DRUG & ALCOHOL FINDINGS *Matrix cell*

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Alcohol Treatment Matrix cell D2

Organisational functioning; Generic and cross-cutting issues

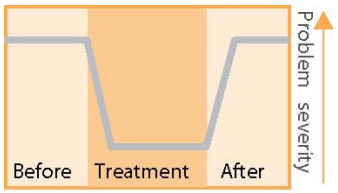
Seminal and key studies, reviews and guidance on the how the qualities and functioning of treatment organisations affect the implementation and effectiveness of treatment for problem drinking.

S Seminal studies **K** Key studies **R** Reviews **G** Guidance **MORE** Search for more studies
Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text

S Support and experience at work needed for training to strengthen commitment to working with drinkers (1980). English studies spotlighted the availability of experience in working with problem drinkers, support of experienced colleagues, and constraints at work including time, prioritisation, and organisational policy. Conclusion was that formal training alone is of limited value in generating therapeutic attitudes unless combined with support and experience on return to work. Discussion in bite's *Highlighted study* section.

S Goal-oriented, well organised and supportive workplaces maximise patient progress (1998). US services which emphasised mission-oriented good organisation, were clear what they expected from staff, and which generated staff commitment to their work and feelings of being supported and encouraged to make decisions, had more engaged patients who made greater progress and were more likely take up aftercare. Similar study (1997) from the same research stable added that the strength of a service's treatment philosophy "is more important [than] the particular theory underlying that orientation". Discussion in bite's *Issues* section.

S Chronic care for chronic conditions (2002). Alternative source. Profound implications of truly treating addiction of the kind seen by many treatment services as analogous to a chronic disease, including continuing care which partners with and is attractive to and manageable by the patient, and is evaluated by what happens *during* treatment ▶figure. Discussion in bite's *Issues* section.



Is this evidence that the treatment worked – or that it failed?

K UK services open to change have more engaged patients (2009). Clients engaged best when services fostered communication, participation and trust among staff, had a clear mission, but were open to new ideas. Organisational health assessment questionnaire used in this study has been recommended for the UK. In the USA, feeding back scores from the tool has been found to motivate agencies to improve. Discussion in bite's *Issues* section.

K Place your agency in front of a potentially unflattering mirror (2007). In the USA, feeding back staff responses to the organisational health questionnaire used in a British study motivated less well functioning agencies to commit to an improvement programme. Discussion in bite's *Issues* section.

R Policy strategies for improving outcomes (2011). Two of the world's most respected addiction researchers also with top-level policy experience explore the evidence that patients' prospects are improved by organisational changes like strengthening managerial capacity and business practices and submitting the organisation to external scrutiny.

R Organisational dynamics of the change process (2011). US review structures findings from the most comprehensive and systematic attempt yet (see studies 1 2 from the same team) to map the processes involved in effective treatment, including the organisational dynamics of implementing and sustaining innovations. As in an English study and guidance, openness to change ("general readiness to embrace innovation") emerges as important quality. Discussion in bite's *Issues* section.

R Implementing continuing care interventions (2011). How to ensure patients who need it receive long-term care or aftercare. Since "People treated for substance use often remain precariously balanced between recovery and relapse", argues for "Assertive linkage to continuing care" and efforts to enhance engagement and retention in recovery resources such as mutual aid groups. Discussion in bite's *Issues* section.

G Strategies to promote continuing care (2009). Expert US consensus on practical strategies to promote aftercare/continuing care based on review of principles of addiction treatment. Discussion in bite's *Issues* section.

G English inspectorate's criteria for quality services ([English] Care Quality Commission, 2015). Official inspectorate of health and social care services ask five key questions of substance use services: whether they are safe, effective, caring, responsive to people's needs, and well-led. Says governance and management should aim for a service which delivers "high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture". More on these criteria in appendices.

