



Enhancing concurrent capability:
A toolkit for managers and staff

A welcoming and engaging strategy

Contents

Introduction.....	5
Why is welcoming important?.....	10
What is a welcoming program structure?	18
Making a welcoming physical environment	22
Welcoming people at initial contact.....	29
Appendices	
1. Stigma: Useful web links and suggested activities.....	42
2. Welcoming walk-through checklist.....	48
3. Take-home information sheet.....	52
4. Welcome wagon ideas	53
5. The importance of telephone calls: Telephone tips and scripts	56
6. Tips for developing printed resources	61
7. Organizing a focus group to discuss welcoming	64
References.....	78

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Table of Contents

Introduction	5
How was this toolkit chapter created?.....	5
Questions we will address within this toolkit chapter	6
Why are we looking into welcoming and engagement strategies?	6
Why is welcoming important?.....	10
What is the definition of welcoming?	10
How does welcoming relate to patient satisfaction?.....	11
What is the impact when we get the welcome right?	12
What can happen when we get it wrong?	14
What is a welcoming program structure?.....	18
Proposed guiding principles for welcoming	18
Program structure and set-up	19
Making a welcoming physical environment.....	22
Provide clear and welcoming signage	22
Make access easy and inviting.	23
Create a bright, cheerful, clean space.....	24
Arrange the space for comfort and convenience.	25
Provide a variety of patient information.....	26
Welcoming people at initial contact	29
Assess language preferences and literacy levels as soon as possible.	29
Make a good first impression.	30
Welcoming people during subsequent contact.....	33
Important points to remember	37
Self-assessment questions.....	40
Appendix 1: Stigma: Useful web links and suggested activities.....	42
Appendix 2: Welcoming walk-through checklist	48
Appendix 3: Take-home information sheet	52
Appendix 4: Welcome wagon ideas	53
Appendix 5: The importance of telephone calls:	
Telephone tips and scripts	56
Appendix 6: Tips for developing printed resources	61
Appendix 7: Organizing a focus group to discuss welcoming.....	64
References.....	78

Introduction

How was this toolkit chapter created?

The content of the chapter was developed following a literature review and discussions within and outside of the organization to establish what resources were available and what needed to be created within AMH. Informal consensus was built and content was validated with a variety of stakeholders who were part of provincial working groups and the AMH clinical network. Representation on these committees was inclusive of provincial and zone partners, front-line clinicians, managers, directors, and patients/clients and their family members. We would like to acknowledge the work of the participants who helped create this resource and are grateful for their valuable contributions.

In addition, we want to thank the clients, mental health peer educators and family members who so generously participated in a focus group to provide critical feedback on the key messages and some of the specific tools contained in this chapter. Their suggestions and validation of content were invaluable.

We are committed to matching the toolkit content to the needs of the people who will be using it. We welcome any feedback, questions, or suggestions for content additions or revisions. We wish to learn from the experiences at the front line, so please let us know how well this toolkit works for you by emailing us at concurrent.disorders@albertahealthservices.ca

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Questions we will address within this toolkit chapter

- Why are we looking into welcoming and engagement strategies?
- What is the definition of welcoming?
- Why is welcoming important?
- How does welcoming relate to patient satisfaction?
- What is the impact when we get the welcome right?
- What can happen if we get it wrong?
- What are the suggested components of welcoming and initial engagement?
- How can I focus on this in my everyday practice?
- How can we, as teams, implement these components at a local level?

Why are we looking into welcoming and engagement strategies?

Internationally, the health-care industry continues to search for ways to make the health-care experience more effective and satisfying for patients and their families (Lee, 2004; Taylor, 1999). Over the years, a vast amount of research data and literature has accumulated describing a range of evidence-based interventions that have been found to be effective in treating people with addiction, mental health and concurrent disorders. Because of this research, numerous evidence-based skills manuals and toolkits are widely available, describing ways to address mental health and substance use disorders in an integrated fashion. However, as this information emerges, the biggest challenge we face, both as individual practitioners and members of wider organizations, is how to implement these recommendations in the real world, how to translate the theory into practice.

It can be argued that the key to successful treatment outcomes within AMH settings, regardless of the treatment approach adopted, is engagement (Godlaski et al., 2009; Reisinger et al., 2003). We cannot begin to use evidence-based interventions until we have successfully engaged the individual seeking support and have addressed their commitment to change (Reisinger et al., 2003). However, we face quite a challenge: research has concluded that both men and women with addiction and mental health issues have significant

difficulties engaging with treatment services (Godlaski et al., 2009) and early drop-out rates are high (NTA, 2005; Stark et al., 1990).

People may be discouraged from seeking help with addiction, mental health and concurrent disorders because they know that these disorders are stigmatized (Martin & Johnston, 2007). They are afraid that because of this stigma and the discrimination that accompanies it, others will react negatively to their situation (CAMH, 2005). For more resources and suggested activities focusing on stigma, see Appendix 1.

When considering ways to engage populations with AMH concerns more effectively in treatment, it is logical to start by ensuring that our systems are welcoming. People with addiction, mental health and concurrent disorders often experience themselves as misfits within health and social care systems and feel unwanted, unwelcome and blamed for the complexity of their problems (Minkoff & Cline, 2004; Minkoff, 1998). It is therefore important that services commit to redressing this balance and make the most of their first contacts with clients (NTA, 2005). A welcoming and caring attitude can begin to break down the barriers of stigma (CAMH, 2005). We need to remind ourselves that the people we work with are the reason we are here; they are not an interruption of our work.

A welcoming and caring attitude can begin to break down the barriers of stigma (CAMH, 2005).

When we make welcoming an organizational priority, we make a commitment to actively reaching out to bring clients with addiction, mental health and concurrent disorders through any of our service doors. We approach our clients with empathy and hope. The key message is that we need to accommodate people, no matter how or where they present.

“Welcoming,” though not formally recognized as evidence-based practice, is considered by most to be a clinical service delivery standard, which can create a strategic energy and solid platform to promote implementation of other evidence-based practice (Minkoff &

Cline, 2004). Without successful welcoming and engagement, there is little hope of retaining people in service and even less likelihood of achieving positive treatment outcomes.

As an organization, we need to develop a welcoming, accessible, integrated, continuous and comprehensive system of care that can support an array of evidence- and consensus-based practices for people with addiction, mental health and concurrent disorders (Minkoff & Cline, 2004).

Key messages

Internationally, health-care industries are striving to make the health-care experience more effective and satisfying for all concerned.

Research data describes a range of evidence-based interventions. There are numerous recommendations, skills manuals and toolkits.

The biggest challenge we face is how to implement these recommendations in the “real world.”

The key to successful treatment outcomes, regardless of the treatment approach adopted, is engagement.

Both men and women with addiction and mental health issues have difficulties engaging with treatment services and drop-out rates are high.

A logical place to start when considering ways to engage populations with AMH issues more effectively in treatment is to ensure that our systems are welcoming.

We need to make the most of first contacts with clients.

Without successful welcoming and engagement, there is little hope of retaining people in service and even less likelihood of achieving positive treatment outcomes.

The people we work with are the reason we are here—they are not an interruption of our work.

 note section

You may wish to take some time to reflect on the information you have just read and make your own notes to summarize issues that stood out for you within this section.

Why is welcoming important?

What is the definition of welcoming?

There are numerous ways to define welcoming, depending on the context. However, there are a number of common elements within each definition. For the purposes of this toolkit, the following definition will be used.

Welcoming is “the act or process of willingly greeting and receiving individuals on arrival with interest, pleasure and courtesy.” As an addition to this definition, it is important to be clear that within AMH, “we welcome all people, not all behaviour.”

Research has shown that even after receiving high-quality, evidence-based care, people can leave health-care settings feeling dissatisfied (Mueller, 1987). Over the years, we have learned that what has the greatest impact on an individual is how they feel they were treated during their experience (Mueller, 1987). People judge their experience by the way they are treated as a person, not by the way they are treated for their problem or disease (Lee, 2004). To further complicate the issue, experiences are often judged on the basis of impression and not reality (Lee, 2004). We need to hold this in mind when delivering services to addiction, mental health and concurrent disorder clients.

Researchers consistently find that the majority of people who seek help for addiction or mental health problems feel depressed, deflated, pessimistic and intensely anxious when they approach services (Godlaski et al., 2009). These emotions are likely caused by a combination of fear of being judged negatively by others, fear of experiencing further rejection, and fear that their belief that they are unable to cope adequately will be confirmed. These feelings are compounded by uncertainty about what will be expected of them if they commit to working with a service or program. Such feelings can cause significant resistance in people but can be resolved positively, within a short time, if we are able to warmly welcome clients when they present (Godlaski et al., 2009).

Successful welcoming has been shown to reduce barriers to access, increase customer satisfaction and help people feel accepted by others. This can lead to a greater sense of self-acceptance in the person seeking help and a sense of hope that things can get better (Godlaski et al., 2009).

We need to welcome people to AMH in both routine and emergency situations (Minkoff & Cline, 2004). It is important to be particularly welcoming to people who cannot be immediately served by the program or service that they initially approach. This will help to communicate a sincere desire to engage that person in care as soon as possible and to welcome her or him into the system as a whole. Even when we are not able to help the individual ourselves, we can help to connect him or her with someone else who can help. We can also assume responsibility for beginning an empathetic, hopeful relationship to help that person stay engaged and get the services they need (Minkoff & Cline, 2004).

It is important to remember that welcoming should not just be experienced by the clients themselves but also by their families and significant others; this can encourage genuine sharing and facilitate wider communication (Minkoff & Cline, 2004; Wen et al., 2007).

How does welcoming relate to patient satisfaction?

Over the years, many studies have focused on patient satisfaction. Despite the variety of environments in which these studies have taken place, the results tend to be consistent.

