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Organizational and Clinical Implications of Integrating an Alcohol Screening and Brief Intervention Within Non-Substance Abuse Serving Agencies

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Abstract

Although there have been efforts to advance evidenced-based practices into community-based organizations the limited successes of dissemination and poor implementation of efficacious treatments within these organizations are beginning to be documented. This article builds on the knowledge gained from organizational research and those internal structures (e.g., culture and climate), which possibly impede or enhance evidenced-based practice implementation within community-based organizations. While there are many evidenced-based practices available to human services organizations, there seems to be a gap between research and the implementation of these clinical practices. Recommendations are provided to better enable community-based organizations to integrate evidenced-based practice into its existing service structures.

Keywords

Culture and climate; evidence-based practice; alcohol screening; clinical supervision

THE PROBLEM

This article builds on the knowledge gained from organizational research and those internal structures (e.g., culture and climate), which possibly impede or enhance evidenced-based practice (EBP) implementation within community-based organizations (CBOs). While there are many EBPs available to human services organizations, there seems to be a gap between research and the implementation of these clinical practices. The National Institute of Mental Health report, *Bridging Science and Service* presents various recommendations (1999), for increasing the usefulness of research within the real world of community-based practice. The report makes clear that research designed and carried out in real world conditions is more relevant to clinicians and regularly applied during practice. Unfortunately, however, knowledge about effective health treatments is not replicated in community-based practice settings (NIH, 1999, 2000). Understanding the breakdown during the dissemination and implementation of EBPs within CBOs would contribute to filling this research to practice gap. Granted a review of the literature may produce a number of alternative explanations for

this gap it should be noted that there is limited data that EBP are routinely carried out by clinicians, hence the main focus of this paper is on the possible barriers within organizational systems.

This article begins by describing the constructs of organizational culture, climate, and why these might be barriers to adopting EBP. This is proceeded by describing a specific EBP that can be easily integrated within many CBOs, measuring if the EBP is carried out (e.g., fidelity checks) thereby exposing any potential implementation obstacles. Fidelity checks will enable CBOs to know if their staff are adopting EBP with some level of reliability and if not establish organizational activities that could increase EBP implementation, adoption, and overall effectiveness.

The specific EBP suggested for interested CBOs follows the National Institutes of Alcohol Abuse and Alcoholism's (NIAAA) recommendations of integrating an alcohol screening and intervention into community-based practice settings' standard of care. This EBP is relatively short and recommended for all social service agencies, not just agencies that serve substance-abusing clients as their primary mission. Community agencies (e.g., those without alcohol specific treatment services) are in a prime position to serve large, varying amounts of individuals and families who may be at-risk of heavy drinking. By integrating an alcohol screening and brief intervention within community-based practice settings that serve a large mass of people, the amount of heavy drinking that usually remained undetected would be exposed and appropriately addressed (McGlynn et al., 2003). The main question being posed is: What would be the effect on clinical practice of implementing a very short alcohol screening and brief intervention to non-substance abuse serving agencies?

BACKGROUND AND SIGNIFICANCE

Although there have been efforts to advance EBPs into CBOs (Aarons & Sawitzky, 2006; Abrahamson, 2001; Burns, 2003; Essock et al., 2003; Glisson, 2002; Goldman et al., 2001; Ringeisen & Hoagwood, 2002), the limited successes of dissemination and poor implementation of efficacious treatments within these organizations are beginning to be documented (Hoagwood, Burnas, Kiser, Ringeisen, & Schoenwald, 2001; Weisz & Jensen, 1999). Studies are underway to investigate the dissemination, implementation, and ongoing success for efficacious clinical treatments and empirically based practices inside community health care agencies. The National Institutes of Health's (NIH, 1999) *Bridging Science and Service* indicates that clinical effectiveness and utility of any new treatments are just as important as efficacy issues in controlled clinical trials when evaluating treatment strategies. Rounsaville, Carroll, and Onken (2001) designed a guide for researchers and clinicians when assessing new behavioral therapy's efficacy and effectiveness. These researchers provided a specific roadmap for investigating potential behavioral therapies. The major emphasis and the impetus for methodological requirements of behavioral therapies research is internal validity (Carroll & Rounsaville, 1990; Waskow, 1984).

