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Introducing Evidence-Based Practices into Substance Abuse Treatment using Organization Development Methods

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Abstract

Background—Dissemination of evidence-based practices (EBPs) in addiction settings is a national priority. We tested Organization Development (OD) methods for dissemination.

Methods— Using OD in two addiction treatment programs we developed an organization-specific treatment plan using employee work teams with the goals of changes in organizational policies and procedures and improvement in practitioner skills.

Results— OD was effectively applied, but EBPs were premature for these addiction programs because they first needed to address more fundamental aspects of client-clinician interaction and agency treatment philosophy.

Conclusion— The OD approach in addiction treatment is complementary to other technology transfer efforts by being: (a) “organization-centered,” engaging practitioners at all levels; (b) “needs-focused,” addressing concerns of the particular organization; (c) flexible in its responsiveness to readiness for change; and (d) relatively affordable. However, before absorbing EBPs, substance abuse treatment organizations must develop strengths in delivering fundamental aspects of care.

Keywords

Evidence-based practices; institutional change; organization development; substance abuse treatment

INTRODUCTION

During the 1990s, deficiencies were identified in addiction treatment agencies including: inadequately trained counselors with large caseloads, inconsistent beliefs about medications and confrontational counseling, treatment plans without behavioral outcomes, and treatment modalities without a clear rationale (1–3). Treatment providers saw the lack of integration of research in practice as resulting from the presentation of research findings in a way that was not understandable, and studies that did not advance treatment knowledge. To facilitate the transfer of research-validated treatment technology to the field, management science was employed to assist treatment organizations adopt evidence-based practices (EBPs) (4,5). Adoption of EBPs has been a significant challenge in all areas of health care for centuries; acceptance of the practice of consuming citrus fruits to eliminate scurvy took more than a century (6,7). We used Organization Development (OD) to help addiction programs implement

EBPs and illustrate implementation challenges and accomplishments with two specific case studies.

METHODS

Examples of EBPs include the Center for Substance Abuse Treatment's (CSAT) Treatment Improvement Protocols (TIPs). Brown and Flynn (8) criticized such approaches for their over-reliance on print media. McLellan emphasized the need for "threat reduction" methods to engage resistant staff, but noted that lack of skilled personnel was a barrier to innovative methods (9). One model used on-site clinical instruction, mentoring, and supervision to help workers use an EBP approach to family treatment of substance abuse. Another model (11) used computer-assisted collection of patient information on the Addiction Severity Index and increased treatment completion rates from 45 to 70%. Since staff training often results in only temporary behavior change, in the absence of organizational supports (1,12,13), the OD approach was used to accomplish essential change tasks (8): Prepare the organization for change through motivational methods, assure sufficient resources for implementation, and engage in outcome assessments.

The OD approach (14) engages employee teams in problem solving for organizational assessment, diagnosis, and treatment. OD is distinguished by the use of a *change agent as catalyst* to gather organizational data, feed it back to the organization, and facilitate cross-functional agency teams in diagnosing problems and planning and executing remedial action (15,16). The consultants were available to each agency for about 18 months, for about 2 1/2 person-days per week. Employee "opinion leaders" were selected by the consultants and top management to participate in teams that chose the intervention targets, designed the work plans, and implemented the changes (14). Desired outcomes included: increased use of EBPs, knowledge of their benefits, and mechanisms to ensure institutionalized change. The consultants familiarized administrators and staff with a range of NIDA-endorsed EBPs using EBP manuals and protocols and tools for client assessment and treatment planning. They recommended ways to modify client intake and assignment procedures, and improve staff and management communication.

TWO CASE STUDIES: DIVERGENT EXPERIENCES

Organization X

This organization is a free-standing, multi-function addiction program that serves a racially- and ethnically-diverse, inner-city client population. A needs assessment used focus groups with administrators, staff and clients with a goal of introducing EBPs or EBP-related program elements. Support was expressed for Motivational Interviewing as an EBP (18,19). However, we discovered two organizational problems: no common standards of client care, and not all employees saw themselves as part of the therapeutic environment. Specific problems included confidentiality violations; breaches in staff-client boundaries; and lack of respect for client self-determination. The agency's Consumer Advisory Committee was helpful in focusing on these dysfunctional staff-client interactions. Further, staff members took offence when clients relapsed or left the program, emphasized client deficits instead of strengths; and did not include clients in treatment planning.

