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Organizational Barriers to Adopting an Alcohol Screening and Brief Intervention in Community-Based Mental Health Organizations

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Abstract

This paper examines two factors related to successfully implementing a brief alcohol screening throughout all community-based mental health organizations. The first issue is related to an organization's internal structures, such as culture and climate that can impede evidenced-based practice implementation. There is literature suggesting that organizational culture and climate affect decisions about whether evidence-based practices are adopted and implemented within health care agencies. Following this literature review on organizational barriers, the history and successes of adopting an alcohol screening and brief intervention are reviewed. Studying, identifying, and understanding the organizational factors associated with the successful dissemination and implementation of best practices throughout community-based mental health organizations would contribute to increasing the likelihood that an alcohol screening and brief intervention are implemented throughout mental health organizations.

Keywords

alcohol screening; community-based mental health organization; evidenced-based practice; organizational culture and climate

Background and Significance

Literature exists indicating that organizational culture and climate affect decisions concerning whether evidence-based practices (EBP) are adopted and implemented within health care agencies (Hemmelgarn, Glisson, & James, 2006). Early diffusion and implementation literature (Nadler & Tushman, 1997; Rogers, 1995; Rousseau, 1997) has indicated that any successful adoption of new technology within an organization is as much a social as a technical formula. Hemmelgarn and colleagues (2006) reported that the social context of an organization can result in different approaches to problem solving, and influence which types of interventions will be selected and how interventions will be put into regular practice. Likewise, the influence of a community-based organization's social context on the choice, method, and everyday implementation of an intervention could

maximize or minimize its overall clinical effectiveness (Aaron, 2005; Hemmelgarn et al, 2006; Hoagwood & Burns, 2005).

There are interesting findings coming from organizational-level studies on internal structures (e.g., culture and climate) that can possibly obstruct or boost EBP implementation within community-based mental health organizations (CBMHOs). CBMHOs are defined as organizations that provide health and human-related services (e.g., bio-psycho-social assessments, counseling, referral services) to individuals and/or families. The interrelated aspect of these organizations is that they are agencies physically residing in a community, reflecting and responding to the emotional, physical, and/or spiritual needs within that specific community.

Although there are many EBPs available to CBMHOs, there is a gap between research on and implementation of these clinical practices. The National Institute of Mental Health presented various recommendations in its report, *Bridging Science and Service* (National Institutes of Health [NIH], 1999), for increasing the usefulness of research within the real world of community-based practice. The report clearly stated that research designed and carried out in real-world conditions is more relevant to clinicians and more likely to be utilized during clinical practice. It is unfortunate that knowledge about effective health treatments is not reflected in CBMHO settings (NIH, 1999). Identifying and understanding the factors associated with the successful dissemination and implementation of EBPs within CBMHOs would contribute to bridging this research-to-practice gap.

The Gap between Research and Practice

Although there have been efforts to advance EBP into CBMHOs (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 well documented (Hoagwood, Bumas, Kiser, Ringeisen, & Schoenwald, 2001; Weisz & Jensen, 1999). The NIH's *Bridging Science and Service* (1999) indicated that clinical effectiveness and utility of any new treatments are just as important as efficacy issues in controlled clinical trials when evaluating treatment strategies.

Barriers Inherent in CBMHOs

Although there could be other reasons for the lack of dissemination and implementation of proven practices throughout community treatment settings, there is emerging literature linking organizational factors with treatment practices (D'Aunno, 2006; D'Aunno & Price, 1985; Hemmelgarn et al., 2006; Knudsen, Roman, Ducharme, & Johnson, 2005; Lamb, Greenlick, & McCarty, 1998; Price, 1997; Price et al., 1991; Read, Kahler, & Stevenson, 2001; Roman & Johnson, 2002; Simpson, 2002). Integrating theory, methods, and data connection activities typically found in behavioral sciences research into organizational services research can lead to vital learning needed to improve the research to practice gaps. Researchers have attempted to study organizational structure and/or characteristics to understand possible barriers when implementing EBP. Although 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 individuals with alcohol-related problems receiving services outside of the addiction treatment field.

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 CBMHO. 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 support staff's activities during the implementation of new technologies (Glisson, 1996).

Defining 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 L. R. James, James, and Ashe's (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 (Hemmelgarn et al., 2006). According to Hemmelgarn and colleagues (2006), mental representations, or what they referred 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), CBMHO's cultures influence quality and outcomes of health services. Not only does culture impact individual attitudes (e.g., job satisfaction, organizational commitment), but also services-related outcomes, such as quality and staff turnover (Glisson & James, 2002). Although specific labels for types of organization's cultures can vary, this study utilizes Cooke and Lafferty's (1994) terms of *ideal* or *less than ideal* (as opposed to best and worst organizations).

