

# Southampton Treatment and Recovery System (STaRS)

## Encouraging the engagement of service users in drug treatment services

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## Improving Compliance in Drug Treatment Services

### A Good Practice Guide:

#### **A new way of working:**

Following recent meetings to address the problem of the low rate of successful treatment completions for service users in Southampton, the Southampton integrated management group, including the Drug Action Team has taken the decision to implement a new way of working for the drug treatment services. This new way of working has been dubbed “STaRS” or the “Southampton Treatment and Recovery System”.

The new system will be implemented incrementally from 25<sup>th</sup> October 2010.

The first table shows the new process and how it will be applied to the differing groups of service users identified:

<b>Process</b>	<b>Appropriate service user group</b>
<ul style="list-style-type: none"> <li>• Initial appointment for referral / triage</li> <li>• Full assessment – CAT and Doctors appt</li> <li>• Prescribing starts within 48 hours – For prison leavers we will endeavour to commence prescribing the day after leaving prison</li> <li>• Key working commences – <b>at least 1 x per week</b></li> </ul>	<p><b>Priority groups</b> (i.e. pregnant, prison leavers, complex health needs, PPO's)</p>
<ul style="list-style-type: none"> <li>• Initial appointment for referral / triage</li> <li>• 2 x key work sessions scheduled as a minimum (plus up to 4 additional meaningful engagements) required prior to scheduling a Doctors appointment/full assessment)</li> <li>• Full assessment – CAT and Doctors appt within 3 weeks of referral</li> <li>• Prescribing starts within 3 weeks of full assessment (probably within 48 hrs)</li> <li>• Key working <b>at least 1 x weekly and group options will be available</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>New presentations</b></li> <li>• <b>Cyclical returners</b></li> <li>• <b>Integrated Offender Management (IOM) referrals</b></li> </ul>
<ul style="list-style-type: none"> <li>• Initial appointment for referral / triage</li> <li>• 2 x key work sessions scheduled (minimum 2, maximum 6 meaningful engagements) required prior to scheduling a full assessment.</li> <li>• Full assessment/general healthcare assessment takes place and service user may be referred for Recovery co-ordination</li> <li>• Key working to commence – <b>at least 1 x per week</b></li> </ul>	<p><b>Non Prescribed</b></p> <ul style="list-style-type: none"> <li>- Stimulant users</li> <li>- Addicted cannabis users</li> <li>- All class A and B users</li> </ul>
<ul style="list-style-type: none"> <li>• Initial appointment continuous prescribing</li> <li>• Continuous prescribing</li> <li>• Key working to commence – <b>at least 1 x per week</b></li> </ul>	<p><b>Transfers from:</b></p> <ul style="list-style-type: none"> <li>- Hospitals</li> <li>- Prisons</li> <li>- Other areas</li> </ul>

It is recognised that service users who are already in treatment need to be considered in more detail. This is because they differ from new or returning presentations because we are asking them to engage with services differently to the way that they may feel they “signed up to” when they entered treatment. This group will initially have an expectation of having rapid access to prescribing with minimal engagement being required. It would therefore take a little time and explanation for their expectations to be modified in line with the new system being rolled out.

**Service user’s already in treatment:**

Positive engagement	<p>Apply new system process.</p> <p><b>Contingency Management</b> to be used to further motivate and reinforce positive engagement.</p> <p><b>Record of Achievement</b> to be kept in service users file – with folder and contents issued to service user to keep and bring to all key work sessions.</p>
<p>Non engagement</p> <p>Disincentivised</p>	<p>Possible sanctions for failure to engage with <b>all</b> elements of Recovery plan (i.e. not just prescribing).</p> <p>Clear explanation of the new system from key workers/staff</p> <p>System of “<b>letters of concern</b>” for failure to attend appointments (key work, groups, clinics)</p> <p>If “<b>letters of concern</b>” prove ineffective, then possible referral to “Review meeting”</p> <p>Review meeting considers case and agrees either new strategies for engagement (i.e. group work) or sanctions.</p>
Continuing engagement	Apply new system process.
<p>Harm minimisation</p> <p>Low threshold</p> <p>Poly drug use</p> <p>Alcohol use</p>	<p>All these SU groups will be dealt with under the same system as above.</p> <p>(Provision for alcohol treatment should be scoped so that appropriate referrals can be made where necessary.)</p>
Complex individual cases that do not fall into the above categories	To be discussed in clinical meetings/with line manager in supervision and strategies formulated appropriately.
Working clients	<p>To be dealt with in the same way as other categories of SU’s.</p> <p>However, Treatment services will need to consider how to offer <b>Out of Hours service</b> provision for those working long hours, shift workers, those working away from home etc</p>