What follows are words that are most commonly used by people to describe positive health-care experiences: caring, kind, compassionate, helpful, comforting, concerned, loving, understanding, empathetic.

You may notice that all of these words relate to how people felt they were treated as people when they made contact with services, and not how they were treated for their problem. They all convey the concept of compassion, which is consistently and significantly related to an individual's satisfaction with care. Other domains consistently related to satisfaction link to courtesy and competence but are a very distant second and third to compassion. It is clear from the literature available that competence and courtesy are expectations within health-care systems and are not considered as anything "over and above" (Lee, 2004).

When patient satisfaction was explored in more detail, five main areas, related to the ways in which individuals or teams behaved, came up consistently.

- | | | | | |
|---|---------------------------------------|--|---|---|
| 1.
Sense people's needs before they ask (intuition). | 2.
Help each other out (teamwork). | 3.
Acknowledge people's feelings (empathy). | 4.
Respect privacy and dignity (courtesy). | 5.
Explain what's happening (communication). |
|---|---------------------------------------|--|---|---|

What is the impact when we get the welcome right?

When we get it right, welcoming and engaging visitors into service can have a significant impact. Take a look at some of the quotes below:

“They made me feel like I was a person, not just some derelict that, you know, shouldn't be breathing.”

“They show that they care: it's not just a job. They want to know you as well as a person.”

“They are open and receptive and don't stereotype me.”

“They ask you how you are feeling and you talk about what is wrong with you. Some places are better at doing that.”

“Someone spent an hour on the phone trying to help me to get a package together, and that amount of work, on a case to improve my life circumstances and make an adjustment in me, is really commendable” (Wen et al., 2007).

Key messages

Even after receiving high-quality, evidence-based care, people can leave health-care settings feeling dissatisfied.

People judge their experience by the way they are treated as a person, not by the way they are treated for their problem or disease.

Experiences are often judged on the basis of impression and not reality.

Most people who seek help for addiction or mental health problems feel depressed, deflated, pessimistic and anxious.

Such feelings can cause significant resistance. This resistance can be resolved positively, if we are able to warmly welcome clients when they present.

We need to ensure that we welcome people to AMH in both routine and emergency situations.

It is important to be particularly welcoming to people who cannot be immediately served by the program or service that they initially approach.

Although we may not be able to appropriately help the person ourselves, we can help connect him or her to someone else within the system who can. We need to take responsibility for beginning an empathetic hopeful relationship to help people stay engaged and get the services they need.

Welcoming should also be experienced by clients' families and significant others.

Compassion is consistently and significantly related to an individual's satisfaction with care.

> | suggested activity | <

Spend a few moments either alone or with one or more colleagues, thinking about a time when you have felt welcome. This can be an experience in any area of your life and does not have to be limited to health care. Make a note of the things that made you feel welcome and that led to you leaving the experience feeling positive.

> | <

Think of a time when a visitor to your service communicated to you that they had felt welcome. What did they say? How did they behave? How did you know you had done a good job?

> | <

Why not send us some success stories or quotes from your own team to add to the toolkit?

concurrent.disorders@albertahealthservices.ca

TIP: Use the focus group facilitator's guide in Appendix 7 to work on these issues as a team.

What can happen if we get it wrong?

Within the research and anecdotally, it is noted that people have reported extreme emotional reactions to feeling unwelcomed within health-care systems. Frequently, this kind of reaction has been shown to lead to a strong distrust of health-care workers, a desire to avoid health-care settings at any cost and a decreased likelihood that these people would seek health care of any description in the future (Wen et al., 2007). This means that one isolated experience of feeling unwelcome may dissuade an individual from seeking help or support from health-care services for any current or future problem.

The feeling of being unwelcome is routinely linked to attitude as opposed to the content of interactions, or what has been said. It is therefore important as health-care workers to remember that people may read a great deal of meaning into brief contacts that do not involve any verbal discourtesy (Wen et al., 2007).

Research has highlighted that unwelcoming experiences involved both non-clinical and clinical staff. This indicates that all workers who have contact with patients/clients, not just front-line clinicians, should be involved and included in work concerning welcoming and engagement strategies (Wen et al., 2007).

A perception of poor staff attitude is a major reason clients give for feeling unwelcome and for not continuing in treatment (NTA, 2005). A feeling that the client/patient is not welcome and that health-care professionals lack interest is closely linked to patient perceptions of interactions being dehumanizing and stigmatizing (Wen et al., 2007; Schulze, 2007). Clients who feel unwelcome in the health system often end up in settings—for example, homeless shelters or jails—that have fewer appropriate resources and supports to meet their needs (Minkoff & Cline, 2004). This can exacerbate their problems. There are many factors that influence health professionals' willingness to welcome and intervene with addiction, mental health and concurrent disorder clients. These include but are not limited to

- **Organizational policy, procedure or protocol:** Policies and procedures can place so much emphasis on targets and productivity that taking time out to be welcoming and engaging is overlooked

or considered less important. Program exclusionary criteria can mean only certain people are welcomed.

- **Role confidence:** Practitioners may have doubts about whether they have the appropriate knowledge, skills, ability or training to deal with issues that may come up if they engage with addiction, mental health and concurrent disorder clients.
- **Previous experiences:** Positive or negative experiences can affect attitudes and the decision to become involved.

If we get the welcome wrong, we can have a profound effect on people. Take a look at some of the quotes below:

“If you were welcome, you would feel better. It makes you feel better; it makes you want to get better. If you are not welcome, you don’t want to get better, you don’t care.”

“They didn’t even want to know who in the hell I was.”

“They don’t have or won’t take the time to actually find out where you are at or how things are affecting your life and why.”

“They are very businesslike...they want to get on with the next patient...it was just an assembly line” (Wen et al., 2007).

Key messages

People have reported strong emotional reactions to feeling unwelcome within health-care systems.

This can lead to a strong distrust of health-care workers, decreased likelihood that people would seek health care of any description in the future, and a desire to avoid health-care settings.

One isolated experience of feeling unwelcome may dissuade an individual from seeking help or support for any current or future problem.

Feelings of being unwelcome are routinely linked to attitude as opposed to the content of interactions.

A perception of poor staff attitude is a major reason clients give for feeling unwelcome and for not continuing in treatment.

A feeling of being unwelcome is closely linked to patient perceptions of interactions being dehumanizing and stigmatizing.

Clients who feel unwelcome in the health system often end up in settings that have fewer appropriate resources and supports to meet their needs, and this can lead to a significant exacerbation of their problems.

There are many factors that affect health professionals' willingness to welcome and intervene.

All workers who have contact with patients/clients should be included in the work of welcoming and engagement strategies.

> | suggested activity | <

> | <

Spend a few moments either alone or with a colleague thinking about a time when you did not feel welcome.

This can be an experience in any area of your life and does not have to be limited to health care. Make a note of some of the things that made you feel unwelcome and that led to you leaving the experience feeling negative.

> | <

Think of a time when a visitor to your service communicated to you that they had NOT felt welcome. What did they say? How did they behave? How did you know you could have done a better job?

TIP: Use the focus group facilitator's guide in Appendix 7 to work on these issues as a team.

What is a welcoming program structure?

A relatively small amount of work has been done within health care to identify what people seeking treatment consider necessary components of welcoming and engagement. What follows is a collection of ideas from the health-care literature examined to date and also information drawn from the customer service industry.

It is noteworthy that the increasing complexity and competition in the health-care industry is similar to other large industries and there are many lessons to be learned from outside health care (Taylor, 1999). We must remember that even simple changes can produce significant increases in levels of satisfaction with the overall health-care experience (Taylor, 1999). It is also important to remember that it is not necessarily what we do but what we say (how we communicate what we are doing) that makes the impression (Lee, 2004). Major efforts to improve process may go unnoticed unless we clearly communicate what they are (Lee, 2004).

Proposed guiding principles for welcoming

The following statements have been adapted from a number of contemporary sources.

1. Every individual and family presenting to AHS, AMH has a consistent experience of initial contact and is welcomed and engaged regardless of their point of entry into the system.
2. Service and program environments are designed to welcome individuals with concurrent disorders and their families into treatment. This is reflected in statements related to policies, procedures, principles and philosophy as well as in program descriptions and orientation materials.
3. Staff recognize their role in the care of individuals with addiction, mental health and concurrent disorders, and welcome and engage these individuals comfortably and confidently.

It is clear that we need to address the issue of welcoming at an individual, system and organizational level if we are to be successful in improving patient experiences and outcomes.

There are several areas that require attention:

- program structure and set-up
- the physical environment
- interaction with clients, both at point of initial contact and ongoing

Program structure and set-up

The ways in which programs and services are set up can have a profound impact on the ways in which staff behave and operate on a daily basis.

Administration: policy, procedures, protocols

It is helpful for services and programs to document the need for a consistent approach that encourages welcoming, engagement and retention in services (Potts, 2008; NTA, 2005).

Procedures and protocols could include the following recommendations:

- All individuals and their families are actively welcomed into service. (This may involve a review of any existing exclusionary criteria.)
- People are given the earliest available appointment after initial contact (NTA, 2005; Stark et al., 1990). Long wait times are a big issue in customer service within all industries (Taylor, 1999).
- Welcoming and motivating letters, texts or telephone calls are used prior to a first appointment, or after a missed appointment with an identified contact person for any queries or questions (NTA, 2005; Davis, 2004; Mueller, 1987; Nirenberg, 1980).
- Staff consistently follow up with people during and after treatment to ensure needs have been met and to look for ways to add value and enhance care and service delivery.

Written mission, vision, values

These statements can be used to explain the service and its philosophy. This kind of information should be available for all people that you serve within orientation materials and also be displayed in waiting rooms and communal areas.