The staff team recognized that implementing EBPs would require that the agency develop standards for treating all clients as respected partners in treatment. Administrators were surprised and initially alarmed at these conclusions, but then empowered the change team to write and implement standards of care, adding them to new-employee orientation and clinical staff training, and evaluating compliance with the standards. While such direct feedback to

administrators can cause a “stonewalling” of change, it was positive here and provided quicker consequences for employees who failed to function professionally in client interactions.

Clinical staff also learned Motivational Interviewing (18,19) through training sessions, “training of trainers” to continue the training throughout the agency, and a Standards of Client Care manual emphasizing a motivational approach to client care.

Organization Y

Organization Y is also a well-established addiction treatment agency serving a racially- and ethnically-diverse, inner city client population with a continuum of care. The consultants initially forged a strong alliance with administrators, in contrast to Organization X where they relied on an employee change team. The process in organization Y was more “top-down” for interpreting needs assessment findings, prioritizing needs, and determining the EBPs to be adopted. Training targeted counselor and supervisor skills. To reduce initial counselor and supervisor resistance to EBPs, clinicians were told that they would not need to abandon their current treatment approaches but that EBPs could be helpful in addressing chronic or nagging problems in client care; EBPs could make the treatment easier and more interesting for the clinician, and more understandable, engaging and effective for the client. After several hours of training, staff were asked to apply their newly acquired skills to selected clients on their caseloads. The staff reviewed treatment plans completed prior to the EBP training and revised those documents in keeping with new EBPs.

Administrators made policy and procedural changes to reinforce the use of EBPs. These included sanctions for client non-compliance with treatment, and monitoring counselor record keeping for client’s stage of readiness for change and its use in treatment planning. However, administrators were distressed at troublesome staff behaviors including giving and receiving gifts, personal relationships with clients, and inappropriate use of counselor authority (both excessive use of authority and failure to exercise authority when needed). When administrators confronted staff, some aggressively defended their behavior, stating that the multiply diagnosed, multi-stressed, and ethnically diverse clients on their caseloads benefited from this non-traditional approach.

The extent to which counselors and supervisors used their newly acquired EBPs remained unclear. Some believed that their prior counseling methods (however poorly defined) were equally effective as EBPs and that clinicians should be free to utilize whatever methods they chose; this frustrated administrators, but they lacked effective sanctions (e.g., staff performance evaluation and dismissal mechanisms).

Two outcomes were (a) using new methods for organizing treatment groups based on clinical rather than administrative factors, and (b) developing a treatment philosophy based on NIDA principles, incorporating the goals of abstinence and harm reduction, and providing guidelines for intensifying treatment for poorly performing clients.

DISCUSSION

Two variants of the OD approach were used in addiction agencies and facilitated the introduction of EBPs in both settings. The approach was “systems-centered,” engaging key players in the change effort and allowing the addiction program to remain in the driver’s seat, specifying the desired target areas, content, and processes of change. The OD approach is also “needs-centered,” emphasizing what the organization’s members think needs improvement, at its level of readiness for change. Thus, this approach incorporates for organizations some of the same principles of “motivational enhancement” (19) that have been developed for individuals. The “open-agenda,” with the organization choosing the focus of change, provides

flexibility that is crucial in facilitating a permissive environment for organizations to uncover issues of concern to staff, administrators, and clients. The OD approach involves time-limited costs that can be spread over some months. The actual cost of this model for one agency, involving 2–3 person-days per week for 12 months is approximately \$25,000, depending on the level of effort required of the consultants. Employee teams can be expensive for the organization, however, and compensatory time may need to be provided for the change team.

The OD approach could be available to a broad audience of addiction programs. Areas where special expertise is required include group facilitation and conflict-resolution. This work could be done by a program “insider” but only if he/she has distance from the organization’s problems and politics, since a major role of the “change agent” is to ally with all parts of the organization. Finally, expertise is needed in the area of EBPs and knowledge of the benefits and limitations of EBPs. Limitations of this evaluation of the OD approach include testing in only two organizations; and the intervention team was also the evaluation team.