### **What are the factors that make a difference when encouraging service users to remain and successfully complete treatment?**

A recurrent theme from research into engagement and retention is the finding that service factors have a much bigger impact than the characteristics of the clients attending treatment. The studies by Millar (2004) and Meier (2005) both showed that client factors played a relatively small role in determining treatment engagement and retention. There is little UK research to identify what these service factors are.

A group of researchers at the Texan Christian University have studied programme, staff and client factors in relation to engagement in drug misuse treatment programmes. For example, Broome et al (2007) found that engagement in drug treatment was better in those programmes that had a better organisational climate and a smaller organisational size.

In a recent review, Orford (2008) summarised these organisational factors as:

- High quality therapeutic relationships
- High quality relationships with the whole treatment team
- High expectations for personal growth
- A moderate level of organisational structure
- Referral and treatment-entry procedures
- Initial assessment procedures
- Treatment environment.

### **What is “meaningful engagement”?**

NICE found strong evidence for brief interventions and its guidance on psychosocial interventions for drug misuse (NICE, 2007) and recommended their use stating that they should be opportunistic, focused on motivation and offered to people in limited contact with drug services. These interventions should:

- Normally consist of two sessions each lasting 10-45 minutes
- Explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour, and provide non-judgemental feedback.

The first two key work sessions at the assessment stage should therefore be used to fully explore the potential service users' motivation to enter treatment and readiness to change their behaviour. Use of the “Motivational (compliance) checklist” (Appendix 1) could be considered as a framework for these interviews.

“Meaningful” engagement does not mean that the service user has to be 100% enthusiastic from the outset. If they are willing to discuss the implications of treatment, the outcomes they wish to achieve, however modest, and the possible consequences for their eventual recovery then this is a good start. Key workers should use motivational techniques to improve the service users' commitment to treatment and eventual recovery

### **Definition of Recovery:**

*‘A process through which an individual is enabled to move from their problem drug use, towards a drug-free lifestyle as an active and contributing member of society.’*

*‘Recovery is most effective when service users’ needs and aspirations are placed at the centre of their Recovery and treatment....an aspirational and person-centred process’*

## **Recovery Plans:**

Staff should note that it has been agreed that STaRS will change the term “Care plan” to that of “Recovery Plan”. The reason for this is to reflect the change of focus in the treatment system to that of encouraging the service user towards active recovery, rather than passive reliance on what the treatment service can provide.

## **Personalisation:**

Southampton Adult Health and Social Recovery Directorate is part of a Total Transformation project to implement Personalisation across the adult Recovery services. These guidance documents are therefore written to reflect the need to plan services in line with the ongoing findings of the Drug Systems Change Pilot (DSCP) and in line with Personalisation. The main principle to be borne in mind is that all service users have the right to be fully consulted about the contents of their recovery plan and the responsibility to be actively involved in achieving their recovery from addiction and rehabilitation back into society.

## **Maintaining engagement with treatment services:**

It is recognised that most service users will experience difficulties in maintaining their commitment to treatment at some time in their treatment journey. At times like this it is important for treatment service staff to work towards increasing their commitment and motivation to continue treatment by every means at their disposal. This may mean imposing sanctions in order to secure compliance, as well as reviewing the Recovery plan to ensure that it is appropriate in the modalities chosen to address the service user’s needs. It is good practice to undertake a review of why the service user is finding it difficult to attend appointments and maintain appropriate engagement with the key worker. The review should be undertaken with the service user and key worker. A helpful Motivation/Compliance checklist is included with this document in order to give some structure to the session and so that important questions are asked and explored.