Having adhered to all the rigors of behavioral research methodologies the logical flow would be to implement findings within community health care agencies. Unfortunately, clinical practices and service system innovations that are validated by all the rigors of research are not being fully adopted in community treatment settings. The substantial disparity between what is known through research and what is being carried out inside of treatment settings has been recorded in cancer care (Cronin, Weed, Connor, & Prorok, 1998), diabetes related services (McClellan, Knight, Karp, & Brown, 1997), and within cardiac care units (Howard & Duncan, 1997).

While there could be a number of reasons for limited dissemination and implementation of proven practices throughout community treatment settings, there is an emerging literature

linking organizational factors as perhaps one explanation for the partial use of EBP with treatment practices (D'Aunno, 2006; D'Aunno & Price, 1985; Hemmelgarn, Glisson, & James, 2006; Knudsen, Roman, Ducharme, & Johnson, 2005; Lamb, Greenlick, & McCarty, 1998; Price et al., 1991; Price, 1997; Read, Kahler, & Stevenson, 2001; Roman & Johnson, 2002). Integrating theory, methods, and data connection activities typically found in behavioral sciences research into organizational services research can lead to vital learning needed in order to improve the research to practice gaps. Researchers have attempted to study organizational structure and/or characteristics in order to understand possible barriers when implementing EBPs. Whereas there is a substantial literature on organizational factors related with implementation of new technologies in the business world (Frambach & Schillewaert, 2002; Klien & Sorra, 1996), little research currently exist examining organizational aspects aiding or impeding the implementation of EBP geared toward those with alcohol related problems.

Several research findings indicate that organization studies are relevant to EBPs implementations as well as client outcomes in mental health agencies (e.g., Aarons & Sawitzky, 2006; Glisson & James, 1992; Hemmelgarn et al., 2006). For example, previous studies indicate that organizational culture and climate affect service quality and client outcomes independently of worker's education, training, and experience as well as the characteristics of the client receiving the service (Glisson & Hemmelgarn, 1998; Glisson & James, 2002; Hemmelgarn, Glisson, & Dukes, 2001).

Organizational culture and climate have emerged as probable concerns not only related to client outcomes, but also when attempting to implement new innovative technology into existing CBOs. This is important because those organizations with less than constructive cultures and climates (e.g., defensive cultures and climates) not only impact quality of client care and outcomes, but they also erect barriers to new service technologies designed to improve overall client health outcomes (Glisson, 1996). Constructive organizations tend to be safe places to try new ideas and practices and supports staff's activities during the implementation of new technologies (Glisson).

While specifically defining an organization's culture and climate could prove difficult (Verbeke, Volgering, & Hessels, 1998), an organization's culture is frequently described as the "way things are done around here," communicate shared norms, beliefs, and behavioral expectations valued by the organization (Cooke & Szumal, 1993; Hemmelgarn et al., 2006; Verbeke et al., 1998). Climate of an organization imitates employees' perception and the emotional responses to the characteristics of their environment (Glisson & James, 2002; James, Hater, Gent, & Bruni, 1978; James & Sells, 1981). Accordingly, while both culture and climate are distinct constructs, they are correlated and able to sway worker attitudes in organizations.

Organizational Culture

Socializing workers in how to behave and go about their work stem from organizational norms and individual attitudes. Theoretical models useful in understanding organizational acculturation include Bandura's (1977) social learning theory, Miner's (1980) expectancy theories as well as James, James, & Ashe (1990) cognitive processing models. When new workers enter the organization, they are educated by means of direct observation, modeling along with personal experiences followed by rewards, punishments, and expected outcomes following one's work behavior (Hemmelgarn et al., 2006). According to Hemmelgarn and researchers (2006) mental representations or as they refer to as schemas, are developed by workers and aid in gaining meaningful understandings of how organizations work. As a result, workers become acculturated to a set of organizational beliefs and expectations helping to guide their interpretation of organizational stimuli, the decisions they make, and

behaviors in which they engage (Hemmelgarn et al., 2006). Basically, culture can be defined as the normative beliefs and united behavioral expectations in an organizational service unit (Cooke & Szumal, 1993).