G Scotland's vision of a high quality service (Scottish Government and Convention of Scottish Local Authorities, 2014). What for the Scottish Government quality consists of in substance use services. Sets out what patients can expect, what services should provide, and how they should relate to patients. "At their heart is a person-centred, holistic, recovery-focussed approach where services and those seeking to address their problematic substance use work in partnership to achieve agreed outcomes."

G Theory into practice strategies ([Australian] National Centre for Education and Training on Addiction, 2005). From one of the world's major workforce development agencies for the addictions field. Chapter on managing organisational change includes the organisational factors which impede or promote change and how to manage them. Discussion in bite's *Issues* section.

G Quality standards for alcohol and drug services ([Irish] Health Service Executive and Ana Liffey Drug Project, 2013). Update adopted by the Irish government of the QuADS standards developed for UK drug and alcohol services. Consists of a checklist of practices which for different types of services constitute quality in management, service delivery, and upholding service users' rights.

G Establishing and running non-residential programmes ([US] Substance Abuse and Mental Health Services Administration, 2006). US consensus guidance. Includes strategic planning, working with a board of directors, relationships with strategic partners, hiring and retaining employees, staff supervision, continuing education and training, performance improvement,

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outcomes monitoring, and promotion of the program to potential clients, funding agencies, and government officials.

G Organisational features underlying successful improvement programmes ([US] NIATx, accessed 2018). Web-based service supported by US government. Model for improving addiction treatment services is based on five principles such as understanding and involving the customer and seeking ideas from other fields. See also these case studies of the principles' roles in improving US services and the Sustainability Model developed with the British NHS to help services choose and implement sustainable improvement projects. Specific aims include cutting waiting times and the number of 'no-shows', for which see cell C2. Discussion in bite's *Where should I start?* section.

MORE This search retrieves all relevant analyses.
For subtopics go to the subject search page and hot topic on why some treatment services are more effective than others.

Last revised 28 September 2016. First uploaded 01 June 2013

▶ Comment/query
▶ Suggest a new document to add to this cell
▶ Return to/go to Alcohol Matrix
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What is this cell about? As well as concrete things like staff, management committees, resources, and an institutional structure, organisations have links with other organisations, histories, values, priorities, and an ethos, determining whether they offer an environment in which staff and patients/clients can maximise their potential. For these and other reasons, agencies differ in how keenly and effectively they seek and incorporate knowledge and implement evidence-based practices. The best might, for example, have effective procedures for monitoring performance and identifying where improvements are needed, facilitate staff learning from research and from each other, and forge learning or service provision links with other organisations. Openness to change and encouraging sources of change such as research and staff and patient feedback emerge as key attributes, along with the will and organisation to implement change. Research cited in this cell is about the impact of these attributes and their identification and development. At this distance from the preoccupation with intervention effectiveness, research is scarce, and generic sources (incorporated for example in Australian guidance) beyond the scope of the matrices become more important.

Where should I start? Arguably no organisation has done more to promote evidence-based improvements in addiction treatment than the US NIATx collaboration. The name recalls its origin as the Network for the Improvement of Addiction Treatment. It has moved beyond that, but addiction remains a major focus. Study after study under the NIATx banner has examined how addiction treatment organisations can become more receptive to improvements and more successfully implement them, work freely available on the NIATx web site.

Loosely based on findings from industry, most relevant to this cell are the "five principles" found to have "consistently influenced efforts to overcome barriers to process improvement", explained by NIATx Director Dave Gustafson in a short video. Note his stress on organisations putting their staff in the customers' shoes – not *assuming* they know what they need and want, but actively finding out. Ask yourself, 'What kind of organisation does that?' – especially when its 'customers' are among the most stigmatised in society, 'alcoholics' and 'addicts' *by definition* incapable not just of doing, but even of really wanting what is best for them. The default position is surely to assume that as an expert, and/or someone who has already extricated themselves from these problems, you know best.