Most clients who drop out of treatment do so between initial assessment and the start of treatment or in the first few weeks after entry to treatment. Research shows that a range of interventions can help to engage and retain clients in treatment. These include: the use of encouraging reminders for appointments; interventions to boost motivation to engage with treatment; quicker entry times to treatment; a more structured induction phase to treatment; accompanying clients to appointments; and, the use of elements of assertive outreach to enhance engagement. (“Towards Successful Treatment Completion” NTA Sept 09)

Planned Treatment Exits is a drug treatment services performance linked target and is measured as follows:-

- **Percentage of adults exiting treatment in a planned way, drug free in a rolling year period. (NDTMS quarterly “Green” reports)**

Southampton integrated drug treatment services, together with the Drug Action Team, have been concerned at the low rate of planned treatment exits in the Southampton area for some time. It has therefore become necessary to re-focus our attention on the service user treatment journey and offer advice on how engagement of the service user can be maximised and how a reasonable level of compliance with treatment can be maintained. Retaining service users in treatment is not just in order to maximise drug treatment services performance however. **“Leaving treatment in**

**an unplanned way is associated with a worse outcome for the service user.**

Research shows that outcomes improve with time spent in drug treatment. Therefore, over time a greater proportion of clients who are retained in effective treatment should start to achieve their treatment goals and begin to leave treatment in a planned way. Facilitating social re-integration is one of the aims of treatment and is an important element of the new drug strategy. There has been a growing interest in recovery from dependence on drugs of misuse. Further integration of the principles of recovery into the drug treatment system is likely to be the next challenge to improve treatment outcomes and increase the proportion of clients who successfully complete treatment and leave treatment services in a planned way. To facilitate more service users to complete treatment successfully, drug treatment services may need to improve their competency in enabling people to achieve their aspirations, reach treatment goals, build social and personal capital and strive for abstinence when they are ready.” (Towards Successful Treatment Completion – NTA Sept 2009).

**In general staff should be aware that:**

- For a service user first contact with any treatment service can be daunting.
- The accuracy and quality of the Recovery planning process will be crucial to well targeted interventions.
- Staff should make use of all contact opportunities (including mobile phones, ‘texting’ etc.) to maintain contact and where necessary remind service users of appointments, especially first appointments for interventions (i.e. group work, doctors appointments, healthcare assessments, ITEP sessions) as well as for regular key work sessions
- The early weeks of treatment are critical to its success

## **1. Professional Discretion**

In working constructively with service users, key workers and Recovery co-ordinators in drug treatment services (referred to as “key workers” throughout) will need to use their professional discretion and judgement, when taking into account the circumstances of the case and when considering issuing service users with a letter of concern. This will include the key workers knowledge of the service user, the risks posed by their drug use and their response to the Recovery plan to date.

Discretion must be exercised on an individual basis. All staff are accountable for the use of their judgement.

**It is crucial that staff and managers record on the case file where discretion has been used and that the reasons are fully documented.**

*Examples where discretion could be used:*

- *Where the service user has been compliant over a reasonable period of time and the absence is out of character, this may indicate circumstances that could be considered as an acceptable reason for missing the appointment.*

- *Where the service user is generally considered to have been truthful throughout their treatment, discretion could be applied where they have indicated an otherwise unsubstantiated reason for having missed the appointment.*
- *Where a service user provides a reason for absence that can be verified with some investigation (i.e. where public transport is said to be late, attendance at other appointments etc) the key worker can take steps to evidence the acceptability of the absence and record this in the case records.*
- *Diversity needs.*

## **2. First appointment to commence treatment:**

In most instances (with the exception of offenders referred from DRR, and some from DIP and Arrest referral) the service user will have self referred for treatment. At this stage the expectations of treatment should be made clear to him/her and a leaflet outlining these expectations given. Two further appointments for key-work sessions should be made for the first week to further test the service users understanding and motivation. Only when the service user has engaged meaningfully with the key worker at this stage, will a doctor's appointment (opiate users) and/or an appointment for a full assessment and general health, Recovery assessment (all other drug categories) be arranged.

All contacts must be fully recorded appropriately in the case record.

