Implementation issues in an innovative rural substance misuser treatment program.

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Substance Use and Misuse: 2012, 47, p. 1439–1450.

Detailed, frank and compelling account of what it takes in the real world (when implementers have to grapple with counsellors and organisations over which they have no control) to introduce a new treatment approach. Key lesson is that each organisation is different; being there, learning about that unique context, and taking it in to account, is what's needed to give implementation a chance.

SUMMARY The treatment approach called SBORT (structured behavioural outpatient rural therapy) builds on what has been learned in rural areas about individual and community characteristics and tailors approaches validated in urban settings for use with rural clients. It was developed and tested over a three-year period by academics and substance use counsellors in a rural Midwestern state in the USA. SBORT is a two-phase, intensive outpatient programme.

A 'pre-treatment' phase includes three individual sessions using motivational interviewing to assess an individual's problems, develop a behavioural change contract, and begin case management. Motivational interviewing engages clients in treatment; case management helps meet their basic human needs so they can attend sessions and remain in treatment; behavioural contracting helps to direct and reward clients as they initiate specific changes in their behaviours. The treatment phase uses social skills training, an approach built on the assumption that lack of fundamental social skills creates discomfort, which leads to substance use to relieve discomfort. Social skills training focuses on enhancing patients' skills using the group setting for teaching and practice. Additionally, culturally informed structured storytelling and thought-mapping help clients develop and practise skills by targeting their problem behaviours and their causes and consequences.

The SBORT project aimed to implement this approach at three sites which mainly provided outpatient treatment. Clients at these sites were almost all white, mainly men, and generally 25–35-years-old. One of the important features of this study was that it selected therapists to learn and adopt SBORT who were already working in the selected substance use treatment programmes. Unlike many treatment research protocols, this project recruited, trained, and supported therapists typical of rural substance user counsellors.

Main findings

Implementation was accomplished through off-site training events and individual and group consultation sessions. During three, two-day off-site training sessions, therapists and programme directors were introduced to the SBORT protocol, instructed in its treatment techniques, and practised the development of social skills. Methods used were didactic presentations of theoretical content, demonstration of treatment techniques, role-playing, and discussion.

Originally these training events were to be the primary means of implementation. However, it became clear that intensive on-site consultation by members of the research team would be more beneficial. Consequently, team members with experience in clinical work and/or clinical supervision each took a site and provided twice-monthly group and individual consultation to the therapists who over five months would be involved in implementing SBORT. Consultation consisted of both individual and group sessions in which therapists were coached in the use of SBORT therapeutic techniques like motivational interviewing, thought-mapping, and behavioural contracting. It also afforded the opportunity for therapists to raise difficulties in their clinical work which might hinder implementation. As therapists delivered the protocol, they were randomly observed by researchers and given feedback and suggestions about their performance.

At first the researchers focused on the protocol and saw therapists as independent from any context except that of their communities. They assumed that if the concepts underlying the protocol and the skills necessary to implement it could be explained, demonstrated, and practised, then implementation would be successful. However, the ways therapists behaved during training sessions indicated that the concepts in and of themselves were of no interest, nor did they seem inclined to invest the time and energy needed to learn the skills. Not until implementation moved to site-specific consultation did therapists begin to express their real concerns and to invest in learning the protocol. This change signalled a shift from the implementation of the protocol as a universal for rural settings, to its implementation in very specific organisational contexts.

In retrospect, it became clear that the therapists were not disengaged entities, rather they were nested within unique sites embedded in unique organisations. At one site therapists saw their parent organisation as unresponsive and talked of the special efforts required to change their treatment approach. At another they spoke of their isolation, lack of clinical supervision, and concern about the adequacy of their skills. At the third site they focused almost exclusively on the needs and fears of their clients in relation to specific aspects of the SBORT protocol and expressed little concern about organisational issues or their abilities to implement the protocol. Only when the research team tailored implementation by responding to local conditions did therapists become willing and able to invest time and energy in learning to execute the protocol.

Although the researchers initially saw therapists as autonomous actors, the therapists never reported seeing themselves this way: organisational context was critical for them. What the research team initially interpreted as lack of interest and intellectual curiosity may have been an inability to envision implementation of the protocol other than in their specific context. They wanted to know how to implement the protocol in their specific setting, with their specific clients, under their specific organisational conditions. Had the implementation strategy not moved to a site-specific approach, implementation might have totally failed.

The therapists' feelings and behaviours were familiar from other implementation research. They were not inclined to read technical material, responded to on-site consultation rather than off-site workshops, those who were older or who had longer treatment or personal experience with addiction tended to have more difficulty with a novel treatment approach, they felt discounted by their own organisations, and some felt exhausted and demoralised by organisational stress. All of these factors needed to be considered to acheive successful implementation.

Measures of therapist performance indicated they followed most elements in the treatment manual in a consistent fashion, but varied on other measures. They were like individuals reading chapters from the same book with a minimum of mispronunciation, but with widely different levels of expression, comprehension, and effect. Quality of implementation is affected by a multitude of factors

beyond the control of an external project seeking to implement a new treatment. Some of this variability may be the result of long exposure to organisational climates that do not foster professional growth and development, or that tend to demoralise or isolate substance use counsellors.

Substance use counselling, at least in these contexts, seems to be very sensitive to the organisational context. The question does not seem to be, 'How do we transfer this research-based treatment approach into a rural practice environment?' but rather, 'How do we transfer this research-based treatment approach into *this* rural treatment organisation?'

The authors' conclusions

If the importance of organisational issues encountered by this study is generally true of treatment settings, then the following are the implications:
• Those who wish to test or introduce treatment approaches must understand the organisations that serve as the context for all activities essential to the introduction of the new approach.
• This probably means that protocols must be sufficiently flexible to adapt to specific organisational conditions, without losing those elements essential to how the treatment works.
• Implementation in real-world settings demands active consultation and supervision that not only ensures training for and maintenance of adherence to the new approach, but also helps therapists tailor the protocol so that it is feasible in their settings. Feasibility appears to be critical to therapists' adopting and implementing new treatments.
• Consultation is necessary to help therapists examine and possibly modify their beliefs, attitudes and frames of reference in order to enable them to learn and implement new treatment protocols. This is a process of assisting therapists in developing a new culture in which new treatments make sense. However, the new culture cannot be inimical to the larger organisational culture in which therapists must work.
• Those developing new substance user treatments must carefully consider the strengths and limitations of specific treatment settings, not only the characteristics and behaviours of the therapists themselves.
• Not attending to the above might mean that a new treatment approach 'fails' to produce desired outcomes, not because of inherent problems with the approach, but because problematic therapist–organisation interactions block implementation altogether or limit treatment intensity so much that clients do not improve.

FINDINGS COMMENTARY Though presented as specific to a rural context, the discovery forced on the researchers that organisational constraints and features which promote or hinder implementation are critical is one noted consistently in research and guidance, and not one specific to rural settings. The featured report offers an unusually detailed, frank and compelling account of what it takes in the real world (ie, when researchers have to grapple with counsellors and organisations over which they have no control) to introduce an unfamiliar approach.

Thanks for their comments on this entry in draft to research author Theodore Godlaski of the University of Kentucky in the USA. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 21 October 2014. First uploaded 13 October 2014

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