One answer is that it is an organisation led by someone open-minded enough to think they can learn from such patients, who takes steps to imbue that ethos across the service, and who is allowed – perhaps encouraged – by the organisation to make the required changes. An example comes from the late 1950s when Morris Chafetz's leadership transformed intake and retention at the alcohol clinic of the Massachusetts General Hospital, documented in studies explored in cell A2's bite. Part of that process was a proto 'walk-through' (see cell C2 for more on walk-throughs) of the intake process to identify barriers from the patient's point of view, seen by NIATx as a key tactic.

Understanding and involving the customer is one of NIATx's five principles. Take a look at the others, see if to you they make sense, and ask yourself if your organisation embodies these principles in its day-to-day work and its change efforts.

Highlighted study Exceptionally seminal were these British studies from Alan Cartwright and colleagues of the Mount Zeehan alcohol treatment unit in Kent, whose findings have since repeatedly been confirmed. From the early 1970s their government-funded Maudsley Alcohol Pilot Project opened up an agenda centred on the therapeutic alliance between patient and helper. In this and other work, the researchers found that the helper's commitment to working with drinkers (a key factor in alliance formation) depended on the workplace environment, including whether it engendered the feeling that this was a legitimate role supported by their organisation. Cartwright and colleagues discovered that staff who felt that working with drinkers was 'not their business' in the environment within which they worked could not be 'trained' into being committed therapists. Their studies turned the focus instead on the messages staff received about the organisation's priorities expressed in its policies, resource allocation and the perceptions induced in staff about whether working with drinkers was a valued and worthwhile use of their time.

Issues to consider and discuss

▸ **What do we know about the 'engaging organisation'?** Over decades of systematic research, Dwayne Simpson and colleagues at the US Institute of Behavioral Research (visit web site for free assessment tools, manuals, and evidence-based advice) developed a model of the treatment process, and then moved on to assessing an organisation's capacity to improve this process as reflected in staff perceptions of the service and of their own professional functioning and needs.

In a study conducted in 2006, they teamed up with England's National Treatment Agency for Substance

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Misuse for what remains the most wide-ranging investigation of the organisational health of British alcohol and drug treatment services. It found clear relationships between the degree to which patients engaged with treatment and organisational features such as team working and mutual trust, whether the service fostered open communication between staff and was receptive to their ideas and concerns, was adequately resourced, and had a clear mission and programme. Like a more or less coherent, well organised department store, all these and other features funnelled to a head in the interaction between staff and 'customer', affecting whether that customer wanted to stay and buy, or preferred to move on and/or do without what they had felt they needed.

Our analysis summed up the findings: "Staff working in an atmosphere of support and respect for their views, and concern for their development, tended to have clients who also felt understood, respected, supported and helped … also influential was the degree to which a service was clear about what it was trying to do and how it was trying to do it, and communicated this to its staff." Similar messages had emerged in the USA in the mid-1990s from the first study to investigate these issues.

Think of the services you know. Do these findings ring true? Look at our analysis of the British study and of the studies cited in the commentary. Are they methodologically strong enough to support these implications? Generally they could only discover *associations* between organisational health and patient engagement, not determine whether one actually led to the other. But on these issues, demanding randomised-controlled-trial proof is unrealistic; it would be unethical to deliberately create a poorly functioning service just to see how badly the patients do.

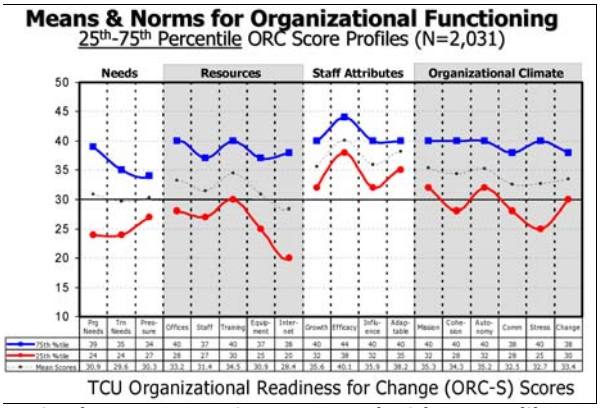
Then we can query whether attributes linked to engagement are always and in all ways positive. After all, a service may have a "clear mission and programme", but both may be misguided, or at least believed to be so by some experts. Does this matter, as long as to staff and patients the service's philosophy of addiction and its treatment convincingly provides structure, clarity and hope? In the US seminal study, strong belief in the 12-step model developed outside scientific processes seemed to underpin positive qualities in treatment services. But even in the USA, in this the 12-step model is not unique: a companion study found that a strong orientation to a distinct philosophy was important, but also that "the strength of an orientation is more important [than] the particular theory underlying that orientation".