## **2. First Contact and follow-up Appointments- Issues to consider that could affect the way a service user engages with treatment services:**

### **Reception:**

Feedback from service users has included instances where people were motivated to enter a treatment service, but were discouraged by an unhelpful reception immediately after entering the service. As a result, the importance of "front of house" staff, such as receptionists, pharmacy counter staff and other front-line staff, in service delivery should not be underestimated. It is also thought by service users that a poor physical environment in a treatment service can be a disincentive, e.g. services which are not equipped for disabled people, where there is no discreet place for clients to give their personal details to staff, untidy and poorly maintained premises and cramped consulting rooms.

There are a variety of initiatives that have been shown by research to assist in enabling services to make the most of first contact and to reduce client attrition in the first few days after contact. Initiatives that have been demonstrated to improve engagement and early retention include:

- Encouraging reminders
- Motivational interventions
- Formal client induction
- Accompanying clients to appointments.

### **Premises**

Drug treatment services premises can be experienced as very daunting and potentially unsafe places, especially for female service users who may be asked to remain in waiting rooms with chaotic male service misusers who may have been involved in violence against women and children.

A number of problematic issues arise especially in respect of female service users and other vulnerable groups:

- **Waiting rooms** (is there the possibility of a secure quiet area for vulnerable groups – i.e. women, ethnic minority, homosexual, transgender and transvestite)
- **Child Recovery/adult dependant issues** where the service user is a sole carer for dependants.
- **Travel and expenses.**
- Is everything being done to remove the physical barriers for **disabled service users**? All steps to make reasonable adjustments must be taken in order to enable a disabled service user to attend appointments. Learning disabilities must be included in this category.

### **Induction:**

Research shows that the use of formal induction interventions to clarify what happens in treatment, what is expected of the client, and dealing with concerns and misconceptions increases service user engagement from the outset. Another study found that just **15 minutes** spent clarifying client expectations from outpatient treatment resulted in a **40 per cent increase** in clients returning for the first session (Higgins et al, 2002). Modified induction procedures have also been shown to be useful in residential treatment – a US therapeutic community developed an interactive readiness training course, which led to more positive client attitudes and improved retention and outcomes (Sia et al, 2000). Another US study showed that senior staff helping to induct clients into a residential service led to an increase in retention (De Leon et al, 2000).

In order to ensure a start to treatment where the service user develops an appropriate relationship with the key worker and engages in the Recovery plan actively from the beginning, comprehensive and constructive induction processes are required. Preferably, the method for delivering induction should be tailored to the individual service users learning style.

### **Other issues:**

- Verbal and written instructions should be given about how treatment, including what will/may happen if they fail to comply with the treatment plan, will operate.
- Use the Motivational Checklist/Recovery planning document (appendix A) to identify issues that may affect the service user's ability to comply with treatment and to gain service user engagement with the Recovery planning process. This document will also encourage both the service user and key worker to consider ways in which these difficulties may be overcome.
- Identify any problems (e.g. diversity issues) that may hinder compliance – particularly with reference to groups.
- Consider the use of a range of appointment cards or diaries (as in the case of service users who are subject to DRR), such as 'daily' (intensive requirements), 'week by week' or '16 weeks in advance'.
- Use SMS text messaging service to remind service users of appointments (HOWEVER – be sure to refer to organisational policy where available)

- Co-ordinate appointments with signing-on days or other appointments/regular activities.
- Give positive comments on good progress and record these for inclusion in the service users Record of Achievement.
- Regularly reinforce potential incentives to compliance such as reminding the service user of their stated reasons for entering treatment and using this to show them any discernible progress made to date.
- Refer service users to “Think Family” for help with child care or other issues in relation to child dependants.
- Involve service users in activities which occupy their time constructively.
- Use partner organisations such as Fairbridge; refer to Princes Trust etc. (depending on the service users’ age).

#### 4. Attending Appointments:

Key workers could consider the use of **SMS text messaging (only to be used in accordance with the employer organisations agreed processes and policies)** to send reminders for when service users are required to attend for appointments. The following groups of service users can benefit most from the use of this provision, but consideration can be given to using texting routinely to remind everyone of appointments.

- Service users who have missed 2/3 appointments and who may be required to see a clinician before they can continue to be prescribed.
- Groups – service users due to attend their first group work session should be sent a reminder text the day before they are due to attend the first session.
- Dyslexia – service users with dyslexia can benefit from texting and key workers who are aware that they are key working a service user with dyslexia should consider using this provision to assist them to comply.