According to Aarons and Sawitzky (2006), community-based organizations' culture influence quality and outcomes of health services. Not only does culture impact individual attitudes (e.g., job satisfaction, organizational commitment), but services related outcomes, like quality and staff turnover, as well (Glisson & James, 2002). While specific labels for types of organization's cultures can vary, this study will utilize Cooke and Lafferty's (1994) characteristic of an *ideal* organizational culture (e.g., acculturated to a set of organizational beliefs and expectations) as emphasizing innovation, autonomy, skill development, trust, open lines of communication, and overall flexibility.

These beliefs and expectations (cultural norms) within ideal organizations not only impact adaptation of EBPs, but they have *survival value* for workers (Hemmelgarn et al., 2001; Schein, 1992). Specifically, these cultural norms support expected behaviors that employees come to depend on during their efforts to survive in an intense environment that demands their constant focus, energy, and emotional resources (Hemmelgarn et al., 2006). Because many CBOs constantly operate under daily stresses, dealing with highly emotional situations, the ideal organizational culture that supports workers survival behaviors, they can be expected to adopt new technologies with limited resistance (Glisson, Dukes, & Green, 2006).

There have been both qualitative and quantitative approaches to measure organizational culture with some arguing for both approaches (Hofstede, Neuijen, Ohayv, & Sanders, 1990). Measuring organizational beliefs and expectations can be captured by quantitative scales (Cooke & Rousseau, 1988; Rousseau, 1990). These quantitative measures of culture describing normative behaviors and expectations can be administered to all organizational workers and then aggregated to obtain an "organizational-level indicator of culture" (Hemmelgarn et al., 2006). Glisson and James (2002) provide a thorough review of issues regarding procedures for determining the appropriateness of organizational culture aggregation, models for understanding individual-level data of organizational-level variables, and appropriate data analytic techniques. While there are qualitative approaches to measuring organizational culture (Cooke & Rousseau, 1988; Rousseau, 1990; Schein, 1990, 1992) this study will not employ any qualitative strategies.

Psychologic and Organizational Climate

The definition of psychologic climate is the employee's, specifically as an individual, perception of the psychologic impact of the work environment on his or her own well being (James & James, 1989; James et al., 1990; James & Jones, 1974). Individuals evaluate what is personally important to them and their personal welfare whether or not aspects of their jobs provide this importance (James et al., 1990). Edmondson (1999) provides an expansive concept of climate explaining that there is a sense of safety within teams. This sense of safety and confidence that the team will not embarrass, reject, or punish someone for disagreeing with that team allows for the perception that one's environment is non-threatening and safe for errors to be expressed, mistakes can be addressed and solutions can be forthcoming. These indicators underscore a general higher order evaluation factor on whether or not work environments are good or bad for one's own personal well being (Hemmelgarn et al., 2006).

In the course of interpersonal discussions related to work perceptions and social learning processes, like modeling (see Bandura, 1977), individuals within an organization can begin to formulate each other's evaluative structures and subsequent perceptions of their work

environment. While there can be an individualized nature to psychologic climate resulting in differences between employees, because of social learning and interpersonal interactions within a specific work unit, employees often agree on their perceptions of the environment (Hemmelgarn et al., 2006).

