Matrix cell

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Drug Treatment Matrix cell D2: Organisational functioning: Generic and cross-cutting issues

S Chronic care for chronic conditions (2002). Alternative source. Truly treating addiction of the kind seen by many treatment services as analogous to a chronic disease, demands continuing care which partners with and is attractive to and manageable by the patient, and is evaluated by what happens *during* treatment. For discussion click here and scroll down to highlighted heading.

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 engaged their staff, also had more engaged patients who made greater progress and were more likely take up aftercare. Similar study (1997) from same research stable found patient participation and outcomes best in services which communicate high expectations for patient functioning, emphasise clear rules and procedures, and have a strong psychosocial treatment orientation. For discussion click here or here and scroll down to highlighted headings.

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. In the USA feeding back scores from the organisational health assessment questionnaire used in this study has been found to motivate agencies to improve. For related discussions click here, here or here, and scroll down to highlighted headings.

K Place your agency in front of a potentially unflattering mirror (2007). Free source at time of writing. US study found that feeding back scores from the organisational health questionnaire used in a British study motivated less well functioning agencies to commit to an improvement programme.

K Organisational correlates of post-treatment drug use (2008). Using advanced methods and large sample of services, this US study asked what makes for an effective treatment agency. Being constrained by funders in terms of services and ability to individualise treatments was the clearest negative factor, quality accreditation the clearest positive.

K Few extra benefits from integrating addiction case management with primary care (2013). Disappointing results of first randomised trial of an explicit chronic care management model for drug dependent patients were perhaps due to addiction treatment not being delivered at the clinic but by linkage to other services, which made little difference to whether patients engaged in treatment. For discussion click here and scroll down to highlighted heading.

K Organisational features which help improvement initiatives 'stick' (2017). Alternative source at time of writing. Follow-up of a US trial of the 'improvement collaborative' model developed by the US NIATx quality improvement resource, investigating what is about some treatment organisations which helps sustainably embed the process in the service's operations. For discussion click here and scroll down to highlighted heading.

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. For related discussion click here and scroll down to highlighted heading.

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 study and guidance from England, openness to change ("general readiness to embrace innovation") emerges as important quality. For discussion click here and scroll down to highlighted heading.

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. Another review found evidence supporting the direct and proactive provision of aftercare services. Related guidance below. For discussion click here and scroll down to highlighted heading.

G Clinical governance in drug treatment ([English] National Treatment Agency for Substance Misuse, 2009). Guidance for providers and commissioners on establishing systems to deliver and demonstrate that the quality and safety of their services are of a high standard that is continually improving.

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 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 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. At web page find also an implementation guide for these standards and standards for residential rehabilitation.

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. Related review above. For related discussion click here and scroll down to highlighted heading.

G Assessing readiness for change and the implementation process ([US] Substance Abuse and Mental Health Services Administration, 2009). Practical, hands-on guide to how to assess an organisation's capacity to identify priorities, implement

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changes, evaluate progress, and sustain quality-improvement programmes, and how to implement these programmes.

G Theory into practice strategies ([Australian] National Centre for Education and Training on Addiction, 2005). From the world's leading workforce development agency for the addictions field. Chapter 7 focuses on the organisational factors which impede or promote change and how to manage them. For discussion click here and scroll down to highlighted heading.

G Assessing workforce knowledge, skills and ability (NHS Health Scotland, 2009). Desired competencies and assessing the training needs of Scotland's substance misuse workforce at all levels, from generic workers who deal peripherally with the issue to specialists. Though mainly for commissioners and local areas, says treatment organisations may also want to use the guide to assess training needs of their employees.

G Organisational features underlying successful improvement programmes ([US] NIATx, accessed 2018). Web-based service supported by US government, whose 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. Related study above. For discussion click here and scroll down to highlighted heading.

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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 (eg, in study listed above) as key attributes.

In the treatment of conditions affected by psychological reactions, it is "the meaning that the client gives to the experience of therapy that is important," and that meaning is constructed from the context within which an intervention is delivered. Forming part of that context is the setting provided by the organisation, its administrative procedures, and the practitioner, whose intervention style, optimism and expectations of treatment will be affected by the organisation within which they work. Rather than seeing the *intervention* as the treatment, arguably it is more realistic to see treatment as a package of interacting elements including (among other factors) the intervention, the way the therapist relates to the patient, the patient's predispositions, responses and how they manage their condition, and the credibility of the context as a healing environment. "Patients may improve simply because they are placed in places that are symbols of competent care," concluded reviewers.

