DRUG & ALCOHOL FINDINGS Matrix cell

Sup-ported by ALCOHOL RESEARCH UK SSA SOCIETY FOR THE STUDY OF ADDICTION Substance Misuse Skills Consortium

Alcohol Matrix cell D4: Organisational functioning; Psychosocial therapies

S Organisational factors affect willingness to work with drinkers (1980). English study of mainly non-medical alcohol counselling and treatment centre staff spotlighted the availability of experience in working with problem drinkers, support of experienced colleagues and, in a later study (1986), time, prioritisation, policy and other constraints at work. Discussion in bite's *Where should I start?* section.

K Organisational health affects counselling rapport and client participation (2009). In England clients engaged best and developed rapport with their counsellors when services fostered communication, participation and trust among counselling staff, and had a clear mission but were open to new ideas. Discussion in bite's *Where should I start?* section.

K Workplace ethos sets context for new counselling methods (2012). Workplace climate including strength of mission, staff cohesion, communications, professional autonomy, not being stressful, and receptiveness to change "underlies the entire process" of 'bottom up' innovation-adoption initiated by counsellors. Discussion in bite's *Where should I start?* section.

K Autonomy and justice help retain counselling staff (2007). Organisations which do not offer autonomy to substance use counsellors, foster a sense of being treated fairly, or promote mutual worker support, risk generating the high staff turnover which impedes workforce development. Discussion in bite's *Issues* section.

R Involve whole organisation in implementing psychosocial treatment (2012). Successful implementation is most likely when the entire agency is the target of the implementation effort rather than individual therapists. Discussion in bite's *What is this cell about?* section.

G Implementing change ([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, and how to implement innovations. Discussions in bite's *Issues* section (1 2).

G Simple ways to improve an organisation's performance. Very helpful US web site from the University of Wisconsin providing research, promising practices and tools that encourage and support process improvement in addiction and mental health care.

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.

MORE Search for all relevant Effectiveness Bank analyses or for sub-topics go to the subject search page and hot topics on why some treatment services are more effective and on individualising treatment.

Close Matrix Bite

Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text

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 have effective procedures for monitoring performance and to identify when and what improvements are needed, facilitate staff learning, forge links with other organisations, and submit to external accreditation and quality assurance. Research cited in this cell is about the impact of these attributes on the human interactions involved in 'psychosocial' therapies, ranging from brief advice and counselling to extended therapies based on psychological theories.

How critical the organisation is was forcefully brought home (2012; free source at the time of writing) to researchers attempting to implement a new psychosocial treatment programme in rural US substance user services: "Organizational issues were far more important than the researchers originally assumed. Therapists spent more time during preimplementation consultation commenting on how their treatment organizations might help or hinder implementation than on any other topic." As these researchers discovered, that is why successful implementation is most likely when the entire agency is the target of the implementation effort rather than individual therapists.

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

At this distance from the preoccupation with intervention effectiveness, research is scarce, and generic sources (incorporated in Australian guidance) beyond the scope of the matrices become more important.

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 also investigated British treatment services.

In cell C4 we forefronted the study's findings on the impact of the ethos and support emanating from managers. It also suggested that in turn these management impacts partially reflect how the organisation seems to its staff, and that organisational features also influence whether counsellors spend 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." Features studied 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 found the same dimensions were related to the degree to which patients in substance use services engaged with treatment. In different circumstances (as in this British seminal study), other organisational features emerge, but workplace climate always sets the context for how willingly and how well staff work with problem substance users, in turn affecting clients' engagement with treatment.

Issues to consider and discuss

▸ **Is your service even *ready* for change?** Take a look at the US guidance listed above on implementing change in substance use services. From page 10 (page 16 of the PDF file) starts a long list of the attributes to be considered before 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 the uncompromising statement that, "If your organization is troubled, you need to build a healthier work culture before change will be possible." But the guidelines also say that implementing evidence-based practices "can help overcome the financial and organizational challenges that make change so difficult" – in other words, that making changes can help overcome the barriers that obstruct change. According to Australia's addictions workforce development agency, one factor in successful change is *needing* to change – in other words, the deficiencies and barriers which obstruct change may themselves generate the motivation to change.

This all makes sense, but doesn't it mean that organisations most in need of morale and performance-boosting change will (if they honestly appraise themselves) be the ones most likely to decide they are in no shape to attempt it, and also the ones least likely to succeed – a stultifying chicken-and-egg scenario leading nowhere? It seems that way, but perhaps the changes needed to *prepare* an organisation for new practices differ from those needed to *implement* those practices? Maybe, for example, the organisation needs to fix its high staff turnover by more equitable personnel policies (see section below) *before* training staff in a new therapeutic approach. That training might itself further help fix the turnover problem, by re-moralising staff and raising their self-esteem – a virtuous cycle rather than a stultifying dead end. 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 be objectively assessed and openly discussed in a staff meeting, or would that be too close to the bone for poorly functioning services?

▸ **Does motivation matter?** The same guidelines discussed 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 Britain? And does it matter *why* an evidence-based practice is adopted, as long as it is? One motivation is, for example, to help the organisation make money – a carrot introduced in Britain in the form of payment-by-results schemes. Is change motivated by money just as good for patients as change motivated by the desire to improve patients' 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.

In thinking about this, look back at cell E2's bite and the issue, "Is payment by results the way to go?", and at the stress placed on therapeutic relationships in psychosocial therapies in cell B4. Ask yourself what different motivations might do to those relationships – especially given the importance of seeming 'genuine' to the patient.

Try this mind experiment, imagining yourself a counsellor working in two very different organisational climates. In scenario one you know the patient has to return for treatment at least three times before the service gets paid for them, and it has been impressed on you 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 the patient's return makes no difference money- or job-wise to you or the organisation, but you strongly feel that unless this patient stays in treatment, they and their family – who you care about – will suffer, and it has been impressed on you that preventing that suffering is what the service is about. To help, in both cases your treatment service has mandated training in retention-enhancing motivational techniques and is monitoring your performance. Do you implement these techniques in the same ways and with the same interpersonal style in both scenarios? And does the patient get the same messages about why you are acting in those ways?

> *Try this mind experiment. Do you take the same actions in the same ways in both scenarios?*

▸ **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 it is 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 limit capacity for accumulating and implementing learning (see for example: 1 2 3).

Australia's addictions workforce development agency devoted chapter 11 of their guidance overview (full guidance available at web site listed above) to staff retention and the costs of high turnover, including lost productivity, decreased morale, increased stress, and reduced 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, where perhaps surprisingly we find highlighted not salary or workload, but the appeal of the work, supervisor relationships, and professional development.

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 because you have the freedom and authority to do the job how you feel it should be done – to "provide quality treatment".

Do you agree with the US authors that this prominence of relationship factors over workload-related factors reflects the investment counsellors make in their relationships with clients? Their interpretation is that caring for and relating to clients who relapse, requiring counsellors repeatedly to pick up the pieces and start again, is the main source of stress in those occupations. By the same token, other relationship factors are the main source of support in

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

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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