DRUG & ALCOHOL FINDINGS Matrix cell

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

Drug Treatment Matrix cell D4: Organisational functioning; Psychosocial therapies

One of 25 cells in the Drug Treatment Matrix

K Organisational health associated with engagement in treatment (2009). In England clients best engaged in treatment 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. 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. For discussion click and scroll down to highlighted heading.

K Healthy organisation related to substance use and patient-counsellor relationships (2011; free source at the time of writing). At US substance use counselling centres, rather than resources, training or equipment, the relational features of the organisation including staff feeling able to influence, trust and cooperate with each other were related to a centre's drug/alcohol use outcomes. Services also differed in the strength of the therapeutic relationships patients reported with counsellors. 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 at the time of writing). Compelling account of what it takes in the real world (when 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 worker support, risk generating the high staff turnover which impedes workforce development. For discussion click and scroll down to highlighted heading.

R Involve whole organisation in implementing psychosocial treatment (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.

R When residential care matters (2002). Informal review from Drug and Alcohol Findings concludes that more severely dependent and problematic substance using clients differentially benefit from residential care. Where studies have found no added benefit this may have been because the service's caseload was limited in severity, or because the study set severity limits so that all the participants could safely be allocated to residential or non-residential care.

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 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. 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 University of Wisconsin in the USA providing research findings, promising practices, and toolkits, all geared to encouraging and supporting administrative and therapeutic improvements in addiction and mental health care 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 discussion click and scroll down to highlighted heading.

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 formal characteristics like staffing, 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 identifying when and what improvements are needed, facilitate staff learning, forge links with other organisations, and seek and welcome external inspection and accreditation.

Research cited in this cell is about the impact of these attributes on the human interactions involved in the 'psychosocial' therapies introduced by cell A4, ranging from brief advice and counselling to extended treatments based on psychological theories. At this remove from the preoccupation with intervention effectiveness, research specific to substance use 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. Here we add that in turn these management attributes partially reflected how the organisation seemed to 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". 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 dimensions were related to the degree to which patients in substance use services engaged with treatment. In different circumstances (as in a seminal British study of alcohol treatment), other organisational features emerge. Though the details differ, workplace climate consistently sets the context for how willingly and how well staff work with problem substance users, in turn it seems affecting clients' engagement with treatment.

Highlighted study How critical the organisation is was forcefully brought home (study 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 helps transform training from a tick-box 'done it' into something 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."

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" – but those challenges may obstruct the very changes which could help resolve them. Yet according to Australia's addictions workforce development agency, a critical factor in successful change is *needing* to change – having shortcomings which demand action.

It seems we have a chicken-and-egg scenario here: organisations whose shortcomings mean they are most in need of and perhaps also most motivated to change are due to those same shortcomings unable to make or even attempt that change. This apparent bind would disentangle if the changes needed to *prepare* an organisation for new practices differ from those needed to *implement* the innovations. Maybe, for example, the organisation needs to fix its staff turnover problem by implementing more equitable personnel policies (see section below), and only then try training and coaching 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. 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? The US guidelines discussed above offer (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 out?", and at the stress placed on therapeutic relationships in psychosocial therapies in cell B4. Ask yourself what different motivations might do to that relationship – especially given 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 difference money- or job-wise, but you strongly feel that unless this patient stays in treatment, they and their family will suffer in ways you have devoted yourself to countering. In both cases, to engender motivation for treatment you apply motivational interviewing principles and techniques in which you have been trained. Do you act in the same way 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 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 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, 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. Relational 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 because you have the freedom and authority 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, requiring counsellors 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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