Beliefs and expectations (cultural norms) within ideal organizations not only impact adaptation of EBPs, but they have *survival value* for workers (Hemmelgarn, Glisson, & Dukes, 2001; Schein, 1992). To be specific, 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 CBMHOs constantly operate under daily stresses, dealing with highly emotional situations, the ideal organizational culture supports workers' survival behaviors, which increases the likelihood that workers will adopt new technologies with limited resistance (Glisson et al., 2008).

Defining an Organisation's Psychological Climate

The definition of psychological climate is the employee's, specifically as an individual, perception of the psychological impact of the work environment on his or her own well-being (L. A. James & James, 1989; L. R. James et al., 1990; L. R. James & Jones, 1974). Individuals evaluate what is personally important to their personal welfare and whether aspects of their jobs provide this importance (L. R. James et al., 1990). Edmondson (1999) provided 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. This safe-work environment allows for a setting in which mistakes can be addressed and solutions can be generated. These indicators

underscore a general higher-order evaluation factor on whether 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, such as modeling (see Bandura, 1977), individuals within an organization can begin to formulate each other's evaluative structures and subsequent perceptions of their work environment. Although there can be an individualized nature to psychological 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 their work environment (Hemmelgarn et al., 2006).

According to Parker et al. (2003), worker attitudes such as job satisfaction, involvement, and commitment could 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 (L. R. James, Hartman, Stebbin, & Jones, 1977). Worker perception is particularly important, influencing the interaction, nature, and tone of the helping relationship (Schneider, White, & Paul, 1998). Any perceived nonsupporting, impersonal, and stressful work environments by the employees results in reflecting insecurities during work interactions. On the other hand, if workers perceive that the organization stands behind them and can 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 psychological and organizational climate is critical in that psychological climate remains a property of the individual worker although the property can be shared with coworkers. According to Glisson and James (2002) and Hemmelgarn et al. (2006), organizational climate exists when psychological 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 used as an organizational-level measure of climate (Glisson & James, 2002; Jones & James, 1979; Joyce & Slocum, 1984). Well-established quantitative measures of organizational climate within social and mental health services are readily available (Glisson & Durick, 1988; Glisson & Hemmelgarn, 1998; Glisson & James, 2002; Glisson et al., 2008).

Importance of Integrating Alcohol Screening and Brief Intervention throughout CBMHOs

In Bien, Miller, and Tonigan's (1993) review of brief interventions for alcohol problems indicated that the earliest health services research on brief interventions for problem drinkers began in the 1960s, dealing with the problems of facilitating referrals after an emergency room visit. Bien and colleagues provided a comprehensive review of research findings to date on the application of brief interventions for alcohol problems in general health care settings along with methodological strengths and weaknesses of studies. The researchers concluded with defining common components of effective brief interventions and discussed implications for future research and practice.

In a more recent project from 1994 to 2002 researchers at the University of Connecticut's Alcohol Research Center (Babor et al., 2006) studied the practicality and effectiveness of a low-cost intervention addressing high-risk drinkers entering managed care clinics. Lessons learned from these studies helped direct the course of this proposed project.

According to National Institute on Alcohol Abuse and Alcoholism (NIAAA; 2004), at-risk drinking and alcohol problems are common throughout the United States. Although much effort and funded services go into treating the alcohol dependent person, findings from the 1992 National Longitudinal Alcohol Epidemiological Survey (NIAAA, 1998) indicates that high-risk drinkers make up 20 percent of respondents, much higher than the 4 to 5 percent measuring as alcohol dependent. Rehm et al. (2003) determined that heavy drinkers have a greater risk of hypertension, gastrointestinal bleeding, sleep disorders, major depression, hemorrhagic stroke, cirrhosis of the liver, and several cancers. The Institute of Medicine's (1990) report stated that if alcohol problems are to be significantly reduced, the foremost focus of interventions should be with people who have a mild or moderate alcohol problem.

The Institute of Medicine (1990) also reported that problem drinkers seek some type of consultation within medical health care or other social services more frequently than alcohol specific treatment services. If any alcohol-related services are rendered by these nonspecialists, it may consist mainly of referring the problem drinker to an alcohol specific service. Often times the problem drinker does not follow through with any recommended alcohol-related service (Bien et al., 1993). Chafetz et al. (1962) found that of the twelve-hundred diagnosed alcoholics entering an emergency room and recommended to seek alcohol treatment, less than 5 percent followed through. A later study conducted by Luckie, White, Miller, Icenogle, and Lasoski (1995) found a similar 5 percent referral followed through in a veteran's health care facility. The introduction of a brief alcohol intervention emphasizing an empathic, respectful, and caring counseling style significantly increased a subsequent appointment (e.g., from 5 percent to 6 percent up to 65 percent to 78 percent; see Chafetz, 1961; Chafetz et al., 1964; Demone, 1963). Bien and colleagues (1993) reported that brief interventions in health care facilities have been tested against untreated controls trials in fourteen nations. Of the dozen studies designed to increase follow-up referrals to alcohol specialists, all but one found significant effects (Bien et al., 1993). According to Holder and Blose (1992), based on current published clinical trials, a brief counseling intervention was among the strongest supported intervention modality in health care settings for alcohol problems as well as the most cost effective.