Defining the treatment package in this way means that each of these factors affects not just how the patient *feels* about their treatment, but the impact it has on the condition being treated. Research cited in this cell is about the impact of these attributes at the level of the organisation. 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 are freely available on the NIATx web site featured above.

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 clients are among the most stigmatised in society, 'alcoholics' and 'addicts' seen *by definition* as 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.

The NIATx logo signifies 'rapid-cycle testing': implement an idea on a small scale, test the change, modify it, test again, and repeat this cycle until the change meets the needs of customers

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 of the Alcohol Treatment Matrix. 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, now seen by NIATx as a key tactic.

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Understanding and involving the customer is just 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. Look too at the freely available results of a follow-up study investigating why some treatment organisations have been able to sustainably embed the NIATx process, and ask yourself if according to these criteria, the services you know have a good chance of incorporating quality improvement within their operations. Resources were one of the sustainability factors, but also institutional commitment to client-centred practice, engaging staff in the improvement process, and having the data needed to find out when things need improving and whether attempts to generate improvements have worked.

Highlighted study Over decades of systematic research, former director 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 listed above conducted in 2006, they teamed up with England's National Treatment Agency for Substance Misuse for what remains the most wide-ranging investigation of the organisational health of British drug and alcohol 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 from the USA in the mid-1990s from the first study to investigate these issues.

Issues to consider and discuss

▸ Should services gear up for long-term care/aftercare? If in treatment populations, addiction at least *behaves* like a chronic relapsing condition, long-term monitoring and care would seem an appropriate treatment strategy. Incorporating this perspective into UK health service quality standards, the National Institute for Health and Care Excellence stipulated that even after having achieved abstinence, problem drug using patients should be offered continued treatment or support for at least six months. Their recommendation is backed by a synthesis of relevant research, which found that patients allocated effectively at random to systematic aftercare/continuing care versus usual care engaged in slightly but significantly less substance use at follow-up.

If we accept continuing care is often desirable, the next question is how to get there. Listed above is a review of how to ensure 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 extend into sustained remission. There are many ways to do this, but the reviewers seemed to favour forging close connections with 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 external resources, another review (listed above) 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? Would diverting resources to extended care mean fewer patients get a chance of any kind of treatment, or help slow the revolving door of treatment re-entry and create space for new patients?

Behind these questions are more fundamental ones about addiction and how drug treatment services should see themselves. Among drinkers, those who at some time become dependent can and commonly do extricate themselves with little or no formal help, but cell A2's bite argued that for drugs like heroin and cocaine, "By the time you have narrowed down to the minority who try these drugs, the very few who become regular users, the fewer still who become clinically dependent, and finally the subset who want to stop but feel they can't without treatment, then you have sifted down to a highly atypical and usually multiply disadvantaged and/or troubled population who find it very difficult to sustainably overcome their dependence" – the caseload of addiction treatment services.

For these people (especially those dependent on heroin with its distinctive 'stickiness'), 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

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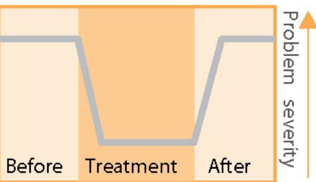
be judged on keeping the condition at bay *while the patient remains in their care*.

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?

Seemingly set against this is the results of the first randomised trial (listed above) of an approach to addiction treatment based on continuing care principles of the kind recommended above. This was not a study of incorporating those principles in an addiction treatment service, but of the rather different context of patients attending a clinic for primary care services, not for addiction treatment. In this context, supplementing primary care with continuing case management of problem substance use gained few benefits. One reason might have been that though case management was co-located at the primary care clinic, addiction treatment was delivered by linkage to external services. In practice, these arrangements made little difference to whether patients engaged in treatment – a possible flaw in continuing care perspectives which see case management by GPs or social care professionals as the hub of the system.

▸ What kind of treatment services do patients find engaging ? At least since the mid-90s NTORS study in England reported its results, it has been known that drug treatment services vary dramatically in their retention and outcomes, a common finding in studies of normal practice outside the context of a tightly controlled study.