According to Parker and colleagues (2003) worker attitudes like job satisfaction, involvement, and commitment serve as mediating mechanisms between climate perceptions as well as other distal outcomes related to employee motivation and overall job performance. Because workers behave in harmony with their attitudes, expectations and beliefs, work environment perceptions evoke outcome expectancies, satisfaction, and identification with one's job or organization (James, Hartman, Stebbin, & Jones, 1977). In view of the fact that worker perception is particularly important influencing the interaction, nature, and tone of the helping relationship (Schneider, White, & Paul, 1998) perceived nonsupporting, impersonal, and stressful work environments by the employees, results in reflecting those insecurities during work interactions. On the other hand, if workers perceive that the organization stands behind them and able to be counted on during stressful periods, they are more likely to be persistent and innovative when faced with possible, unexpected problems (Hemmelgarn et al., 2006).

The distinction between psychologic and organizational climate is critical in that psychologic climate remains a property of the individual worker though the property can be shared with coworkers. According to (Glisson & James, 2002; Hemmelgarn et al., 2006) organizational climate exists when psychologic climate perceptions are shared among workers within a particular work unit such as the organization, team, or division.

When this agreement exists, aggregated measures of organizational climate can be computed and employed as an organizational-level measure of climate (Glisson & James, 2002; Joyce & Slocum, 1984). Quantitative measures of climate have existed much longer than culture measures. Well-established quantitative measures of organizational climate within social and mental health services are readily available (Glisson et al., 2006; Glisson & Durick, 1988; Glisson & Hemmelgarn, 1998; Glisson & James, 2002).

CONSIDERING AN EBP

Effective mental health services require some things to occur within organizations if those responsible to carry out these services are to comply with these activities. These services should be appropriate, valid, and effective with the population being served (Glisson, 2002). The ideal EBP should have progressed through the rigors of random controlled trials throughout the field of study (Burns, Hoagwood, & Mrazek, 1999; Hoagwood et al., 2001). Having selected to appropriate intervention, staff must adhere to the documented protocols. While there is a tendency to adjust the protocols in order to fit them to the agency, doing so often undermines the calculated outcome (Glisson, 1996; Henggeler & Schoenwald, 1999; Martin, Peters, & Glisson, 1998). A final consideration is the therapeutic relationship between the client and service provider. Successful outcomes can be directly related to the quality of the alliance (Blanz & Schmidt, 2000; Connors et al., 2000; Florsheim, Shotorbani, Guest-Warnick, Barratt, & Hwang, 2000). Although there may be other EBP that could meet the recommendations listed above, the one being put forth addresses these considerations as well as follows the National Institute on Alcohol Abuse and Alcoholism's request. There may be much that can also be learned from the attempts to integrate single-system designs into practice, as well as the organizational innovations literature.

The Recommended EBP to be Introduced

The NIAAA has developed a clinician's guide for helping patients who drink too much (NIH, 2005). This guide was created for primary care and community-based services providers in order to integrate an alcohol intervention into standard care services. Its overall goal was to assist those who are in prime positions to make a difference, screen for at-risk drinking, and provide a brief intervention. According to Fleming et al. (2002) clinical trials have shown that providing a brief intervention can lead to significant and long lasting reductions in drinking levels in those who are considered at-risk drinkers. Clinical trials have also demonstrated that repeated alcohol focused brief interventions with a health care provider can lead to significant improvements for dependent drinkers (Willenbring & Olson, 1999).

The step-by-step clinician guide begins with a simple one question (e.g., do you sometimes drink beer, wine, or other alcoholic beverages?) prescreen, if answered no; the session is ended documenting no alcohol use. If the client indicates they do sometimes drink alcohol the next step would be collecting a bit more information using the Alcohol Use Disorders Identification Test (AUDIT), NIAAA suggested tool. The AUDIT provides a scoring tool and those below the positive score (e.g., seven or below) will be advised to stay within maximum drinking limits as well as recommending to lower their limits or abstaining from any alcohol use. Those clients scoring within the positive range (e.g., eight or above) on the AUDIT, the clinician will move to Step 2 and assess for alcohol use disorders. In order to determine whether there is a maladaptive pattern of alcohol use causing clinically significant impairment or distress, questions adapted from the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV), Revised* will be asked. There are recommended brief interventions for at-risk drinkers and both dependent and non-dependent drinkers. The interventions provide the opportunity to educate and intervene as well as follow up during the next visit.