#### 5. Key working:

The relationship between the key worker and the service user is often the most significant factor in encouraging the service user to remain engaged and to remain motivated to continue with treatment. There is research to indicate that when the service user perceives the key worker as caring about whether they succeed or fail in treatment that they comply to avoid “letting down” the key worker, whom they perceive as having “put themselves out”. It is therefore important that the key worker uses a variety of motivational techniques and uses pro social modelling to ensure that the service user remains engaged and maintains momentum

- Service users need to know that their **absence matters** to their key worker – research supports this.
- Service users need a **positive experience** from the beginning of their contact with drug treatment services. Use of Pro Social modelling techniques is very important in order to facilitate this.
- **Quality of contact with the key worker** and the constructive use of time. Service users need to feel there is a purpose in coming to see their key worker. If they are meeting their key workers for short periods of time and no

constructive work is being undertaken, they are more likely to “opt out”. **Early meetings with the service user must include Recovery planning** in which the service user has an input.

- **Home visits** – Knowledge of service user’s family life has traditionally helped drug treatment services to cement relationships between key workers and service users. Occasional home visits provide an opportunity to get to know family, friends or significant others who may help sustain the commitment to treatment. A partner or a close relative or friend may be in a position to help service users keep their appointments.
- **TOPs should be used as a means of ongoing assessment** of the service users’ progress during treatment. Recovery plan documentation should be used as a dynamic tool for continuous assessment and continuous improvement and refining of the services we offer the service user.
- **After a failure to attend appointments** – key workers could use a formal meeting with the service user to stress the importance of attendance, take into consideration difficulties in attendance, and re-induct the service user.

## **6. Recording issues:**

Key workers should record all contacts with the service user appropriately and in sufficient detail, so that it is apparent what work has been completed in key work sessions.

Where the service user has offered an explanation for missing appointments, this should be fully recorded along with the key workers views on whether this constitutes a credible and acceptable reason.

Where a line manager has been consulted, this should be recorded on the case file.

## **7. Through care (prisoners and prison leavers only)**

- Contact by letter, telephone or visit should be maintained with prisoners serving a sentence, throughout their period in custody where possible.
- Reply to letters promptly or acknowledge receipt when a full reply may take longer.
- Liaise with CARATS, seconded prison probation officers and other prison staff wherever possible.

### **The responsibility of staff**

- Think diversity, think equal opportunity, think individual needs
- Ensure waiting rooms are kept clean, tidy and welcoming with relevant and up to date posters and leaflets.
- Model pro-social behaviour at all times.
- Be on time for appointments and prepare for sessions.

- Make sure follow-on appointment(s) are made.
- Use induction sessions together with clear written information in the form of leaflets, etc.
- Show service users where things will happen – i.e. show them group room venues, what will happen when they come to the treatment service in unsocial hours. Walk them through entry into a building.
- Ensure Recovery plans include a formal statement of expected attendance and behaviour.
- Use Recovery plans constructively. Involve the service user. Negotiate realistic achievable objectives. Use the Recovery plan as a tool and refer to it during key work sessions.
- Ensure termination reviews are carried out and involve service user feedback – we can learn from service users.

#### **Record of Achievements:**

From **25<sup>th</sup> October 2010** each service user will be issued with a “Record of Achievements” folder. Copies of documents in the folder will be kept on file.

The purpose of the record of achievements is motivational, ensuring that **all** positive progress is noted and recorded, as part of the overall contingency management of the case. When service users are wavering in their commitment, the Record of Achievement can be used to remind the service of the progress they have made to date and this will serve to further encourage them to remain in treatment.

Even where a service user disengages from treatment, a letter outlining the service users’ achievements and progress to date should be sent to them, to underline what aspects of treatment they have completed, or responded to well. The record of achievement can then be used to remind them of the progress made previously, should they return to treatment at a point in the future.

