DRUG & ALCOHOL FINDINGS *Matrix cell*

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Alcohol Treatment Matrix cell D4

Organisational functioning; Psychosocial therapies

Key studies on how treatment organisations affect implementation and effectiveness of psychosocial therapies. Explores the effects of high staff turnover, how to reduce it, and the importance of services being ready for change, and asks whether change driven by money is just as good for patients as that motivated by desire to improve their lives.

S Seminal studies **K** Key studies **R** Reviews **G** Guidance **MORE** Search for more studies

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S Organisational factors affect willingness to address problem drinking (1980). Involving mainly non-medical alcohol counselling and treatment centre staff, an English study turned the spotlight on organisational factors in the development of a positive attitude to working with problem drinking patients – in particular, the support of experienced colleagues and the availability of experience in working with these patients. Later the same lead researcher was able to add (1986) time pressures, case priorities, departmental policy, and other workplace constraints. For discussion click and scroll down to highlighted heading

K Organisational health associated with engagement in treatment (2009). In England engagement with treatment and rapport with counsellors were strongest when services fostered communication, participation and trust among counselling staff, and had a clear mission but were open to new ideas. Related US study from the same research stable below. For discussion click and scroll down to highlighted heading.

K Workplace ethos sets context for adopting new counselling methods (2012). Workplace climate including strength of mission, staff cohesion, communications, professional autonomy, lack of stress, and receptiveness to change "underlies the entire process" of 'bottom up' innovation initiated by counsellors. Related UK study from the same research stable above. For discussion click and scroll down to highlighted heading.

K Human relations environment related to patients' substance use (2011; free source at time of writing). At the time unique in its combined analysis of the links between substance use outcomes and variability at the level of patient, counsellor and service, this US study discovered that rather than resources, training or equipment, it was the human relations environment of US substance use counselling centres which was related to a centre's outcomes. Salient dimensions included whether staff felt able to influence, trust and cooperate with each other. Services also differed in the strength of the therapeutic relationships patients reported with counsellors, differences also related to outcomes. Implications were that "assuming causality … better outcomes could be achieved by both improving … organizational functioning [and] the alliance of counsellors with their patients". For related discussion click and scroll down to highlighted heading.

K Organisational context is key to implementing new ways of working (2012; free source or original article at time of writing). Compelling account of what it takes in the real world (where implementation staff 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 into account, are needed to give implementation a chance. For discussion click and scroll down to highlighted heading.

K Autonomy and justice retain counselling staff (2008). Organisations which do not offer autonomy to substance use counsellors, foster a sense of being treated fairly, or promote mutual support between workers, risk generating the high staff turnover which undermines workforce development initiatives. For discussion click and scroll down to highlighted heading.

R Involve the whole organisation in implementing psychosocial treatment programmes (2011). Successful implementation is most likely when the entire agency is the target of the implementation effort rather than individual therapists. For related discussion click and scroll down to highlighted heading.

G English drug services define their own quality standards (2016). From bodies representing the addictions treatment sector in England, standards developed after consultation and piloting with services. Designed to guide services in assessing how they support people into and through recovery and the quality of vital aspects of their organisations. Includes standards for non-residential and residential rehabilitation services and an implementation guide for the non-residential standards.

G Is your service even *ready* to improve? ([US] Substance Abuse and Mental Health Services Administration, 2009). How to assess an organisation's capacity to identify priorities, implement changes, evaluate progress, and sustain

effective programmes, plus how to implement innovations. For discussions click here and here and scroll down to highlighted headings.

G Simple ways to improve an organisation's performance. Helpful web site from the USA's University of Wisconsin, providing research findings, promising practices, and toolkits, all geared to encouraging and supporting administrative and therapeutic improvements in addiction and mental health services.

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. For related discussions click here and here and scroll down to highlighted headings.

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What is this cell about? As well as concrete things like staff, resources, management committees, and an institutional structure, organisations have links with other organisations, values, an ethos, and policy priorities, 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 have effective procedures for monitoring performance, identifying when and what improvements are needed, facilitating staff learning, and forging links with other organisations, and test these procedures internally and by submitting to external accreditation and scrutiny. Research cited in this cell is about the impact of these attributes on the human interactions involved in the 'psychosocial' therapies introduced in cell A4, ranging from brief advice and counselling to extended programmes based on psychological theories of how dependence arises and how it can be overcome.