Orientation materials

Orientation materials available to all patients/clients and new members of staff should include

- details about services offered
- contact numbers for within and after working hours and in times of crisis and emergency
- clarification of processes
- information on how to get to the service (e.g., maps and bus routes)
- information about what to bring to appointments
- handouts (leaflets and posters) on addiction, mental health and concurrent disorders to appeal to a broad range of people
- handouts on anti-stigma measures and approaches

We need to ensure that all written information is clear, easy to read, easy to understand, colourful, user-friendly, and sensitive to cultural issues and to other issues such as literacy levels and low vision. Staff may need to be innovative and use pictures and not words in some situations. There are numerous websites that can help out with this (www.nchealthliteracy.org). (See Appendix 6.)

> | suggested activity | <

Spend a few moments either alone or with a colleague thinking about some of the policies, procedures and protocols currently followed within your program.

How do they enhance or reduce your ability to welcome and engage clients into service?

What changes, if any, could you make as a team? Do you have a team mission statement or vision?

Do you have orientation materials? Is this information easily available and clearly displayed?

Think about providing take-home information sheets to give to the people you serve (see Appendix 3).

Making a welcoming physical environment

There are many simple but effective ways to make physical space more welcoming.

Provide clear and welcoming signage.

A welcoming environment is easy to navigate (North Carolina Health Literacy, 2010). Appropriate signage can help patients/clients to move through your physical space and through your processes with ease. This is especially reassuring for people with limited literacy who may feel particularly anxious or intimidated when locating and entering a building. Clearly display the name of your service or program and hours of operation. Provide emergency contact numbers, to extend the feeling of welcome beyond your operating hours.

You could also display a “welcome” sign at the entrance to your program. Think about the languages this may need to be displayed in.



Welcome

Signs should be simple, clear and visible. You may want to consider using a large font and bold colours. It may be useful to colour-code signs, particularly if your service is housed within a building with other services. Coloured lines or symbols on the wall or the floor can help people navigate.

Signs should be available in a number of languages and Braille where appropriate. People should be directed all the way through the building. Examples of areas that may need to be signed are the entrance and exit, waiting room, interview rooms, examination rooms, meeting rooms, nursing station, staff area, washrooms, telephones, and refreshment area.

*Ask me—
I can help.*

Staff will look more welcoming and accessible if they wear badges that display their names and encourage contact. For example, badges may read, “Ask me—I can help.” You could also consider displaying photographs of team members labelled with their names in the waiting room.

Process signs should also be available to help individuals to understand what is required or what is likely to happen next.

Examples of process signs

Please let reception staff know that you have arrived.

Please take a seat and wait for your name to be called.

If you have waited for longer than 20 minutes, please let staff know at the reception desk.

Please take a ticket and wait to be called.

Visiting hours are between 1 p.m. and 8 p.m. every day.

Doctors’ rounds are between 10 a.m. and noon every morning. Please remain on the unit at this time.

Make access easy and inviting.

Provide parking, free and close to the building if possible (Douglas & Douglas, 2004; Davis, 2004). If this is not possible, provide clear information about where to park or alternative ways to travel in to the service. Lack of transport can be a significant factor in non-attendance (Ashton, 2005).



Ensure parking lots and the exterior of the building are clean (IPIRC, 2008). Ensure there is disabled access (Douglas & Douglas, 2004). Look at this from a number of different perspectives (Davis, 2004).

Try to ensure that the front entrance is accessible to all and exterior and interior doors are easy to open. Ensure that there is an accessible route throughout the facility with clear floor space and minimal clutter.

Create a bright, cheerful, clean space.

Aim for natural light (IPIRC, 2008; Douglas & Douglas, 2004; Davis, 2004; Taylor, 1999) and cleanliness: stains on walls and carpets do not make for a good first impression.

Hang pictures, photographs and artwork on the walls (Douglas & Douglas, 2004). Try to reflect cultural diversity (IPIRC, 2008). Maybe members of the staff team could bring in photographs they have taken. Posting artwork done by clients might also be an attractive option. Consider having some music playing (Davis, 2004).



Arrange the space for comfort and convenience.

- Set up furniture in waiting areas and meeting rooms to promote communication and make it easier to interact (Douglas & Douglas, 2004). Consider having a quiet area in your waiting room for those people who are feeling anxious, agitated or unwell. This area would need to be visible to reception staff.
- Recognize the need for personal space and privacy, particularly when discussing personal information. Try to ensure private areas are available (NTA, 2005; Douglas & Douglas, 2004; Borfitz, 2001) and always knock before entering a room.
- Work towards meeting the needs of families. This can include providing facilities for children, toy boxes in waiting and communal areas and interview rooms, and drink machines (Douglas & Douglas, 2004). Lack of child care can be a significant factor in non-attendance (Ashton, 2005).
- Provide public washrooms and ensure they are clean (Douglas & Douglas, 2004). Public amenities should be accessible and clearly marked at heights detectable by all users. Try to provide a changing table for care of infants.
- Try to have books and magazines available that appeal to a wide range of people. If you can, provide access to tea, coffee and water. Invite people to contribute ideas by providing a suggestion box.



Provide a variety of patient information.

If possible, assign one person from the team to learning about and designing simple, easy-to-read material. Websites are available that will help with the work (www.nchl.org). Consider creating a leaflet to explain your program or service to the people you serve or to let them know about the integration of addiction and mental health services.

Bulletin boards can be very useful but should be well maintained, current and designed for your client population. It is a nice idea to include information about local activities; this can create relationships and encourage community involvement.

Some services may choose to have a PowerPoint or DVD running in the waiting area describing the service and the process to follow.



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suggested activity | <
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Take a look at the following photographs. Given the information you have just read, think about what is good and not so good about each of the waiting areas you see.



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Now spend a few moments, either alone or with a colleague, thinking about your own physical environment.

What could be done to improve the space you have or build upon things you are already doing well?

Put yourself in other people's shoes: think about things that may be trauma triggers for the people you serve. How easily could these things be changed? Who would need to be involved to ensure these changes were made?

TIP: Use our staff welcoming walk-through checklist (see Appendix 2) to help review your physical environment.

Welcoming people at initial contact

Initial contact is extremely important within any organization. First impressions really do count. We need to ensure visitors to our services feel welcomed, cared about and reassured from the moment they make contact. Having people present to our services is something to be celebrated and every effort should be made to connect with and engage each person. All encounters are therapeutic opportunities (Taylor et al., 2010). See the take-home information sheet in Appendix 3.

Look towards making courtesy and respect more important than efficiency (Lee, 2004; Taylor, 1999). Begin with the intention of providing help, not just assessing need (Taylor et al., 2010).

Consider the following suggestions to help you welcome visitors at the initial point of contact.



Assess language preferences and literacy levels as soon as possible.

There is often a mismatch between a health worker's level of communication and the client's level of understanding. For a variety of reasons, people seeking our services may have a limited ability to obtain, process and understand the basic health information they need to make good health decisions. See the tips for developing printed resources in Appendix 6.

We need to adopt a “patient-friendly” approach, addressing these needs and encouraging questions. The most important thing to remember is that you cannot tell by looking who has problems with literacy or why, and you cannot rely on individuals to tell you. To be on the safe side, we need to provide information that is easily understandable to everyone. Effective communication with clients/patients has been shown to improve medical outcomes and reduce rates of anxiety, pain and psychological distress, while increasing compliance and symptom resolution (Weiss, 2007; ntlh.org, 2010).

Make a good first impression.

Smile. Make eye contact and shake hands when this is culturally appropriate. Meet and greet people (everyone in a given party) by name where possible and introduce yourself.

Think about the way you dress for work. Our personal appearance shapes first impressions of the organization. Always dress in a way that is professional, tasteful and tidy (Palliser Health Region, 2009).



Be aware of your verbal communication.

Consider the tone of your voice (Potts, 2008) and the pace of your speech. Speak slowly and use plain language. Avoid jargon.

Orient clients to your service.

Introduce the client to the service or program: describe what you offer, explain procedures to follow, clarify misconceptions, answer questions politely, and take time to listen and respond to concerns (NTA, 2005; Mueller, 1987).

Always explain what will be happening next in the process (Lee, 2004). Tell them, for example,

- what to bring to a first appointment
- what information they will be asked for
- when and how they will be allocated to a key worker

Be considerate.

- Be aware of the language you use: words can wound because of the negative stereotypes society attributes to them or because they betray a lack of understanding. Remember any barriers to service: for example, literacy issues or poor vision. Patients may need help reading, understanding or completing the material they are given and are unlikely to ask you for help. Offer assistance if there are any forms to be completed.
- Actively solicit short-term and long-term needs (Lee, 2004). Only collect essential information. Avoid duplication or unnecessary questions (Weiss, 2007).
- Encourage people to ask questions at any time. It is important that your responses to any questions and comments be credible and knowledgeable (Taylor, 1999).
- Be aware of who can hear the conversations that you are having with visitors or other staff members, wherever you are in the building. It is always a good idea to test this out!
- Apologize for any delays and thank people for waiting (Palliser Health Region, 2009). Communicate any potential delays (Lee, 2004).

- Always use “please” and “thank you.” Try to ensure that no one feels ignored (Palliser Health Region, 2009). Where possible offer tea, coffee or water (Godlaski et al., 2009; Potts, 2008).
- Don’t pass anyone without making eye contact or smiling. Avoidance can be a missed opportunity (Lee, 2004).
- Think about the ways in which staff interact with one another in the communal areas. We must remember that this can have an effect on visitors to our service and that people will pick up on the emotional atmosphere.

Take language differences into account.

If possible, collect information in an individual’s preferred language (Weiss, 2007). Where appropriate, provide translations of documents or recruit an independent translator. Avoid ad hoc family translators unless it is an emergency (Kirmayer, 2010; NTA, 2005).

Make telephone contact welcoming.

