satisfaction about the center and covered conceptual dimensions such as professionals' skills and behaviors, access and amount of information. Likert scale response categories used were terrible = 1; mostly dissatisfied = 2; neither good nor bad = 3; mostly satisfactory = 4 and excellent = 5. For the purpose of data presentation we considered the response on the Likert scale as scores.

We also collected socio-demographic data, age, gender, ethnicity, level of education, and marital status.

2.3. Data analysis

Data were analyzed using Statistical Package for the Social Sciences (SPSS), version 21.0. Descriptive statistics such as percentages and means were used to describe the sample on the various variables. Univariate logistic regression was used to evaluate the relationships between overall satisfaction (satisfied vs. dissatisfied) and all the demographic variables. When the expected cell number was lower than five in the contingency table, Fisher's exact test was used.

2.4. Model building

The dependent variable, “Satisfied” was regarded as a dichotomous variable and coded 0 = “No” response and 1 = “Yes” response. Univariate logistic regression analysis was then performed to identify variables for inclusion into the model. Statistical significance at $p < 0.10$ level was used to determine the significance of variables for inclusion into the model. Nominal scale variables with more than two levels (such as race and centers) were entered as $k - 1$ dummy variables. For the ethnic variable, Malay was treated as the reference group while for centers, center A in Kuala Lumpur was used as the reference group. For ordered categorical data with more than two levels, the variable was entered as $k - 1$ dummy variables with the lowest level used as the reference group.

Significant variables in the univariate analysis were entered simultaneously (forced entry method) into binary logistic regression to evaluate their independent predictive value for overall satisfaction.

3. Results

3.1. Socio-demographic characteristics of the study population

Of the 502 patients approached, 425 agreed to participate and completed the questionnaire representing a response rate of 85%. Except for two females, all the respondents were males. The gender distribution of the sample was reflective of the MMT population. Their age ranged from 14 to 74, with a mean age of 39.2 (SD = 2.1) years. The majority of the sample was Malay respondents (80.7%). Other socio-demographic characteristics of the study population are shown in Table 1.

3.2. Association of socio-demographic variables with overall satisfaction

Table 1 compares characteristics of patients in the two groups: satisfied (i.e., responded with a “Yes”) versus dissatisfied (i.e., described their overall satisfaction with a “No”). Univariate logistic regression analysis indicated that overall satisfaction was not associated with the demographic variables of sex, age, race, and education category and length of time on MMT at significance level of $p = 0.1$ (Table 1). Only marital status and treatment centers were found to be statistically associated with overall satisfaction.

3.2.1. Predictors of overall satisfaction in the multivariate logistic regression

Table 1 shows that only marital status and treatment centers were found to be statistically predictive of overall satisfaction and therefore were included into the multivariate model. Table 2 shows the results of the multiple logistic regression model predicting overall satisfaction with MMT services. Compared to someone who was divorced or separated, the odds of being satisfied with MMT services was about three