> *Does it matter if a service's philosophy is misguided as long as it provides structure, clarity and hope?*

Finally, organisational culture may be influential, but does it trump specific performance-enhancing procedures? Perhaps the most important thing is not for an agency to understand, respect and support staff, but to incentivise them to achieve/do what the agency wants – as with Scottish GPs incentivised to offer brief interventions. Given the concern for patients to be expected of helping professionals, and the concern over their own management-observed performance to be expected of any employee, it may be enough to let clinical staff know when their patients are doing poorly and suggest remedial action, trusting that this will prompt a suitable response. Can such procedures work well whatever the organisational culture, or will they only be implemented and effective in conducive environments?

▸**Do we know how to promote organisational effectiveness?** The studies explored above were about what kinds of organisations are *naturally* more effective. Can we build on their findings to go a step further and actually *engineer* greater effectiveness? Australia's addictions workforce development agency alerts us to a potential 'catch 22'. Under the heading, "First things first: Is a change needed?", chapter 7 of their workforce development guidance(listed above) points out that first an organisation has to accept the need to change – yet the very agencies most in need of improvement may be the ones least likely to acknowledge this and act on it.

One way to square this circle has been trialled by the US research stable highlighted above – alerting the service to how its staff see it and how this compares with other services. Faced with the graphically presented evidence (▸illustration), senior staff from agencies which scored as less open to change and staff suggestions were the ones most likely to commit to change.



Seeing how your service compared with norms like these persuaded US services to commit to change

Another way agencies can open themselves to an awareness of the need to change is to submit themselves for approval to accreditation agencies, but two of the world's most respected addiction experts found this a weak lever for improving outcomes. More promising are the 'walk-throughs' advocated by the US collaboration featured in the

starting point section. These involve senior staff placing themselves in the patients' shoes and (for example) experiencing their service's intake and induction procedures – but would a poorly functioning service consider such an exercise? After assessing the evidence, the US experts favoured subjecting agencies to market forces, of which in the UK the most prominent models are payment-by-results schemes. Such schemes can force change, but sometimes this is limited what is required to gain the externally imposed carrots and avoid the sticks.

We have described an apparent bind: ideally health services and charities whose mission is to serve patients and clients will willingly open themselves to influence and scrutiny and embrace improvements, but the ones doing least well in that mission are probably also the ones least likely to take those steps. External pressure seems the solution, yet the same organisations may react by doing just what is needed to satisfy their funders or inspectors (which may bear a loose relationship to patient welfare) rather than engaging in a sustained improvement programme focused not on external requirements, but on the needs and aspirations of their actual and prospective patients. In places the market mechanism of patients voting with their feet has been an option, but it may be eliminated as mega-services take over in local areas, offering to do everything for the commissioners. Is this bind real, is there a 'best' way round or through it, or must it be worked out anew each time? Are some services *right* not to be *too* open to change, even to resist it? After all, every change carries a cost in terms of at least short-term disruption, use of resources, and perhaps alienating or confusing some staff and patients. As with fixing the roads, in principle improvement is good, but if you have so much of it that drivers are constantly frustrated by one set of roadworks after another, it starts to get in the way of driver progress and well-being rather than promoting them. And in the real world, is change usually forced on organisations not by some deliberate improvement process, but as an emergency response to cope with events (like budget cuts) which make the status quo unsustainable?