Have a person, not a machine, answer the telephone (Weiss, 2007). Try to answer the phone promptly and deal with messages appropriately (IPIRC, 2008). When answering the phone, say “good morning” or “good afternoon,” state the name of the service or program, state your name, and ask how you can help. See Appendix 5 for telephone tips.



Practise good listening skills.

Listen carefully, in a way that makes the person feel truly listened to (Wen et al., 2007). Be pleasant and supportive (Pinfold et al., 2005; Douglas & Douglas, 2004) and acknowledge the person as an individual (Wen et al., 2007).

Show an interest in the person (Mueller, 1987) and try to be empathetic (Taylor, 1999). Think about how you or one of your closest friends or family may feel in this situation.

Think about your body language and gestures (Borfitz, 2001).

Remember that subtle signs of facial expression and body language are almost impossible to fake.

Ensure information is understood.

Provide appropriate information and literature. Never assume things make sense to people because you are familiar with the topic.

Remember that when people are seeking help, they may have higher levels of anxiety. This can significantly reduce the amount of information they can comprehend and retain.

Welcoming people during subsequent contact

- Remember that many of the points raised in the previous section, “Welcoming People at Initial Contact,” remain relevant.
- Welcome and include the family and significant others, where appropriate (Kirmayer, 2010; Wen et al., 2007; Minkoff & Cline, 2004). Update individuals or family members periodically (Palliser Health Region, 2009).
- Learn the names of clients and their families (Mueller, 1987). Take an active interest in the whole family and help them to feel that they are part of the “healing team” (Lee, 2004).
- Try to remember the content of previous interactions and build upon it (Lee, 2004). Document key issues or useful information to aid memory. Communicate any potential delays or changes to the plan (Lee, 2004).

- Demonstrate a willingness to get to know the other person without judging (Wen et al., 2007). Recognize the unique characteristics of each individual (Wen et al., 2007). See the person as a whole, not just in terms of the problems they present with.
- Accept the person for who they are and respect their choices and lifestyle (Godlaski et al., 2009). Try to establish a real understanding of the situation and concerns (NTA, 2005). Try not to look for “the problem.” Think of the time you spend with people as a way to see the skills, abilities, creative ideas and strengths they bring. Consider meeting with community organizations to bridge cultural gaps (Kirmayer, 2010).
- Be considerate of individuals’ priorities and respect what is important to them (Palliser Health Region, 2009). Acknowledge the needs of the patient/client even at the expense of your own agenda (Wen et al., 2007). Respond to needs (NTA, 2005) as best you can in a safe respectful way.
- Work to reduce the power imbalance in the relationship (Wen et al., 2007). Demonstrate a hopeful attitude toward recovery (Potts, 2008). Ensure the individual has a sense of control over decisions and treatment: this reduces feelings of helplessness (Douglas & Douglas, 2004).
- Be honest. Promote a culture of honesty and open communication (NTA, 2005).
- Take complaints seriously and be seen to act upon them (NTA, 2005). Offer practical assistance where possible (Godlaski et al., 2009; Ashton, 2005).
- Consider being flexible with appointment times to better suit the client and their other commitments. This can go a long way towards fostering respect and trust.
- A handwritten letter expressing concern that an individual has not attended an appointment has been shown to significantly increase the likelihood of that individual returning to service. Personalized emails and phone calls have a similar impact (Ashton & Witton, 2004).

Take an active interest in the whole family and help them to feel that they are part of the “healing team” (Lee, 2004).

- After discharge, consider introducing routine callback as part of your care package. This is an excellent way to finish the experience positively, gather feedback and encourage people to use aftercare services (Ashton & Witton, 2004; Lee, 2004).
- Intermittent motivational reminders can also help keep people engaged with aftercare and may in themselves be therapeutic (Ashton & Witton, 2004).

> | suggested activity | <

> | <

Spend a few moments either alone or with a colleague considering these suggestions.

Think about what may be a good fit for your environment. Remember that by your example you can help others to appreciate the importance of certain ways of behaving and promote change.

Reflect on what you are already doing well as a team and areas where you may like to improve current practice.

You may want to take some time to look at the tips and examples of content for telephone scripts that are provided in Appendix 5. Discuss with colleagues ways to improve or tailor the scripts to ensure a consistent approach to answering the telephone. Send them back to us to share good practice.

> | <

Think about the times when the client doesn't follow the script, when things don't go the way you had hoped or planned. Think about the ways in which we deal with those people who are a little more challenging when they come into contact with our services. How do we welcome the intoxicated, hallucinating, agitated, aggressive, distressed or suicidal person? Remember we welcome all people, not all behaviour.

What works well and what doesn't?

Are there some ideas you could script to help members of your team deal with situations in a better way?

> | <

Spend time in the waiting area, communal areas and interview rooms. Listen to the sounds and conversations you can hear. Be aware of what people coming into your service or program can hear. Reflect on this with your team.

Important points to remember

- **Cues associated with a welcoming environment will differ** as people's culture, belief systems, spirituality, and other aspects of their background differ, and will need to be reviewed at a local level by individual teams. We must respect the diversity of traditions and experiences present in our communities and workforces. Services need to remain open-minded and be prepared to learn. It is important for teams to think about the populations they serve. It may be wise to review Statistics Canada sites to learn more about which population groups are living in the geographic area. As professionals, we must understand the populations that we work with and adapt our communication style, technique and tools to suit these populations. It may also be useful to elicit the help of local cultural community organizations to act as "culture brokers" and to give advice (Kirmayer, 2010). Partnering with the community on any level can be a great way to begin to address stigma (Martin & Johnston, 2007).

Think about immigrant and refugee considerations. There are approximately 239,000 immigrants coming into Canada each year. Almost 35,000 of these are refugees. Immigrants tend to settle in large cities and present to primary care services. Before 1960, the majority of immigrants came from Europe. Today, however, we see immigrants coming from Africa; the Middle East; Latin America; the Caribbean; and South, Central and East Asia. Of the top 20 health conditions reported in immigrant populations, four fall within the AMH field:

Abuse and
domestic
violence

Anxiety

Depression

PTSD/
Torture

Cultural and linguistic difficulties, together with a lack of evidence-based practice for this group, can lead to poor development of services (Swinkels et al., 2010; Tugwell et al., 2010). Locally focused, targeted interventions can have significant positive impact, improve engagement and retention in treatment and enhance the patient experience and outcome (Pinfold et al., 2005).

- **The situation does not have to be perfect to be welcoming and engaging** (Godlaski et al., 2009) and significant changes do not always require additional funding or resources. It is important to focus on what can be done with what we have. There does not have to be a conflict between being welcoming and maintaining efficient administrative procedures. Both are required and achievable (Ashton & Witton, 2004).
- **We need to work on welcoming** at an organizational, program and individual level. However, things don't have to happen all of the time by all of the staff. One person going the extra mile on one occasion can be enough to engage an individual into service and ultimately to enhance the patient experience, satisfaction and outcome (Lee, 2004). We all have a responsibility when it comes to welcoming: outcomes are delivered by teams, impressions are delivered by people (Lee, 2004).
- **To ensure that the environment is “right” for our patients, we also need to think about making it “right” for staff.** If we are aiming for a welcoming “front of house” we need to consider areas “behind the scenes.” Often one of the missing things in health care is rest areas for staff. Health-care environments are often full of stress and staff need space to reflect and regroup.
- **You don't have to be an expert** in addiction, mental health or concurrent disorders to help someone struggling with the problems associated. Neither do you have to be the expert in welcoming: talk to your clients and the people you serve to see how you are doing and what they would like to see. Remain open to new ideas and differing viewpoints and work with your teams to explore innovative solutions to common issues. Learning from our mistakes is a great way to do it better next time.

It is important to focus on what can be done with what we have.

> | <
suggested activity | <
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Spend some time alone or with colleagues thinking about the population that you serve.

What are the major ethnic and cultural groups accessing your services?

Are there some populations that face even higher levels of stigma and fear? (e.g., Justice clients)

How can we ensure that we are welcoming of everyone?

> | <

Spend some time alone or with colleagues thinking about the staff-only spaces in your environment.

What could be done to improve the space you have or build upon things you are already doing well?

How easily could these changes be achieved?

Who would need to be involved to ensure these changes were made?

Send us stories about groups you have successfully worked with to improve access and welcoming.

 note section

Self-assessment questions

How would you define welcoming?

Explain in a few sentences or phrases why welcoming is important.

What can happen if we do not welcome people appropriately?

What are some of the areas we need to think about when it comes to welcoming and initial engagement?

How might your own biases and stigmatizing beliefs about addiction and mental illness be getting in the way of welcoming?

Reflect on the elements of this toolkit that had most significance or impact on you as an individual practitioner.

List some of the ways you feel that you, both as an individual and part of your team, can develop with regard to welcoming and engagement.

What are your next steps?

Conclusion

We hope this toolkit has given you some useful information about welcoming and engaging clients and supplied you with some tools and resources to use in your own practice and teams.

If you have any questions, comments or stories to share, please contact concurrent.disorders@albertahealthservices.ca

APPENDIX 1

Stigma: Useful web links and suggested activities

Canadian sociologist Erving Goffman said that stigma is “the situation of the individual who is disqualified from full social acceptance.” Stigma happens when people have personal characteristics or beliefs that are disapproved of by society or a specific social group. We show stigma, sometimes unconsciously, through our actions and our attitudes, which convey the message that we do not accept the person and we do not feel hopeful on their behalf.

Below is a list of useful web links and suggested activities that we would encourage you to review and reflect upon.

The focus of this resource is to create awareness of how stigma is enacted and to challenge staff to examine their own practices.