At this distance from the preoccupation with intervention effectiveness, research is scarce, and generic sources (such as that incorporated in Australian guidance listed above) beyond the scope of the matrices become more important. But lack of research does not mean lack of importance in the real world of everyday practice; if you doubt this, read below about our "Highlighted study".

Where should I start? With a US study listed above from the research stable (the Institute of Behavioral Research at the Texas Christian University) which earlier had investigated British treatment services, a study also listed above.

Cell C4 highlighted the US study's findings on the impact of the ethos and support emanating from managers. Here we add that in turn these management attributes partially reflected how the organisation was perceived by its staff, and that organisational features also influenced whether counsellors spent time and effort keeping up with research and becoming better counsellors. For the authors, "organizational climate underlies the entire process of innovation adoption, from the development of innovative thinking, to specific attitudes toward the innovation, and eventual adoption of new practices". Putatively influential components of organisational climate included strength of mission, staff cohesion, open communication between staff and management, professional autonomy, a non-stressful workplace, and openness to change.

The US research team's British study listed above found the same components were related to the degree to which patients in substance use services engaged with treatment. In different circumstances (as in a seminal British study listed above), other components of workplace climate emerge. Though the influential components may differ, workplace climate consistently sets the context for how willingly and how well staff work with their problem substance using clients, affecting these clients' engagement with treatment.

Highlighted study How critical the organisation is was forcefully brought home (document listed above) to researchers attempting to implement a new psychosocial treatment programme in rural US substance use services. In their own words, "Organizational issues were far more important than the researchers originally assumed. Therapists spent more time during pre-implementation consultation commenting on how their treatment organizations might help or hinder implementation than on any other topic." Rather than repeating a standard implementation method, the task became, "How do we transfer this research-based treatment approach into *this* [emphasis added] rural treatment organization?"

> *"Organizational issues were far more important than researchers originally assumed"*

As these comments suggest, successful implementation is most likely (document listed above) when the entire agency is the target of the implementation effort rather than individual therapists, and the agency's needs and peculiarities are taken into account, including its ability and willingness to provide the ongoing supervision/coaching which in cell C4 we found can transform training from a tick-box 'done it' into an investment which actually benefits patients.

Issues to consider and discuss

▸ **Is your service even *ready* for change?** Take a look at the US guidelines on implementing change in substance use services listed above. Since the USA is where most of the research has been done, they ought to be as evidence-based as any. On page 10 (page 16 of the PDF file) starts a long list of factors involved in deciding whether your organisation is ready *even to attempt* the envisaged change, and/or has much chance of succeeding. On page 15 (page 21 of the PDF file) comes this uncompromising statement: "If your organization is troubled, you need to build a healthier work culture before change will be possible."

> *Troubled organisations "need to build a healthier work culture before change will be possible"*

It all makes sense, but doesn't it also mean that organisations most in need of morale- and performance-boosting change will (if they honestly appraise their readiness for change) be the ones least likely to attempt it? The US guidelines say evidence-based practices "can help overcome the financial and organizational challenges that make change so difficult" – yet those challenges obstruct the very changes which could help overcome them. On the other hand, challenges motivate change: according to (document listed above) Australia's addictions workforce development agency, a critical factor in successful change is *needing* to change – having shortcomings which demand action.

It seems a chicken-and-egg scenario: organisations whose shortcomings mean they are most in need of and perhaps also most motivated to change, may due to those same shortcomings be unable to make or even attempt that change, let alone make it stick. However, this apparent bind could disentangle if the changes needed to *prepare* an organisation for trying to implement new clinical practices differ from those needed to *implement* those practices. Maybe, for example, the organisation needs to fix its staff turnover problem by implementing more equitable personnel policies (see section below) *before* trying to train and coach staff in a new therapeutic approach. That training might itself further reduce excessive turnover by re-moralising staff and raising their self-esteem. Then instead of a stultifying bind, we have the beginnings of a virtuous circle.

What has been your experience? Do you work in the kind of organisation which could honestly appraise itself against the US guidelines' criteria for readiness to change? Could these objectively be assessed and discussed openly in a staff meeting, or would that be too close to the bone for a poorly functioning service?