Lessons Learned from Screening and Brief Intervention Studies and How It Helps in the Development and Implementation of Best Practices

As the result of Bien et al.'s (1993) work and other lessons learned, the researchers concluded that common elements exist among effective brief interventions, they have: (1) significantly more positive effect than no alcohol-related intervention, (2) similar effects as a more extensive intervention, and (3) improved effectiveness on subsequent treatment services. According to Williams et al. (2006) most primary care patients who screen positive for heavy drinking or alcohol use disorders showed some motivational readiness to change, with those who have the most severe symptoms being the most ready.

CBMHOs are in a prime position to screen and intervene on large amounts of individuals seeking some level of health services. Clinical trials have demonstrated that brief alcohol interventions can advance significant, lasting reductions in drinking levels in at-risk drinkers who are not alcohol dependent (Fleming et al., 2002). A number of drinkers evaluated as being alcohol dependent will better accept referral to addiction treatment programs as the result of integrating a screening into standard care (Fleming et al., 2002). Even for patients who do not accept a referral to further alcohol services, repeated alcohol-focused visits with a health provider can lead to significant health improvement (Lieber, Weiss, Groszmann, Paronetto, & Schenker, 2003; Willenbring & Olson, 1999).

Often times heavy drinking goes undetected throughout CBMHOs. The NIAAA developed a clinician's guide for helping patients who drink too much (NIH, 2005). This guide was created and tested within medical, primary care providers to integrate an alcohol intervention into standard medical care services. Its overall goal was to assist medical professionals 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 patients who are considered at-risk drinkers. Clinical trials also have demonstrated that repeated alcohol focused brief interventions with a health care provider can lead to significant improvements for dependent drinkers (Willenbring & Olson, 1999). In a recent study of primary care practices, for example, patients with alcohol dependence received the recommended quality of care, including assessment and referral to treatment, only about 10 percent of the time (McGlynn et al., 2003). Clients are likely to be more receptive, open, and ready to change than many service providers expect. According to Miller, Thomas, and Mallin (2006), most patients did not object to being screened for alcohol use by clinicians and were open to hearing advice afterward.

With the evidence being clear that implementing an alcohol screening and brief intervention in health care settings produces widespread positive outcomes (Babor, Aguirre-Molina, Marlatt, & Clayton, 1999; Babor & Higgins-Biddle, 2000; Babor, Higgins-Biddle, Higgins, Gassman, & Gould, 2004; Babor, Higgins-Biddle, Dauser, Higgins, & Burleson, 2005; Babor et al., 2006; Bien et al., 1993; Fleming & Manwell, 1999; Kahan, Wilson, & Becker, 1995), many of these studies discussed organizational barriers as the next prime area of study. Babor et al. (2005) stated that "... implementation of both screening and brief intervention was associated with organizational factors and provider characteristics" (p. 367). Although provider training and orientation has been reported as being possible barriers, Roche, Horham, and Richmond (2002) emphasized a major paradigm shift away from training obstacles to factors encapsulating organizational structures.

Conclusions

Understanding the impact that an organization's culture and climate have on the successful implementation of clinical interventions and measuring these organizational issues would seem essential before implementing any new intervention into its system. Measuring organizational barriers and responding to those barriers prior to the introduction of new interventions could improve the intervention's adoption and sustainability rates over time, which would also positively impact the intervention's effectiveness on client outcomes. Babor et al. (2005) made a strong case for studying organizational factors. The researchers stated that independent of the delivery model, organizational factors are "... significantly associated with implementation success and should not be ignored in the planning and implementation of alcohol screening and brief intervention programs" (p. 367). In 2007, Babor et al. concluded that "... the extent to which a given delivery model is likely to work best within a managed care organization depends on complex provider and organizational characteristics" (p. 21). Of particular interest is Robert Wood Johnson Foundation's April 2007 cutting back report (Robert Wood Johnson Foundation, 2008) indicating that alcohol screening and brief intervention had not been tested outside of research settings and that a large amount of knowledge remains unknown. The health care field needs to move beyond "if" EBP adoption training should be part of the clinical process, and needs to consider measuring how to best implement these proven practices. With the evidence clear that a certain practice works, such as the alcohol-related intervention discussed earlier, the next step is to make sure it is implemented as a standard practice in all CBMHOs with as few barriers as possible. Health care workers cannot assume that just because research has proven that an intervention is effective in research settings it will be easily incorporated into

regular practice. There needs to be a concentrated and purposeful effort to implement EBPs into existing CBMHOs, making sure to pay close attention to organizational and any other barriers that may be present.

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