Useful web links

Stigma is based on prejudice: Alberta Human Rights information

www.albertahumanrights.ab.ca/publications/bulletins_sheets_booklets/sheets/protected_grounds/stereotyping.asp

Centre for Addiction and Mental Health: What consumers say about stigma

www.camhcrosscurrents.net/archives/spring2010/what_consumers_say.html

Mental Health Commission of Canada: Opening Minds Campaign

www.mentalhealthcommission.ca/English/Pages/openingminds.aspx

Mental Health Commission of Canada: Opening Minds Campaign. Stigma: The Facts

www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2009/Stigma%20The%20Facts.pdf

Mental Health Commission of Canada: “Trial by fire: Stigma in the health care system,” by Ellen Neilsen (n.d.)

www.mentalhealthcommission.ca/SiteCollectionDocuments/Anti-Stigma/Trial%20by%20Fire.pdf

Mental Health Commission of Canada. (2008). *Out of the shadows, forever: An overview*

www.mentalhealthcommission.ca/SiteCollectionDocuments/brochures/MHCC_eVersion.pdf

Canada. Parliament. Senate. The Standing Senate Committee on Social Affairs, Science and Technology. Kirby, Michael J. L. (Chair). (May 2006). *Out of the shadows at last: Transforming mental health, mental illness and addictions services in Canada*

www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/rep02may06-e.htm

Suggested activities

The following activities are presented as possible team development opportunities for managers and staff groups. These suggestions can be used as a part of team-building, since an examination of stigma within addiction and mental health service touches on diversity, acceptance of difference, and reflection on improved practices and advocacy.

Not all activity ideas are suitable for all teams. Choose the ideas that best fit the needs and comfort of your team.

As a first step in building awareness, activities should be preceded by inviting all individuals to take time to review the resources and websites listed above. All activities should be moderated by a skilled facilitator who is open to hearing a variety of positions.

Activity: Team retreat questions

Choose from among these questions to create focused discussion about the stigma associated with addiction and mental illness and the actions that can be undertaken to change the underlying prejudices. It is strongly recommended that no matter what combination of questions are chosen, the facilitated discussions end with discussion about how to improve service to clients.

1. What are the ways in which stigma is present in your work?
 - For clients?
 - For families?
 - For your colleagues?
 - For you?
2. Have you ever experienced prejudice associated with working in addiction and mental health service?
 - From your family and friends?
 - From clients?
 - From other health professionals?
 - From your organization?
 - From your colleagues?

3. If you answered yes to any part of question 2, what was the experience like? What changed as a result of the experience? What should have changed?
4. Given the many ways stigma is present, what can you do personally or collectively with your team to advocate for equality and to promote inclusion in situations like the ones you've discussed?
5. What would anti-stigma practice look like in the context of [*name of your specific service*]?
6. What can you commit to doing to bring about this kind of service?
 - Today?
 - Next month?

Activity: Assumption testing

For use with stakeholder teams who are partners in care. This activity should be facilitated by a knowledgeable clinician. Have the team imagine in their minds Friday night in an ER waiting room. Most people in the room are clearly injured or suffering from a physical ailment. However, one middle-aged woman appears to be intoxicated or somehow “out of it” rather than “sick.” She is dishevelled and mumbling to herself.

Questions for discussion:

- What are your first thoughts as you hear the description of this situation?
- What negativity do you think this person may experience from those around her? Think of other patients, families, security, health professionals.
- How do you monitor your assumptions? How do you ensure that this client, like any other, is welcomed?

Activity: Vignettes

These vignettes can be used as an awareness exercise with any audience. Consider each of the following vignettes. Each person has their own experience of prejudice—what would it be like to be in their place? As a personal reflection or working in small groups, try speaking about their experience of service from their point of view. How would they describe what it is like to come to your service each day?

Vignette 1

I am a 48-year-old widow who struggles with her weight. I have been attending this clinic for two years now and I find the chairs rather uncomfortable to sit in. When I come here, I always try to find the chairs that do not have armrests so that I can sit more comfortably in the waiting room.

What could be better? What else should you consider?

Suggested considerations: Assess the physical features of chairs. How well do these meet the needs of larger people? What would it be like to use these chairs if you were heavier and larger?

Evaluate the waiting room. How many chairs are there without arms? How popular are the chairs without arms? How many new chairs could be ordered?

Are there other barriers for the larger clients? What are the chairs like in the consulting rooms once people leave the waiting room?

Vignette 2

I am an 18-year-old gay female. I have been receiving addiction counselling now for one year. When I came in for counselling I was asked if I was aboriginal. This made me feel uncomfortable. What does that have to do with it? Are all addicts aboriginal? I mean, I do have a dark complexion...Also, I have noticed that there are posters of only white teens on the walls as well as heterosexual couples.

What could be better? What else should you consider?

Suggested considerations: To practise skillful engagement, remember why people seek our services. Skilful addictions staff work to determine how they can be of assistance to individuals in addressing their addiction concerns. All staff should be attuned to a client's verbal and non-verbal cues and pick up any discomfort any question may be causing.

Is there a situation in which it would be relevant to ask a person, early in their experience of a service, whether they are aboriginal? For example, in your area, are there services, funds or programs this person could qualify for because they are First Nations? What are these resources? When would it be appropriate to introduce these re-

sources to a person? The counselling staff are best qualified to assist the client in accessing resources within the context of their treatment plan.

When we ask a question that is not relevant to the addiction itself, what underlying assumptions are we implying or betraying? The Health Information Act requires that staff collect the least amount of information necessary to provide treatment.

Posters should convey diversity. If the “official” posters displayed in your office do not picture diversity, seek out artwork or other images that do.

Vignette 3

I am a 52-year-old immigrant male from Yugoslavia.

I have been working as a janitor for health services for 10 years now.

I like the evening work because I do not have to interact with many of the day staff in the hospital. I know that the hospital can be very busy at times and staff can be stressed and frustrated when communicating with me. I still struggle with the English language at times and I sometimes feel bad about this.

What could be better? What else should you consider?

Suggested considerations: What do you know about your cleaning staff? Who do they report to? How much interaction do they have with staff and with patients? In what ways have you included them as part of your health-care team?

What are the personal and health benefits of having clear communication with the cleaning staff? www.unison.org.uk/acrobat/14565.pdf

What are the benefits of retaining the services of someone like the man in this vignette?

Vignette 4

I am a 30-year-old male who has a learning disorder and speech impediment. I find it hard to understand what people are saying sometimes, especially when I attend my weekly appointments at the clinic. I sometimes don't say anything because I don't want to look stupid.

What could be better? What else should you consider?

Suggested considerations: Consider the implications for treatment planning. In what ways is this person being provided with the education and skills necessary to advocate for himself?

Consider the implications for clinical supervision. How is this man's silence being interpreted by the clinical staff? If they don't know about his educational and medical history, how is it that these important health determinants have been overlooked?

What modifications can staff make to assist this person with understanding the speech of others? For example, staff could use plainer language, speak more slowly, write things down, repeat instructions, and review ideas from the last visit. You can also ensure that this patient's needs are communicated within the case notes or team conferences.

Does case management include contact with a speech pathologist or other professional? Do clinic staff know what this person's communication preferences are?

APPENDIX 2

Welcoming walk-through checklist

The therapeutic milieu of any service begins as soon as people approach the service and continues every time they enter. What do people hope for as they come to your door? Most people have basic expectations: they hope to be offered care, to get what they came for, and to know they are in the right place. However, beyond being friendly, the social and emotional environments of our AMH services need to welcome people as partners in care. Beyond being clean and safe, the physical environment should be easy to navigate and amenable to everyone.

This walk-through checklist has been designed to act as a quick, informal assessment of observable signs of welcoming within your current environment. Consider using the walk-through checklist routinely and making it a regular part of your team-building.

Welcoming walk-through checklist

1. Program structure and set-up

QUESTIONS	ALREADY DO THIS	COULD EASILY DO	THIS WILL TAKE TIME	THIS WILL BE HARD	COMMENTS AND REFLECTIONS
Do policy, procedures and protocols document the need for a consistent approach that encourages welcoming, engagement and retention in services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do protocols recommend these measures?					
· All individuals and their families are actively welcomed into service.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· People are given the earliest available appointment after initial contact.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Welcoming and motivating letters, texts or telephone calls are used prior to a first appointment and after missed appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Staff consistently follow up with people during and after treatment to ensure needs have been met and to look for ways to add value and enhance care and service delivery.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are mission, vision and value statements available and easily visible to those visiting the service?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are orientation materials available to all patients/clients and new members of staff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is this information easily available and clearly displayed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do the orientation materials include the following content?					
· details about services offered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· contact numbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· clarification of processes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· information on how to get to the service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· information about what to bring to appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are information leaflets or posters on addiction, mental health and concurrent disorders readily available?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are the posters or leaflets written to appeal to a broad range of people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Does available literature include anti-stigma information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is written information					
· clear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· easy to read	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· easy to understand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· colourful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· user friendly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· sensitive to literacy levels, low vision and culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Welcoming walk-through checklist

2. Physical environment

QUESTIONS	ALREADY DO THIS	COULD EASILY DO	THIS WILL TAKE TIME	THIS WILL BE HARD	COMMENTS AND REFLECTIONS
Is there a welcome sign displayed at the entrance to the program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are the name of the service and hours of operation clearly visible?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are emergency contact numbers available?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is the front entrance accessible to all and are exterior and interior doors easy to open?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is there an accessible route throughout the facility with clear floor space and minimal clutter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is your service “barrier-free”? (Think of physical limitations such as weight challenges, hearing loss, and mobility issues.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is the space bright, cheerful and clean?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have artwork and other images that express hope?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have you considered the physical sensitivities of the people who use your service, bearing in mind the heightened sensitivity of being unwell? (Examples are sensitivities to light, aromas, chemicals, and the proximity of others.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a quiet spot where people can sit apart from other people if they are feeling stressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Does the physical environment meet the needs of families? Are there toy boxes, books, and other ways of keeping children interested and entertained?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a private space to discuss personal information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is there parking close to the building?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are there clean and accessible public washrooms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is there appropriate signage throughout, indicating where key areas are and the processes to be followed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is the signage readable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are there up-to-date, informative bulletin boards?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a “welcome wagon” area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a suggestion box?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are there facilities for tea, coffee or water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Welcoming walk-through checklist

3. Interaction

QUESTIONS	ALREADY DO THIS	COULD EASILY DO	THIS WILL TAKE TIME	THIS WILL BE HARD	COMMENTS AND REFLECTIONS
Do staff follow these rules of positive interaction?					
· Answer the phone promptly, skilfully and courteously.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Make eye contact and shake hands when this is culturally appropriate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Speak slowly and use plain language.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Always use the words “please” and “thank you.”	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Answer questions politely, take time to listen, and respond to concerns.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Explain what will be happening next in the process.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Apologize for any delays and thank people for waiting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Encourage people to ask questions at any time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Welcome and include the family and significant others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

APPENDIX 3

Take-home information sheet

Consider creating an information sheet or welcome card to give to clients. You may wish to include welcoming statements such as those listed below, or write your own.