## Appendix One

### Motivational (Compliance) Checklist

To be completed at the first appointment with the key worker and then afterwards as required:

#### **Background Information:**

1. History of drug misuse –  
How long have you been involved in using drugs?

2. Have you been in drug treatment before? If so have you exited treatment before it was completed?

3. If you have left treatment, why?

4. What happened after you left treatment?

5 Do you think that you will complete another course of drug treatment?

6. Do you think that you may have difficulties in attending appointments in future?

#### **Ways to enable compliance:**

7. If you are working how far away from the treatment service do you work?

8. How will you get to the service? Do you think there may be a problem?

9. Do you tend to forget appointments?

10. Do you work shifts?

11. Can we contact your employer? What are their details?

12. Have you ever missed work/appointments due to ill health?

13. Have you missed appointments due to oversleeping?

14. Do you have responsibility for other people?

15. Is there anyone who could stop you attending your appointments?

16. Do you need to be reminded about your appointments: mobile phone number?

17. What is the best time to make your appointment? I.e. pay day, benefit day?

18. Any other ways we can help?

**POSSIBLE BARRIERS TO CHANGE:**

AREAS FOR DISCUSSION	RESPONSE
Have there been times when you think that you have no control over your life?	
Have ever been treated unfairly by others? If so why do you think that might be?	
Can you describe times where you treated others unfairly because they were different to you? (e.g. race, ethnicity, religion, gender, age, class, disability, sexuality)	
What could stop you changing?	
Have you ever thought that your reading and writing has stopped you changing?	
How do you feel about doing work that involves reading and writing?	
Do you understand things better if they are in pictures or diagrams rather than in writing?	
Could you complete worksheets?	
Could you learn from real life examples?	
Are there any good things about your life that you would like to stay the same?	
Are you happy to work alone or would you like your key worker to help you?	
Is there anything else that would help us work with you?	

## WHAT WOULD HELP YOU COMPLETE YOUR TREATMENT?

AREAS TO DISCUSS	RESPONSE
If you have been unable to complete a period of treatment in the past? Why was this?	
If you have missed appointments with drug services before why was this?	
If you have previously completed periods of treatment successfully, what helped you do this?	
What could stop you attending appointments this time? (i.e. other people, work commitments, forgetfulness)	
Could you tell me about times when appointments have been missed because you are ill? Could this happen again?	
Tell me about any responsibilities you have to Recovery for others?	
Can you tell me about the times when you have trouble getting up in the morning?	
When would be the best time for you to attend?	
How will you get to the service?	
Do you have any religious commitments that you need to attend?	
How is best to contact you? Could there be any difficulties in you receiving letters?	Mobile phone:
Any other ways we can help?	

**KEYWORKERS – NOW TAKE THIS CHECKLIST TO THE NEXT WEEKLY MEETING FOR DISCUSSION.**

## **Appendix Two**

### **Southampton Treatment and Recovery System**

#### **Guidance for drug treatment key workers on Adjustments that may assist service users with Mental Health Needs**

We work with many service users who have mental health problems of different severity. Whether this is depression, anxiety, bi-polar disorder, schizophrenia, personality disorders, either being under the Recovery of mental health specialists or managing with fewer interventions, service users who are experiencing these difficulties will often need adjustments in order to assist them through to the completion of their treatment.

What is suggested here are some strategies that key workers may want to think about and discuss with individuals as methods by which they can assist and help somebody to better access treatment. Service users may or may not be addressing their mental health needs, what we need to do is to try and make sure that their mental health needs are considered in putting together and delivering a meaningful and achievable plan of work for them.

1. Try and find out the nature of the mental health problem and the sorts of symptoms that the person experiences so that you know what the issues might be. I.e. is anxiety a problem? Do they experience panic attacks? OCD? Insomnia? Depression? Difficulty concentrating? Are they withdrawn? Do they have the high/low mood swings of bi-polar disorder? Lack energy and motivation?

You don't need to be a mental health expert just to ask for a few details of the kinds of symptoms people experience so that you can think through what the implications are for treatment and what may be beneficial in overcoming any barriers.

2. Remember, purposeful activity can very often be valuable for somebody with mental health needs. Inactivity generally tends to worsen mental health problems, so don't discount proposals for any activity as part of the Recovery plan – just look, wherever possible, for the adjustments that will make it possible for the person to undertake the work.
3. Liaise with other agencies where appropriate and get them involved in the design and/or the delivery of the Recovery plan (e.g. MENDOS, MIND, Community Mental Health Teams)
4. Take your time; be clear about what is happening and what will be happening during the person's contact with the service. Uncertainty can quickly create unmanageable anxiety. As can expectations that the service user feels unable to meet, so think about the amount of

engagement that is being required and keep it at a level that is going to be achievable for the person – stagger modalities rather than load everything at one time.