Fully exploring what accounts for these variations would take us way beyond addiction into organisational theories and findings from business, health services and the voluntary sector in general. We can, however, start more manageably with a reminder of our interpretation of this cell's *Highlighted study*: "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."

Think of the services you know. Does this ring true? Look at our analysis of the highlighted study and of the other studies cited in the commentary on that study. Are they strong enough to support these implications? After all, a service can have a "clear mission and programme", but both may misguided, or at least, believed to be so by some observers. Does this matter as long as to staff and patients, the programme is convincing, and provides structure, clarity and hope? Note that in a US seminal study, it was not scientific understandings of addiction which seemed to underpin these positive qualities, but a strong belief in the 12-step model developed outside scientific circles. However, in being able to foster coherent and effective treatment organisations, the 12-step model is not unique: a companion study found that having a strong orientation to a distinct treatment philosophy was important, but also that "the strength of an orientation is more important [than] the particular theory underlying that orientation".

Dimensions of organisational culture described above seem important, but do they 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 them to achieve/do, whether or not they feel understood and involved – as with Scottish GPs incentivised to offer brief interventions.

Given the concern over patient welfare 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 not doing well and suggest remedial action, as in a study of US substance use therapy centres (discussion in cell C4).

Can such procedures work well whatever the organisational culture, or will they only be implemented and effective in conducive environments? In this same study, of the three centres, the feedback system worked only at one, being strongly associated there with improved psychosocial functioning among patients whose counsellors had been warned these patients were not doing well. At the other two centres, there was virtually no such relationship.

In similar research by the same authors among a larger sample of services, features of the organisation including staff perceptions of being able to influence other workers, trust and cooperation among staff, and management's openness to communication from staff, were related to a centre's average drug/alcohol use outcomes, and also to the average strength of the therapeutic relationship between patients and counsellors as perceived by the patient. It seems that in these kinds of services, whether routine care, or specific improvements like the feedback system, work well depend partly on organisational features.

▸ Do we know how to *make* an organisation engaging and effective? The preceding issue was about what kind of treatment organisations are *naturally* more effective. Can we build on these findings to go a step further, and actually *engineer* more effective organisations? Australia's addictions workforce

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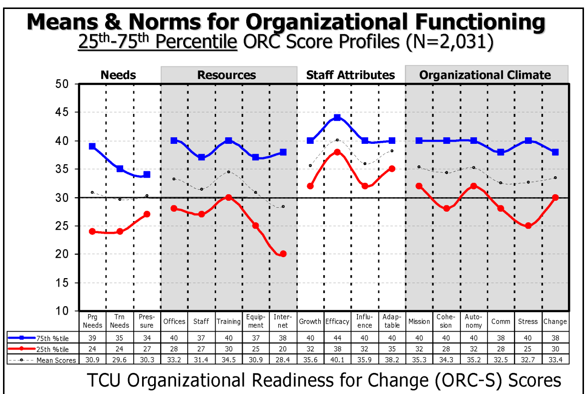
development agency alerts us to a potential 'catch 22'. Under the heading, "First things first: Is a change needed?", chapter 7 of their workforce development guidance (listed above) points out that first an organisation has to accept the need to change – yet the very agencies most in need of improvement 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 responsible for the *Highlighted study* – 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.



	Prg Needs	Trn Needs	Pres-sure	Offices	Staff	Training	Equip-ment	Inter-net	Growth	Efficacy	Influ-ence	Adap-table	Mission	Cohe-sion	Auto-nomy	Comm	Stress	Change
75th %tile	39	35	34	40	37	40	37	38	40	44	40	40	40	40	40	38	40	38
25th %tile	24	24	27	28	27	30	25	20	32	38	32	35	32	28	32	28	25	30
Mean Scores	30.9	29.6	30.3	33.2	31.4	34.5	30.9	28.4	35.6	40.1	35.9	38.2	35.3	34.3	35.2	32.5	32.7	33.4

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 judged this a weak lever for improving outcomes. More promising are the 'walk-throughs' advocated by the US collaboration featured in the *Where should I start?* 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 to 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. Sometimes the market mechanism of patients voting with their feet has been an option, but one which 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 rather than promoting it. And in the real world, is change normally the result of a deliberate improvement process, or forced on organisations as an emergency response to cope with events (like budget cuts or staff/patient welfare scandals) which make the status quo unsustainable?

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