- You have taken a difficult step just by deciding to come here.
- We are glad you are here! We are here to listen and help.
- We will work with you to create a plan for your recovery.
- You are not alone. Many people are dealing with substance use, addiction or mental health issues.
- Be gentle with yourself. Recovery is a process and there will be easier times than others. You can learn something from all your experiences.
- Remember we will try to answer any questions or concerns you have.
- There is no such thing as a stupid question.
- “A journey of a thousand miles begins with a single step.”
– Confucius

Optional – include on back of page

Here is some information you may find helpful in your recovery process:

- local agency’s name, hours and contact information
- local emergency numbers and crisis information
- local 12-step programs or other groups agency routinely refers to
- local agencies that may provide resources (e.g., CMHA)
- websites with general recovery info (e.g., stages of change)

*You have taken a difficult step
just by deciding to come here.*

*We are glad you are here!
We are here to listen and help.*

Local agency’s name, hours,
contact information



APPENDIX 4

Welcome wagon ideas

Believing in a client and demonstrating hope for a full life and optimal potential for health can be very welcoming and empowering. Many of the people who come to your service will be hoping to make significant life changes and will therefore benefit from having access to resources within their communities to build skills and establish support networks. A “welcome wagon” providing local, accurate, and appropriate information and opportunities can be extremely helpful.

The following list of ideas may assist you and your team when creating your own welcome wagon for those who are new to the area. In addition, this suggested activity is a good way to start thinking about which services you may want to connect or partner with in your community.

This list of suggestions is not intended to endorse any program, affiliate or agency, nor is it an exhaustive list of possibilities. The suggestions below indicate some of the most frequently referred-to services, as well as services of interest to new members of a community. The list could be made into a single handout, used as an inventory to your existing pamphlet area, or added to a client handbook upon entry to a specific program.

Be sure to add up-to-date contact information and a brief description of each service.

Alberta Health Services

- Health Link pamphlet (1-866-408-5465)
- Mental Health Helpline (1-877-303-2642)
- Addiction Helpline (1-866-332-2322)
- Listing of doctors accepting new patients
- Walk-in clinic pamphlets
- Listing of local hospitals
- Public health office pamphlets (immunizations, parenting, dietitian, etc.)
- Sexual health offices (birth control, HIV/AIDS, pregnancy)

- Seniors' health
- Recreational therapist contact information (business card)
- Occupational therapist contact information (business card)

Other services for better living

- Police: 911 and non-emergency numbers
- Poison Control Centre (1-800-332-1414)
- Fire Department: 911
- Abuse, violence, crime (local shelters, transition housing, victim's assistance, family violence, sexual assault recovery specialists, John Howard Society, In from the Cold programs—temporary shelters in churches, etc.)
- Child & Family Services of Alberta/Child Welfare
- Legal Aid
- Credit Counselling Services, Money Mentors
- Housing agencies, Canadian Mental Health Association (CMHA)
- Food banks, soup kitchens
- Clothing banks—Salvation Army
- Volunteer programs
- Listing of local psychological service providers
- Support groups (Suicide Survivors, grief and loss, eating disorders, gay and lesbian, addictions, diagnosis-specific disorders or conditions)
- Listing of societies (Alzheimer's Society, Cancer Society, Multiple Sclerosis, etc.)
- Local newspaper listings of societies and associations
- Aboriginal groups, committees, societies, friendship centres
- Native Counselling Services
- Drop-in centres and community centres for seniors, parents, singles, teens, toddlers
- Dentists
- Optometrists

Important areas of interest

- Transit services (maps, schedules, contact information)
- Taxi information (vouchers if possible and appropriate)
- Current maps of the area
- Listing of local schools for children
- Listing of alternative or specialty schools
- Daycare and after-school care services

Some agencies have pamphlets, booklets, postcards or calendars of events already published and ready for distribution.

A simple phone call or email can get you a wealth of contact information. To ensure ongoing information updates and restocking of supplies, teams may designate one member to take responsibility or request that the supplier send packages monthly or quarterly to meet demand for resources. Some programs and services have accepted donations from businesses to have free vouchers, discount coupons, dental floss, fridge magnets, business cards, stickers, jar openers, bookmarks, and other items included in grab baskets placed in waiting rooms. Links to city or town websites can provide information of interest to post in your waiting areas.

Please check out InformAlberta for more information on a variety of topics in your area: www.informalberta.ca

Please discuss any endorsements with your direct supervisor before posting, ordering or handing out materials. These actions reflect the atmosphere of an Alberta Health Services property, and any conflict of interest needs to be considered.

Appendix 5

The importance of telephone calls: Telephone tips and scripts

A telephone call is often a person's first interaction with an organization. The first call offers an excellent opportunity to establish rapport and can set a positive tone for the rest of that person's experience. For this to happen, it is everyone's responsibility to make callers feel welcome with a friendly greeting and an earnest effort to listen and assist.

This information sheet pulls together pertinent information on telephone etiquette and strategies. It was written following a review of paper and web-based resources and discussion with clinicians and administration staff from a number of service areas. The information in this document is by no means exhaustive and is intended to act as a starting point for reflection and discussion.

Telephone tips

Below are a few suggested ways you can please people on the telephone when both receiving and making calls.

Be efficient.

Staff in your area should be able to perform basic telephone functions well: for example, transferring calls and putting calls on hold. Staff should try to answer the phone by the third ring, because a slow response can discourage callers. Note paper should be kept close to all telephones.

Convey a welcoming and professional tone.

Use the first couple of rings as a chance to get into a positive frame of mind. Smile before you pick up the phone. Welcome and make every call with a warm positive attitude.

Answer the telephone professionally with a friendly standardized greeting, letting the caller know which service they have reached:

“Good morning/afternoon/evening, thank you for calling...Program or Department Name, my name is..., how can I help you?”

Speak and listen with the caller's needs in mind.

Try to listen attentively with your whole mind on the caller. Allow the caller sufficient time to speak. Remember, the caller may be very anxious and it may take a little while for them to communicate their needs.

Pausing slightly between words or phrases can help the other person to hear what is being said. You can express warmth by using the caller's name but do not overdo it: repeating the caller's name over and over throughout the conversation can be annoying.

If necessary, help the caller to stay focused using gentle prompts. Take notes to help you remember what the caller said. Confirm understanding by summarizing the caller's request or query.

Keep the caller informed. Let them know what you are doing: for example, if you are looking for appointment times in the calendar, tell the caller that's what you are doing.

If you need to consult someone else in the office, ask for permission to do so or put the caller on hold. If a caller is on hold for a longer time, update her or him periodically. Always thank the caller for holding when you return to the call.

Keep the conversation positive and evoke confidence in your program.

Give positive verbal nods to let the caller know you are listening: for example, "Sure," "No problem," "I see," "I understand."

Use positive, definite language and words like "happy," "good," "best" and so on. "Does that sound good?" is much better than "Is that OK?"

The more positive words we use, the better the impression your caller will get. Equally, more definite language such as "straight away" or "certainly" will also build confidence in your program and organization.

If you have to say something that may be considered negative, try to finish with a positive option: "We don't have an appointment for that day; could I suggest the following week?"

Suggest that the caller do something, rather than giving direct orders. Here are some useful “suggestion” phrases: “Could you please send in...,” “It would be great if you could...” “It is important that we get...”

Think about the tone, tempo and volume of your voice. When callers are angry, agitated or distressed, try to ensure that your tone, tempo and volume do not mirror theirs. It is always best to remain calm and clear. Reacting in this way can often promote the caller to calm down too.

A good way to deal with irate people is to remember the acronym LAST:

- L**isten
- A**cknowledge (how the person is feeling)
- S**olve the problem
- T**hank them

Sometimes, you may have to include an apology on behalf of the larger system.

End the call efficiently and leave a good last impression.

Confirm all meetings, arrangements and agreements at the end of the call to avoid misunderstandings. It can be useful to have the caller repeat the day and time of an appointment. Remember to communicate any information necessary to prepare the person for their visit (required arrival time, what they should bring along, etc.).

Give the caller a cancellation number and ask them to call if they are unable to attend the appointment.

Have a warm, positive close. People remember the first and the last impressions on the telephone.

Thank the person for calling and see if there is anything else that you can help with.

Carry out any actions required from the phone call and record any notes or arrangements as quickly as possible.

Telephone scripts

Using good telephone technique can help teams achieve desired performance excellence. You can help to ensure ongoing exceptional service by developing a script that team members can follow and use as a guideline. A call script can be very simple or complex, depending on your needs.

To develop an effective telephone script, you must be intimately familiar with the reasons that people are calling, identify the desired direction that calls should take, and identify likely possibilities that may exist during the call.