5. Give consideration to the possibility of group work if this fits with clinical or social need, but be mindful of the potential difficulties that group work may bring for somebody with mental health needs e.g. the demands of being interactive in a group situation if depression and anxiety are difficulties. If this is not possible, look for alternative ways of working on a one-to-one basis.

6. Concentration can often be a problem. Again, limit the amount of time concentration is needed and offer to make a note of important things for the person to take away with them. Sometimes writing things in a notebook each time may be of value. If a lot of written material isn't appropriate use bullet points, diagrams and other visual methods, just to provide the person with something they can look at again later or refer to if need be.

7. If somebody is withdrawn be prepared for silences; try doing practical tasks/activities; have a relaxed and consistent approach. Appreciate the difficulties of engagement when there are mental health needs and pace work accordingly.

8. Always work in a quiet and calm environment. If somebody experiences anxiety there is more likelihood that they are going to become agitated in noisy busy situations. There may be the need to avoid long waits in reception and to keep appointments to a length of time that is manageable for the individual in question.

9. Consider the timing of appointments. Depression can often be worse in the morning, meaning that an appointment later in the day is more likely to be manageable for the person.

10. Regularly check with the person that the approach being used is working. They will be the best guide about what is going to be, or is proving, most helpful.

## Appendix Three.

**Southampton Treatment and Recovery System**  
**Autistic Spectrum Disorder (including Asperger's)**  
**Guidance for key workers on Adjustments to Consider**

Autism, including Asperger's Syndrome (AS), is a lifelong developmental condition characterised by a triad of impairments: difficulties forming social relationships, problems with verbal and non-verbal communication and the development of strong, narrow, obsessional interests. People with Asperger's usually have an average or above average IQ. However, this may mask difficulties with social awareness. Many people with autism can be confused by what is going on around them and can quickly become very anxious. Some can display extreme behaviour in certain circumstances, with no awareness of the impact this will have on others.

What is suggested here are some strategies that key workers may want to think about in working with service users who have Asperger's or high functioning autism.

1. Liaison with other appropriate services may prove very helpful. The Hampshire Autistic Society may be able to provide advice and guidance on individual cases. Carole Hiorns, Outreach Officer, 02380 633951

2. In terms of Recovery planning, the low level of translation of experiences and the cognitive basis of the disability means that those with AS are unlikely to be suitable for cognitive skills programmes.

One-to-one key work practice is recommended.

3. Service users with Asperger's are unlikely per se not to engage with drug treatment staff, unless perhaps clinically depressed (of which the incidence is quite high) or the approach of staff leaves them feeling anxious and confused. People with Asperger's tend to enjoy the opportunity to talk, although they may have the inability to engage easily in the topics that the key worker wants to talk about. In particular, there may be a tendency to wish to focus on their "special interest" or be a reluctance to discuss things which do not interest them.

A "contract of what is to be talked about" may be useful, with time limits applied to talking about what the person wants to talk about and what you need to discuss. Being seductive about the topics you want to discuss, to stimulate curiosity, is helpful and it is also important to be very clear about what it is that you **need** to talk about.

Non-verbal communication doesn't work, so verbal communication needs to be simple and clear. Sometimes, it will be necessary to break into monologues to get the person with AS back on track. If a contract has been agreed, then time can be given to what the person wishes to talk about and then you can ask for your time. If a "special interest" is apparent, it is important to allow some time for this and then move over to what you need to discuss.

It may not be possible to gather all the information you need during one interview.

Keep the atmosphere emotionally calm. Be curious rather than critical when questioning and exploring

Remember that people with AS can have difficulty in knowing what their emotions are and often cannot understand them.

4. A confrontational approach will not work with somebody with AS. It requires an enquiring approach which is non-critical – seeking explanation from the person and exploration.

5. Try to avoid using mental verbs like “hopes, “fears”, and “knows”. This is difficult language for somebody with AS, who will have problems relating to these emotional descriptors. Similarly concepts such as ‘pride’ and ‘self-esteem’ are hard as these require the individual to understand feelings about how other people see you, which is often difficult for somebody with AS.