POSSIBLE REASON WHY SOCIAL WORKERS FAIL TO INTERVENE ON ADDICTION

Social work case loads, regardless of agency type, consist of problem drinkers (Wechsler & Rohman, 1982). In public assistance organizations, about 25% of the case loads make up those with problem drinking (Begun, 2004). With a brief alcohol-related screening and intervention well established to have a significant impact with high risk drinkers, social workers are in a prime position to intervene with problem drinkers, however, many social workers fail to intervene. According to many researchers, the main factor seems to be the lack of alcohol specific social work courses and field placements. The great need for social workers to obtain training in addiction studies is largely going unmet (Abbott, 2000; Abradinski, 2004; Gorman et al., 1990).

The limited educational and training experiences received by students coming out of schools of social work may result in barriers to conducting assessments of clients with alcohol or other drug problems (Begun, 2004; Gilbert & Terrell, 2002; Miller & C'DE Baca, 1995). According to Fewell and King (1993), because problem drinkers present themselves with various and multiple issues, untrained MSWs lack the insight to recognize symptoms of alcohol problems often times resulting in a misdiagnoses.

In order to overcome this barrier, social workers need to be trained. Alcohol-related knowledge is positively related to social worker's ability to identify problem drinking and their willingness to work with this population (Bailey, 1970; Peyton, Chaddick, & Gorsuch, 1980).

WHY SHOULD NON-SUBSTANCE ABUSE TREATMENT FACILITIES ADOPT THIS PRACTICE?

Implementing this alcohol screening and intervention as a routine service within community-based social work practices enables the detection of alcohol problems, which many times goes undetected. According to Miller, Thomas, and Mallin (2006) many patients do not have any issues around being screened for alcohol problems and upon completion of a screening are more open to advice afterwards. While there could be barriers to implementing any new therapeutic approach, it would be important to know if CBOs are able to integrate an evidenced-based intervention (e.g., alcohol screening and brief intervention) into existing services with high fidelity.

RECOMMENDATIONS FOR THOSE WITH LOW FIDELITY

Once organizations are able to train and implement this EBP, they will be able to measure if the intervention is being carried out with some level of fidelity. Conducting regularly scheduled checks, such as comparing the number of clients coming into the agency with the completed screening and brief intervention documentation, should present an organization with implementation percentages. Low fidelity to the EBP would indicate possible organizational barriers and the opportunity to intervene.

Glisson and colleagues describe several strategies when intervening at the organizational level (see Glisson, 2002; Hemmelgarn et al., 2006, availability, responsiveness, and continuity, Availability Responsiveness, and Continuity [ARC] intervention). Two strategies are discussed here, one addressing organizational culture (i.e., macro) and the other centering on climate (i.e., micro). While there are many identified ARC interventions at the macro level, one that seems best suited for this paper is the use of their proposed change agents (Hemmelgarn et al., 2006).

Change Agents (macro)

These are workers who are trained to work with treatment teams, administrator, key opinion leaders, and community stakeholders (Hemmelgarn et al., 2006). Rogers (1995) specifically describes characteristics of successful change agents as those who hold credibility in the eyes of those who are to be involved in providing social services. Change agents influence and teach others, listen to as well as empathize within, the organizational structure. Change agents diagnose problems in the implementation of new technology process', motivate interest about a new or innovative technology, along with work with opinion leaders in the community to stabilize the adoption of the new protocols and ensure EBP continuation (Glisson, 2002). According to Glisson (2002),

“much of the change agent’s work is aimed at bridging the social and technical gaps between those seeking to implement the technology or innovation (e.g., an evidence-based practice) and those who are expected to benefit from it (e.g., schools, courts, families, community members). In addition to working with teams, change agents and boundary spanners work with the organization’s administrators, community leaders, and community advisory groups to develop the types of norms, expectations, perceptions, and attitudes that will lead to success.” (p. 246)

The overall goal of those agents of change is to work in the organization and community creating a social context that supports the objectives of the organization’s technologies and treatment approaches.