A script can be a measure to help staff feel that they are meeting expectations and to motivate continued dedication to good practice, but it should act as a guideline only. The order of the script is not as important as the content and it is vital that you create a script that works for you. Scripts can help with specific scenarios, but all staff must be able to deviate from the script and respond to the here and now.

Key words and phrases to stimulate team discussion about creating a telephone script

“Good morning/afternoon/evening, thank you for calling [program or department name]. My name is [name]. How can I help you?”

- “No problem.”
- “I understand.”
- “Does that sound good?”
- “We don’t have an appointment for that day, could I suggest the following week?”
- “Could you please send in...?”
- “It would be great if you could...”
- “It is important that we get...”
- “What will need to happen for today to be useful to you?”
- “Is there anything else I can help you with today?”
- “Feel free to ask me any questions you may have. I have the time and I can help.”
- “If you are unable to keep your appointment, will you let us know so we can open it up to someone else? The number to call is ...”
- “It sounds like this appointment is important to you and I know your counsellor/nurse/worker is looking forward to seeing you.”
- “I am sorry to hear about the experience you have had. How can we move forward from here?”

APPENDIX 6

Tips for developing printed resources

You may find the need to develop client information resources.

The following tips may help you to define the content of your resource, to format the information so it is inviting to read and to be aware of AHS visual identity standards that may apply to your resource.

Before you start, ask yourself three questions:

- What is the purpose of, or what do I hope to accomplish with, this resource?
- Who is the audience, or who am I writing the resource for?
- What is the appropriate tone?

Purpose

Is written or verbal communication best?

Not all information is best communicated in writing. It is being able to recognize differences in clients and finding ways to ensure that they receive and understand the information that is important.

When we talk to someone face-to-face, we're able to adjust our speech to ensure that we are communicating our information. There is the advantage of visual cues and discussion that allows us to readjust messages if needed. Take time to think about who will be reading what you write and recognize that different readers will understand different messages.

Audience

Analyze your audience before writing.

Client resources related to concurrent disorders have the potential to cover many audiences with wide-ranging characteristics. For example, audiences could include clients and their family, friends or caregivers. These groups, in turn, could vary in age, education, comprehension skills and levels of engagement. This increases the challenge of developing client resources that are appropriate to everyone and may point to the need to segment these audiences before developing resources.

Get to know the audience you serve and you can easily determine how to rework content. This may be as simple as reflecting diversity in age, gender, race and other qualities in visual representations of people.

Analyze your audience before writing so you'll know what format, style, vocabulary or level of information is expected. This will help ensure that the resources are both appealing and easy to understand. It will also help you to predict what issues or problems your audience may have with the content so you can solve those problems in advance.

Questions to ask about audience

- Who are the readers?
- What do they want to read?
- What type of writing characteristics do they expect?
- When, where and how do they read?
- Why would they want to read the resource?
- Who will engage the services?
- What do they want?
- What expectations do they have?
- What needs do they have that the services can satisfy?

Tone

Keep content as basic and clear as you can.

Use plain language, avoid jargon and take advantage of software that can review text for reading levels. Avoid using acronyms and abbreviations.

Ensure language used throughout is positive.

Resources should reflect your attitudes, core values, beliefs and ethics.

Choose photographs and illustrations with care.

Photos, pictures and graphic elements help to make resources more appealing and easier to read.

- If you use photos, be sure to represent ethnic diversity.
- Photos of facility entrances or staff can help prepare clients for first visits.

- Photos can depict client involvement without focusing attention on clients. Examples are photos shot from the back or side of the client, or with the client in the background.
- Brainstorm interesting photos or pictures that could be used to create the look and feel you want the client to get from the resource.

Cautions about using photos

- Avoid reinforcing stereotypes and try to be inclusive of all people.
- Changes in hairstyles and fashion and developments in technology can make photographs look dated.
- Cartoons may be seen to trivialize subject matter.

Other tips

Find fresh eyes to do your editing.

Don't edit your own writing. Ask someone else with no foreknowledge of the words to review your copy. They will really read what is there and pick up mistakes more quickly and easily than the writer.

Test resources with the audience.

Once you have created the item, it is well worth your time to ask a few clients with whom you have a relationship to look at it and provide feedback as honestly as possible.

Familiarize yourself with AHS communication tools.

AHS Visual Identity Standards provides advice on design of documents and the standards to be observed when using the AHS logo and AHS naming conventions.

www.albertahealthservices.ca/org/ahs-org-visual-standards.pdf

The *AHS Writing Style Guide* will help you make consistent word choices and avoid writing errors.

<http://insite.albertahealthservices.ca/VisualIdentityStandards/mcs-vis-writing-style-guide.pdf>

Additional items of value can be found on AHS Insite.

AHS logos: <http://insite.albertahealthservices.ca/903.asp>

AHS templates: <http://insite.albertahealthservices.ca/902.asp>

Evaluate and review on a regular basis.

Placing a production date on the resource assures your audience that the resource is current. A review date on the resource serves as a reminder to review the resource and update it as needed.

APPENDIX 7

Organizing a focus group to discuss welcoming

This appendix provides a guide, sample outlines and templates for planning and hosting focus groups with staff or clients on the topic of welcoming and engagement strategies. The objectives are

- to provide information about the utility and structure of focus groups
- to demonstrate the value of focus group work within current practice
- to provide tips and templates to enable teams to begin meaningful and directed conversations about the development of welcoming and engagement
- to stimulate reflection on what is working well, barriers to excellence and potential innovations.
- to encourage the development of welcoming and engagement strategies and facilitate concurrent-capable care

Please use this guide as you see fit within your own teams and as it relates to your service area and target population.

What is a focus group?

A focus group is a small number of relatively similar people who come together to provide information during a directed and moderated interactive group discussion. Data is usually taped and transcribed so themes can be identified.

Why use focus group methodology?

- A focus group is a good way to
 - initiate the right conversations with the right people at the right times
 - encourage discussion around a particular topic, explore issues and answer questions
 - gather specific feedback, comments and opinions from a targeted group
 - test assumptions

- build excitement about a particular topic
- build rapport within and between teams
- focus groups are particularly useful at the beginning of a process or project.
- focus groups are used in planning, marketing and evaluation phases.

Remember

- Most people like to be asked for their opinion and are not shy about voicing it.
- To make focus groups valuable we must apply the findings.

What should I do before forming a focus group?

- **Determine the purpose and objectives of the focus group and write a purpose statement.** The purpose and objectives must be clear and specific. The clearer this information is, the easier the rest of the process will be.
- **Establish a timeline for planning and implementation** (see facilitator's outline).
Experts recommend planning a focus group session four to eight weeks ahead of the time you want the group to meet.
- **Identify the participants.** It is recommended that focus group organizers aim for six to 12 diverse participants. Fewer than six can limit the conversation and more than 12 can be too many voices.
It can be useful to have participants unfamiliar with the agenda before the focus group begins to ensure they do not form opinions in advance. It can be useful to have separate focus groups for front-line staff, managers and supervisors to foster open and honest discussion. Develop a list of key attributes you want in a participant, then shortlist who to include.
- **Select facilitators who**
 - are knowledgeable about the project
 - have a working knowledge of group dynamics and a reputation as a good meeting leader
 - encourage members to speak freely and spontaneously
 - ensure everyone participates and no one dominates

- keep discussions on track
- are able to deal tactfully with outspoken group members
- are able to remain objective

It is a good idea to have one facilitator to lead the discussion and one to observe and take notes.

Be cautious about the potential for a power imbalance when selecting a facilitator.

Remember: You do not need to hire a professional facilitator.

- **Develop a list of questions.**
 - All questions should be relevant and open-ended.
 - You can include one or two introductory or “warm-up” questions.
 - Questions should proceed from general to more specific.
 - Questions should be presented in order of importance.
 - Questions should be simple and meaningful.
 - Avoid potentially embarrassing or sensitive questions.

Review the list of questions with the purpose statement in mind and eliminate any that do not fit.

Ask a skilled editor to look at the wording of the questions.

Rewrite as necessary.

Test the questions out with colleagues before using them within the focus group.

- **Prepare a script or facilitator’s outline (see sample outline).** Even if you are experienced at running groups, it is advisable to use a scripted outline. This ensures that facilitators stay on track and on time, and all focus groups are conducted in a similar manner.
- **Choose the location.** The location needs to be
 - comfortable for the number of participants attending
 - set up in a way that encourages conversation
 - accessible
 - close by for participants to cut down on travelling

Think about the message you are sending with the choice of venue.

Reserve the venue in plenty of time (two to four weeks before).

- **Choose a focus group format.** It is recommended that focus groups
 - are an hour and a half to two hours long
 - follow a prepared agenda or outline and are led by a facilitator to ensure they remain on track
 - use five to seven open-ended questions (with key words or prompts)

Although it is anticipated that the focus group discussion will follow the facilitator's outline, this is not always the case in practice. It is not always necessary to follow the outline exactly as long as all of the necessary issues have been covered by the end of the session.

Don't be afraid to follow up on interesting issues, but don't get lost in tangential discussions that are not relevant to the questions.

Examples and templates

Potential welcoming focus group questions

1. Think of a time when you felt welcomed and a time when you felt unwelcome. Talk through the experience with the group. (This can be in any area; it does not have to be limited to health-care experiences. Think about the wider service industry.)
2. What do you think are the key elements of welcoming? (What has to be present for the experience to be welcoming?)
3. What do we do well in health-care settings with regard to welcoming individuals with addiction, mental health and concurrent disorders? (current state)
4. What could we do better in health-care settings with regard to welcoming individuals with addiction, mental health and concurrent disorders? How can we enhance what we are already doing? (future state)
5. What are the challenges we face, the barriers to successful welcoming? How can we begin to address these?
6. What is the best way to share these findings and our success stories with other programs?