▸ **How should services gear up for long-term care/aftercare?** From cell A2 we know that offering patients aftercare or continuing care following a period of more intensive treatment does modestly help sustain reductions in drinking. Arguing that dependent drinkers who also use other drugs materially differ from those who do not, a review of aftercare trials focused on patients solely dependent on alcohol (though they may have also smoked tobacco) and on high quality randomised trials. Compared to usual approaches (mainly supportive counselling and promoting Alcoholics Anonymous attendance), its findings supported aftercare options which more proactively and regularly re-contact the patient and are more active in their interventions. Effective interventions also targeted the patient's family network and sought to improve coordination between different healthcare sectors. Their findings led the reviewers to propose weekly telephone monitoring by a specialised nurse – calls initiated by the patient, but failing this, by the nurse. Home visits and specialist counselling would be an option if indicated, and in general the programme should be adapted to individual needs.

Similar implementation recommendations can be found in a review listed above of how to ensure aftercare/continuing care happens. It argues that services must become "assertive" in linking their patients to continuing care options if brief experiments in sobriety (recovery initiation) are to become sustained management of the condition or sustainable recovery maintenance. There are many ways to do this, but the reviewers seemed to favour forging close connections with external recovery support resources such as mutual aid groups, and seeing it as a core part of your business to promote these to patients and help them engage and stay engaged with these supports.

Is this enough, or should the initial treatment service directly take responsibility for extended monitoring and care? Rather than linking to other resources, another review found evidence supporting the direct and proactive provision of aftercare services of the kind which might best be offered by the original treatment service. An advantage is that this would be under the control of the service; they could ensure it reinforced the original programme and adapt and (de-)intensify in response to the patient's needs. If they did, how would that square with the drive in Britain to contain costs and maximise the numbers completing and leaving treatment (how services are increasingly called to account)? Would diverting resources to extended care mean fewer patients get a chance of any kind of treatment?

Underlying these practical issues are more fundamental ones about substance use dependence and how treatment services see themselves – for which unfold the supplementary text.

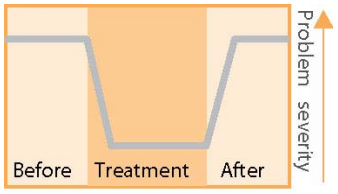
Supplementary text Click to close

There is no need to buy into conceptualisations of addiction as a chronic neural disorder in order to argue for chronic care. The broad cross-section of drinkers who at some time become dependent commonly have the resources to extricate themselves from a phase not too deeply embedded in their lives, but some are too severely and multiply disturbed to 'bootstrap' themselves out of their troubles. Though these are the drinkers who tend to turn to or get directed to treatment, still they take longer than average to achieve remission.

For the typically multiply and deeply troubled treatment caseload, perhaps services should see themselves as offering chronic care for what *in the circumstances of these patients' lives and given the resources society is prepared to offer them* often is a chronic condition or one to which patients repeatedly gravitate. The

implication is that rather than lasting post-treatment remission, services' performance should be judged on keeping the condition at bay *while the patient remains in their care*.

According to this vision, post-treatment relapse is a sign that treatment was working, not that it failed ▸ figure. That was the view of a US expert who advised Public Health England on addiction treatment. In turn he said that meant lengthy treatment contact has to be palatable to and manageable by the patient, long-term monitoring of patients has to be a recognised and funded part of treatment, and staff are needed to manage continuing care who like case managers and GPs, are keyed into the broader spectrum of health and social services.



Is this evidence that the treatment worked – or that it failed?

Close supplementary text

The need for regular, frequent, proactive and possibly too direct provision rather than just linkage, means that effective continuing care is not going to be cheap or ad hoc; it has to be organised and funded. US experts strongly in favour of extended care had to admit that "effective interventions such as extended monitoring and incentives for good performance often come with an increased price tag". How does that square with the drive in Britain to contain costs and maximise the numbers completing and leaving treatment? Would diverting resources to extended care mean fewer patients get a chance of any kind of treatment? Is there a trade-off between extending episodes of care and extending care to more people?

Close Matrix Bite