Because there are complex macro level barriers to implementing and adopting EBP, a variety of interventions may be required to occur simultaneously (Henggeler & Schoenwald,

1999; Hoagwood et al., 2001), however, introducing change agents to address macro level barriers are important (Aldrich & Herker, 1977; Bartel, 2001; Callister & Wall, 2001; Rogers, 1995) and prove to be effective (Glisson, 2002; Glisson & Schoenwald, 2006).

Clinical Supervision (micro)

The role of clinical supervision as a mainstay for competent professionals dates back to the oath of Hippocrates (Bernard & Goodyear, 1998). Unfortunately approximately 30% of training programs provide clinical supervision and most of their graduates do not move into positions as a clinical supervisor (Powell & Brodsky, 2004). Further one study noted that less than 57% of substance abuse counselors receive clinical supervision (Powell & Brodsky, 2004). Although these figures on past clinical supervision may not accurately describe today's professional, so little information exists on the topic that it is hard to refute. Recently a clinical supervision revival of sort's has emerged that has been mainly influenced by treatment provider's use of EBP in order to produce better client outcomes. Early EBP manuals placed little emphasis on clinical supervision, for example, *A Cognitive Behavioral Approach: Treating Cocaine Addiction* (Carroll, 2000) dedicated three pages on the subject of clinical supervision strategies whereas, *An Individuals Drug Counseling Approach to Treat Cocaine Addiction: The Collaborative Cocaine Treatment Study Model* (Mercer & Woody, 2000) offered three paragraphs on the subject.

This increased attention to clinical supervision in part regards the growing need for adherence to prescribed treatment methods. The Center for Substance Abuse Treatment identifies three areas of focus for treatment agencies to meet increasing demands: (a) monitor, evaluate, and promote clinical competence, directly and objectively; (b) ensure fidelity to evidence-based practices; and (c) increase treatment efficacy and cost-effectiveness (CSAT, 2007). These three areas represent separate areas of function within an agency yet together form a continuum under the theme of quality improvement. One of the hopefully obvious issues EBP represents is that funders know what they are paying for and expect results based on the stated practice.

Fidelity or the adherence to the prescribed method over time represents one of the more necessary functions in developing and maintaining a proven practice. An advantage of timely and regular supervision involves monitoring the professional's adherence to the prescribed method. This involvement provides a meaningful opportunity to look at practice skills that often prevent drifting away from critical aspects of service delivery. This investment should improve outcomes through adherence which translates to economic benefits and has been noted to improve staff morale and counselor job satisfaction (CSAT, 2007).

It appears that many professionals consider clinical supervision as "a given" in the counseling process and place little emphasis on the quality and experience of the supervisor. The point being, clinical supervision did not receive due support until the recognition that maintaining fidelity of the intervention largely depends on many activities found within clinical supervision. Recent reviews of effective clinical practice prominently identify the necessity of clinical supervision to sustain quality in delivery of therapeutic interventions (Kendall & Beidas, 2007). This finding supports the argument for clinical supervision as a necessary treatment component to produce the best client outcomes and therefore should be a billable service.

This limited discussion offers a glimpse into the value of clinical supervision. Hopefully, more such reports will detail the supervision strategies and the vital role it plays in social services quality. In closing, administrators should consider increasing the quality and presence of clinical supervision for three reasons: (a) it offers support to counseling staff

raising morale and client outcomes; (b) a necessary component of EBP; and (c) it positively influences overall climate of the organization.

CONCLUSION

Social service agencies that can integrate EBP technologies into their system with some level of fidelity will be able to meet the demands from current funding sources. These organizations will also be better positioned to implement future best practices. In addition agencies will recognize organizational barriers to implementing EBP that will allow implementation of strategies to accommodate new clinical technologies into its system.

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