Example of a facilitator's outline

The following script will be given to the facilitator ahead of time to guide preparation and delivery of the focus group.

Facilitator's outline—for use with pre-group planning

time approximate timings **idea** ideas you may wish to incorporate

Pre-group requirements

- time**
 - Be sure you have allotted time in your calendar for the duration of the focus group, PLUS time before to set up, AND time afterwards to tie up the process and pack up.
 - If you are running a two-hour session, we recommend blocking out four hours.
 - Arrive at the location before the participants (30 minutes or more).
- idea**
 - Set out the refreshments, pens, paper, name tags, etc.
 - Arrange the room so all participants can see one another (a round table or U-shaped chairs are recommended where possible).
 - As participants arrive, welcome them and try to put them at their ease.
 - Try to set the tone—participants should have fun and feel good about the session.
 - Point out the location of refreshments, name tags and sign-in sheets.
 - Remember you are here to
 - make sure every participant is heard
 - get full answers to the questions
 - monitor time closely
 - keep the discussion on track
 - head off exchanges of opinions about individual items

Facilitator’s outline—for use on the day of the focus group

time approximate timings **idea** ideas you may wish to incorporate **script** scripted dialogue

Focus group title, purpose and objectives

- **Title:** welcoming addiction, mental health and concurrent disorder clients into service
- **Purpose:** to explore the concept of welcoming as a way of engaging individuals in treatment and improving treatment outcomes
- **Objectives:**
 - elicit ideas and strategies for welcoming within AMH services
 - develop potential action points and next steps
 - share success stories and good practice

You may want to print out the title, purpose and objectives and display them for reference throughout the meeting.

Focus group meeting details

Day

Date Time

Location

Participants

List expected participants and use a sign-in sheet to record actual attendance.

Meeting materials

- facilitator’s outline
- note pads and pencils
- dry-erase board or flip chart
- laptop
- watch or clock
- participant sign-in sheet
- name tags
- markers
- projector
- refreshments

Welcoming comments, opening remarks and introductions **20 minutes**

script *I would like to thank you all for making your time available to attend this focus group session today. We'll be exploring the experience of welcoming as a way of engaging individuals in treatment and improving treatment outcomes.*

My name is and I work

I am joined today by (co-facilitator or note taker's name) who will be helping to record the salient points raised here today.

I also want to thank.....who were involved in the organization of today's focus group session.

I want to take a few moments now to go around the room and have everyone introduce themselves.

It would be great if you could let everyone else in the group know your name, where you are working right now and what it was that prompted you to participate in today's group.

idea You can add an icebreaker question or activity in here if you like.
 EXAMPLE: Have each person in the group write down one statement about them that is true and one that is false. Have each member of the group read both of these statements out loud in turn. The remainder of the group has to guess which of the statements is true.

script *And now, some background to today's session—AHS, AMH is looking to facilitate a number of focus group sessions across the province to inform the welcoming of addiction, mental health and concurrent disorder clients into treatment.*

Why?

Over the years, a growing body of evidence has shown us how best to treat individuals with addiction, mental health and concurrent disorders, but treatment outcomes in the field remain poor.

It has been argued that the key to successful outcomes, regardless of the treatment approach we adopt, is engagement.

The first step in engaging addiction, mental health and concurrent disorder clients is to welcome them.

Without successful welcoming and engagement, there is little hope of retaining individuals in service or implementing evidence-based interventions, and therefore even less likelihood of achieving positive treatment outcomes.

script *Definition of welcoming*

“The act or process of willingly greeting and receiving individuals on arrival with interest, pleasure and courtesy.”

As an addition to this definition it is important to be clear that within AMH services, “We welcome all people, not all behaviour.”

idea You may want have this definition up on the wall for reference throughout the focus group.

script *The purpose of this session is to gather your feedback and opinions, and to get your ideas on how we can do better in welcoming individuals into AMH services.*

The valuable comments you provide today will guide future developments.

The focus group session will last about two hours. I would like everyone to contribute as much as possible.

We have not planned to take any breaks, but there are refreshments you can help yourself to at any time. Feel free to get up and stretch as needed.

We will be mindful of the time and will move the discussion along to ensure everything gets discussed during the allotted time.

For those of you not familiar with the building, the washrooms are located.....

No fire alarm testing is expected today, so if the alarm does sound, the nearest exits are.....

Review facilitator role, participation guidelines and process **10 minutes**

script *My role here today is to ask questions and to listen. I won't be actively participating in the conversation, only guiding it. I want you to feel comfortable to talk to the group and not just to me.*

Please feel free to share your thoughts and points of view, positive or negative, even if they differ from what others have said.

There are no right or wrong answers.

Let's aim to have only one person talking at any time so everything said today can be fully heard.

The objective of the session is to run through (number of questions) questions related specifically to welcoming addiction, mental health and concurrent disorder clients into our services.

script *We will try to run through the questions in order but if we deviate it is no big deal.*

idea It may be a good idea to have the questions printed out on boards or walls so everyone can see them and for reference throughout the session. Read through all of the questions out loud before returning to the first question for discussion, so all participants know which topics are going to be discussed.

script *The major points raised in the discussion session today will be recorded anonymously by the co-facilitator in written form. All information will be confidential.*

OR

The session will be audiotaped and transcribed so key themes can be extracted and accurately summarized. All comments will be anonymous. Nothing you say on tape will be linked to you.

As participants you have the right to withdraw from the session at any time. (You will still be reimbursed for your time.)

ANY QUESTIONS BEFORE WE BEGIN?

Ask questions

60–70 minutes for all questions

- time**
- Calculate ahead of time how long you want to spend on each question.
 - Ask questions in order.
 - Be sure to get full answers.
(Not “we need more money” but “we need more money to buy....”)
 - Be sure to clarify the meaning of what is said (regarding culture or locality).
 - Be sure to hear from everyone in the group.
- idea**
- If the conversation is being dominated by one or two individuals, you may want to use a round-table approach to ensure you hear from all participants.
 - If domination persists, you may want to ask the group how to increase their participation.

Question 1

“.....”

Reflection

Bring discussion to a close.

Reflect back on what has been said in response to question 1.

idea

The co-facilitator or note taker may be in the best position to do this.

Question 2

Reflection

Bring discussion to a close.

Reflect back on what has been said in response to question 2.

Question 3

Reflection

Bring discussion to a close.

Reflect back on what has been said in response to question 3.

Question 4

Reflection

Bring discussion to a close.

Reflect back on what has been said in response to question 4.

Question 5

Reflection

Bring discussion to a close.

Reflect back on what has been said in response to question 5.

Wrap-up and thanks

20–30 minutes

script

OK, so that is all the questions we had wanted to explore today.

The information you have shared today has been interesting and insightful.

We would now like to spend five to 10 minutes summarizing the key points raised in relation to each of our key questions to ensure we have represented the discussion correctly.

idea The co-facilitator or note taker may be in the best position to do this.

script *The findings from today will be summarized and then a copy will be sent to all of you.*

We hope that the information drawn out of today's session can be translated into action points and taken back to your practice areas to promote welcoming.

Sometimes people in focus groups think of things they want to say after the discussion has moved on or the session is over. If you would like to add further comments, we are around for a little while and you can talk to us privately.

If anyone in the group is interested in further information or would like to have further input.....(Note: This may not be an option.)

Thank you everyone for attending today's session.

Post-group requirements

idea Immediately after the session, confer with the co-facilitator and clarify any areas that are not clear while the conversation is still fresh in your mind.

In the week following the session, meet with the co-facilitator to interpret the results.

- Read the focus group summary.
- Look for trends. Highlight any themes, problems or questions.
- Consider next steps and pick out potential action points.
- Identify issues that require further clarification or need to be addressed at a different level.

idea Once the analysis is complete and written up, send copies to all group participants.

Think about any learnings you may want to pass along to other facilitators or to incorporate into the guide. Please send all suggestions to concurrent.disorders@albertahealthservices.ca

Recruitment poster template



VOLUNTEERS NEEDED!

We are looking for six to 12 staff
(from this program/unit)
 to participate in a focus group on

**“Welcoming addiction, mental health
 and concurrent disorder
 clients into service”**

The session will last about two hours
 and is scheduled to take place on *(date)*.

Compensation for your time and
 travel expenses is available.

We would love to have you come and join us!

For further details please contact
(Name, phone number, email address)

Name Phone number Email address	Name Phone number Email address	Name Phone number Email address	Name Phone number Email address	Name Phone number Email address	Name Phone number Email address	Name Phone number Email address	Name Phone number Email address
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Thank-you letter template

Letters and cards seem to be more personal. You could use e-cards specifically designed for this purpose. Group emails are not recommended.



Date

Dear *(name)*

I just wanted to send you a note to thank you again for attending the focus group session *(focus group title)* on *(date)*. Your contribution was very much appreciated.

As I said at the focus group, the information gathered from the session will be summarized over the coming days. Key themes and proposed next steps will be highlighted and a copy of this information will be sent to you directly. We hope that the focus group and its findings will be beneficial to you and your team as you move forward with your welcoming and engagement strategies.

If you require any more information or would like to discuss anything further, please contact *(contact names and details)*.

Sincerely,

(facilitator and co-facilitator names)

Thank-you email template

Dear *(name)*

I just wanted to send you a note to thank you again for attending the focus group session *(focus group title)* on *(date)*. Your contribution was very much appreciated.

As I said at the focus group, the information gathered from the session will be summarized over the coming days. Key themes and proposed next steps will be highlighted and a copy of this information will be emailed to you directly. We hope that the focus group and its findings will be beneficial to you and your team as you move forward with your welcoming and engagement strategies.

If you require any more information or would like to discuss anything further, please contact *(contact names and details)*.

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