Avoid terms that are confusing if taken literally e.g. “take a seat”. These sorts of terms may not be understood. Language must be simple and to the point.

6. Always give clear explanations of what is happening, why and how long things are going to take.

7. People with autism may not understand personal space They may invade your personal space or need more space than the average person.

8. Changes in routine are very often difficult. Establish a comfortable routine for working and try to stick with it. If changes are going to occur, (e.g. change of key worker, seeing the person) make sure the person is well informed in advance and be prepared for heightened anxiety.

9. Waiting rooms can be difficult for people with autism. Try and establish how the individual feels & if waiting in reception is likely to cause anxiety arrange appointments so this doesn't have to happen.

10. Drawings and other visual methods can sometimes be useful to assist understanding.

11. Only deal with one issue at a time. Don't overload. Give people time to respond as people with autism may take longer to digest information before answering. Don't move on to another question too quickly.

## Appendix Four

### Southampton Treatment and Recovery System

#### DYSLEXIA

#### Guidance for key workers on Possible Adjustments

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Dyslexia takes many forms and affects individuals differently. You will need to discuss with the individual involved which of the suggestions below may be of use, and also ask them if there is anything they can suggest.

Remember, for our work it is important to put things in place to help people who have dyslexia and who may therefore have difficulties with:

- reading, writing, spelling
- poor memory
- visual or auditory difficulties
- poor organisation
- slow speed of processing
- Social interaction

These difficulties can lead to lack of confidence, low self esteem, anger, frustration and anxiety.

1. Take your time, be at ease and put the service user at ease. This is good practice for all service users but those with dyslexia can experience even more stress through the confusion that this disability can cause.

2. Use the texting service to remind of appointments. Suggest a digital and/or analogue watch. Put appointment reminders into mobile phones.

3. Provide with a diary and write appointments and other important information about what is expected of the individual in the diary. Encourage them not to have treatment appointments too close to other things that are happening that day to allow themselves plenty of time.

Make sure people have appointment times and telephone numbers written correctly if you have not written them down for them. Often order of numbers can get muddled.

Some service users may ask for copies of letters to be sent to a relative or friend so that they can remind them so you could check whether this would help.

If warning letters have to be sent, key workers could consider also using texting as an additional way to alert somebody to the missed appointment and what the consequences of this may be.

If the key worker writes anything down for the person, make sure handwriting is clear. Joined up writing may be difficult. If you ask them to write anything, offer them a number of different pens and pencils as this can make a difference.

<p>4. Leaflets can pose problems for many service users with literacy difficulties and this can be compounded by dyslexia. Make sure leaflets are fully explained with key points highlighted with a highlighter pen should the individual wish to refer to it again (check which colour highlighter pen is best for the individual). Encourage the asking of questions if they forget anything they have been told at any time.</p>
<p>5. Make sure any written material (i.e. letters from us) is in an appropriate format:</p> <ul style="list-style-type: none"> <li>▪ Use fonts such as Arial or Comic Sans</li> <li>▪ Keep font size at 12 or more</li> <li>▪ Use bold to highlight rather than italics or underlining</li> <li>▪ Keep lines left justified with a jagged right edge</li> <li>▪ Use bullets or numbers rather than continuous prose</li> </ul>
<p>6. Use coloured paper instead of white. There is no consensus on colour as individuals need different backgrounds. However, there does seem to be some preference for cream.</p>
<p>7. If explaining procedures consider presenting it in a flow chart.</p>
<p>8. If giving instructions put in an appropriate visual format as well as verbalise. Everything that is verbalised should be in simple, unambiguous language. Instructions should be clear and one at a time.</p>
<p>9. Use pictures, diagrams and graphics to reinforce information &amp; ideas.</p>
<p>10. If trying to get information across break it down into small bite size chunks. For example a list of “do’s” and “don’ts”.</p>
<p>11. Remember, somebody with dyslexia will tire quicker than others because far greater concentration is required. Listening, concentrating and understanding, especially against background noise can result in mishearing and misinterpreting important information. Work at a steady pace, in manageable chunks in a quiet environment.</p>
<p>12. Don’t ask people with dyslexia to copy down information, read aloud or write up on a flipchart.</p>