OD is another option available for addiction programs interested in adopting EBPs and can enhance the effectiveness of other approaches. The model can harness the energy and creativity of the workers who will use the changes, and includes the supervisors and administrators whose support will be needed to reinforce the changes.

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References

1. Lamb, S.; Greenlick, MR.; McCarty, D., editors. Bridging the Gap between Practice and Research: Forging Partnerships with Community-based Drug and Alcohol Treatment. Washington, D.C: National Academy Press; 1998. p. 264
2. Simpson, DD. Effectiveness of drug-abuse treatment: A review of research from field settings. In: Egertson, JA.; Fox, DM.; Leshner, AI., editors. Treating Drug Abusers Effectively. Malden, MA: Blackwell; 1997. p. 41-73.
3. Forman RF, Bovasso G, Woody G. Staff beliefs about addiction treatment. *J Subst Abuse Treat* 2001;21:1–9. [PubMed: 11516921]
4. Simpson DD. A conceptual framework for transferring research to practice. *J Subst Abuse Treat* 2002;22:171–182. [PubMed: 12072162]
5. Backer, TE.; David, SL.; Soucy, G. Introduction: the challenge of technology transfer. In: Backer, TE.; David, SL.; Soucy, G., editors. Reviewing the Behavioral Science Knowledge Base on Technology Transfer. Rockville MD: National Institute on Drug Abuse; 1995. p. 1-20. NIDA Research Monograph #155
6. Mosteller F. Innovation and evaluation. *Science* 1981;211(4485):881–886. [PubMed: 6781066]
7. Rogers, EM. Diffusion of Innovations. 4. New York, NY: The Free Press; 1995. p. 519
8. Brown BS, Flynn PM. The federal role in drug abuse technology transfer: a history and perspective. *J Subst Abuse Treat* 2002;22:245–257. [PubMed: 12072168]
9. McLellan AT. Technology transfer and the treatment of addiction: what can research offer practice? *J Subst Abuse Treat* 2002;22:169–170. [PubMed: 12072161]
10. Liddle HA, Rowe CL, Quille TJ, Dakof GA, Mills DS, Sakran E, Biaggi H. Transporting a research-based adolescent drug treatment into practice. *J Subst Abuse Treat* 2002;22:231–243. [PubMed: 12072167]
11. Carise D, Cornely W, Gurel O. A successful researcher-practitioner collaboration in substance abuse treatment. *J Subst Abuse Treat* 2002;23:157–162. [PubMed: 12220614]
12. Baldwin TT, Ford JK. Transfer of training: A review and directions for future research. *Personnel Psychology* 1988;41:63–105.

13. Clarke N. Job/work environment factors influencing training transfer with a human service agency: some indicative support for Baldwin and Ford's transfer climate construct. *International Journal of Training and Development* 2002;6(3):146–162.
14. French, WL.; Bell, CH. *Organization development: Behavioral Science Interventions for Organization Improvement*. 6. Upper Saddle River, NJ: Prentice-Hall; 1999. p. 343
15. French, WL.; Bell, CH. *Organization Development: Behavioral Science Interventions for Organization Improvement*. 2. Englewood Cliffs, NJ: Prentice-Hall; 1978. p. 271
16. Gosin MN, Dustman PA, Drapeau AE, Harthun MI. Participatory action research: Creating an effective prevention curriculum for adolescents in the Southwestern U. S Health Education Research 2003;18(3):363–379.
17. French, WL.; Bell, C. *Organization Development: Behavioral Science Interventions for Organization Improvement*. 3. Englewood Cliffs, NJ: Prentice-Hall; 1984. p. 347
18. Miller, WR.; Zweben, A.; DiClemente, CC.; Rychtarik, RG. *Project MATCH Monograph Series, Volume 2*, NIH Publication No. 94-3723. National Institute on Alcohol Abuse and Alcoholism; Rockville, MD: 1992. *Motivational Enhancement Therapy Manual*.
19. Miller, WR.; Rollnick, S. *Motivational Interviewing: Preparing People for Change*. 2. New York: The Guilford Press; 2002. p. 428