▸ **Does motivation matter?** US guidelines listed above offer (page 2 of document, page 8 of the PDF file) seven reasons why a treatment organisation might want to implement evidence-based practices. Ask yourself, what among these is mostly driving change in the organisations or jurisdictions you know of? And does it matter *why* an evidence-based practice is adopted, as long as it is?

One of the reasons is to help the organisation make money: "Proven, targeted treatments also may enable programs to eliminate less effective program elements and increase volume, thereby improving the bottom line." Financial carrots to effective practice have most notably been introduced in Britain in the form of payment-by-results schemes, which are intended to fund services according to how far they achieve the desired changes in their patients. Is change motivated by money just as good for patients as change motivated by the desire to improve their lives? Of course, in a non-profit organisation, these two motivations should be in concert, because 'profit' is ploughed back into helping patients – but in practice, sometimes charities act like commercial businesses.

To help you think about this, look at cell E2's exploration of the pros and cons of payment-by-results schemes, including their possible effects on clinical practice. At the same time, note the stress placed on therapeutic relationships in cell B4. Ask yourself what the different motivations which might drive an organisation could do to those relationships – especially given the same cell's discussion of the importance of seeming 'genuine' to the patient.

> *Try this mind experiment … does the patient get the same messages about why you are acting in those ways?*

Try this mind experiment. In scenario one you are a counsellor who knows a patient has to return for treatment at least three times before the service gets paid for them, and that if the service fails too often on this criterion, you will be out of a job and possibly a discredited entrant to the treatment labour market. In scenario two, their return makes no direct difference money- or job-wise, but your service's ethos and practice are based on experience and research indicating that staying in treatment protects patients and their families from the harms you and the service are devoted to countering. In both cases, to bolster the patient's motivation for returning for treatment you try applying the motivational interviewing principles you recently learnt about in training. Inside the

consulting room, do you implement these principles indistinguishably in both situations? And does the patient get the same messages about why you are acting in those ways? Are the impacts the same? What if they ask, 'Why should I come back next week? What good will it do?' How do you reply in scenarios one and two? Are you being equally genuine in both cases?

What makes good counsellors want to stay? Obvious, yet often overlooked: a service can't efficiently implement new therapies and build on those it has, if forced to start all over again every few months due to high staff turnover. In substance use treatment, 'churn' due to market forces and re-commissioning cycles severely limits capacity for accumulating and implementing learning (see for example: 1 2 3).

Australia's addictions workforce development agency devoted a chapter of their guidance listed above to staff retention and the costs of high turnover, including lost productivity, undermined morale, aggravated stress, and poorer quality and availability of services. That raises the issue of how to retain the staff you'd like to keep. Addressed in the same chapter, perhaps surprisingly we find highlighted not 'hard' issues like salary or workload, but the appeal of the work, relationships with supervisors, and opportunities for professional development. The human relations attributes of the organisation, including staff perceptions of being able to influence other workers and trust and cooperation between staff, have also been found (study listed above) to be related to how completely a service helps its clients turn away from substance use.

Similarly, for the substance use counsellors in a US study listed above, it was not 'hard' factors like caseload, hours worked, and time away from the frontline which seemed to affect 'burnout' and the desire to quit, but whether the organisation fostered a feeling that though things might be hard, they are fair, you get support from colleagues to help you cope, and compensatory job satisfaction derives from the freedom and authority the service allows you to do the job how you feel it should be done – to "provide quality treatment".

> *Interpersonal relationships at work are highly predictive of the well-being and stability of counsellors*

Do you agree with the authors that this prominence of relationship factors reflects the investment counsellors make in their relationships with clients? Their interpretation is that caring for and relating to clients who commonly relapse – meaning counsellors have repeatedly to pick up the pieces and start again – is the main source of stress in these occupations. By the same token, it seems relationship factors are also the main source of support in managing that stress. Here's their conclusion: "Counselors working in settings in which the established pattern of interaction provides a sense of autonomy, fairness, and interpersonal support are less likely to express symptoms of emotional exhaustion, and are less likely to desire to quit their jobs. The interpersonal relationships characterizing the work environment – the milieu within which therapeutic alliances are built – are highly predictive of the well-being and stability of those who engage in counseling occupations."

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