LOOKING FOR DIFFERENCES WHEN EVERYTHING'S THE SAME:

The Role of Organizational Culture in Improving Client Outcomes

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OVERVIEW

- Residential behavioral health treatment, whether for MH crisis stabilization or for SUD treatment, tends to follow many standardized practices.
- However, many of these practices may have evolved not from evidence-based practice, but for convenience (of the staff) or other reasons.
- Changing some of these standard practices can have significant impact on client experience, which translates to both better outcomes and improved client perception of the treatment experience.
- Changing these practices – finding and creating the *differences* that make our programs stand out from others in a meaningful way – means *organizational change*.
- There are “naughty things” no one talks about. We’ll cover some of those.

CULTURE

Culture is critical. It defines us, guides decisions, strengthens teamwork, creates consistency and cohesion among the staff.

- A *client-centered culture* promotes autonomy, empowerment, and improved outcomes. What does that look like?
- Look at power imbalance. How often do clients really get to choose what they're doing?

  How can we do this differently?

CULTURE

Foundational work on organizational culture and mental health comes from Fallot & Harris' (2009) work on trauma-informed cultures.

- Trauma affects the way people approach potentially helpful relationships
- Trauma can occur in the service context itself
- Trauma affects staff members as well as consumers in human service programs.

POWER STRUCTURES

- *Power structures* are present in every organization but rarely talked about. They deeply impact client experiences and can affect outcomes.
- If we don't talk about culture and power structures, they can become weaponized.
- If our clients don't feel empowered, they don't learn to develop autonomy and ability to manage their day-to-day issues. We may teach the skills, but the client doesn't get much opportunity to practice them.
- *Reducing the power imbalance* between clients and staff yields greater client satisfaction, the client gets the opportunity to practice the tools they are learning, and that, in turn, is going to improve client outcomes.

TRAVELER AND GUIDE MODEL (FORD, 1989)

- Clyde Ford, MA, D.C., a therapist originally trained as a chiropractic physician, developed the *traveler/guide* perspective while working with clients that needed help, but hadn't had success in the past. His approach to mind/body healing, called *Somatosynthesis*, incorporates the *traveler/guide* model to help clients find healing.

- Instead of *expert and patient*, Ford's (1989) *traveler and guide* model sees the client as knowledgeable and capable, and the staff member not as an expert, but as an experienced traveler along a similar path who can guide and assist the client.

- When we adopt the traveler/guide model, we recognize the client as expert in their own healing, and empower them to find the right path, with our help and guidance.

PATERNALISM

- This arises from the inherent imbalance in power dynamic. It is a double edged sword, as some paternalistic actions are likely necessary and appropriate (Bladon, 2019). However, constant awareness of its existence allows us to reduce the power imbalance.

  - *Examples of paternalism:*
    - Imposing treatment decisions without authentic patient collaboration. Getting a client to sign a pre-prepared treatment plan, rather than discussing client's goals, for example.
    - Restricting a client's rights and freedoms
    - Prioritizing the provider's perspective over the client's
    - Dismissing a client's concerns or experiences
    - Rigid and inflexible scheduling

IMPACTS OF PATERNALISM

- Damaged therapeutic relationship / rapport
- Compromised autonomy and self-determination
- Reduces the focus on patient-centered care

REDUCING PATERNALISM

- Encourage and advocate patient autonomy
- Foster a *truly* collaborative approach; involve clients in all decision making
- Implement an organization-wide trauma-informed approach to treatment that involves every policy and staff member (see Fallot & Harris, 2009)
- Implement burnout prevention strategies for staff

SUBTLE COERCION

Subtle coercion refers to indirect or less overt means of influencing a client's behavior or decisions that covertly reduce client autonomy and self-determination (Norvoll & Pedersen, 2016).

- *Examples of subtle coercion:*
  - Incentives, rewards, or privileges for compliance with treatment
  - Threats of consequences (implied or direct), such as loss of privileges or increased restrictions
  - Pursuasion and encouragement to encourage a specific outcome
  - Interpersonal leverage, such as offering help with a legal issue in exchange for compliance with treatment
  - Inducements, such as financial or material incentives for compliance

SUBTLE COERCION – IMPACTS

- *Potential impacts of subtle coercion:*
  - Perception of unfairness, if clients feel manipulated
  - Erosion of trust, when clients experience their autonomy being compromised
  - Ethical concerns: The balance between client autonomy and well-being can easily be lost when subtle coercion is used.

REDUCING SUBTLE COERCION

- *Strategies to reduce subtle coercion:*
  - Implement an organization-wide trauma informed approach to treatment (see Fallot & Harris, 2009)
  - Provide holistic, comprehensive case management that is client-driven
  - Train staff in de-escalation and non-coerciev approaches
  - Monitor and evaluate the use of subtle coercive measures

INDIVIDUALIZED CARE AND SUSPENDING JUDGMENT

- All clients deserve excellent care, regardless of their demeanor, attitude, emotional expression, communication style.
- Excellence in care means that each client's needs are attended to with openness and recognition that each path to healing may be different.
- We all claim to do individualized treatment, but how often is treatment actually individualized, or at least actually individualized outside of the one-on-one counseling session?
- How can we (staff members) individualize every client interaction?
- Set the standard that each interaction begins with a question

THE ROLE OF STAFF IN CULTURE

- Organizational culture, for better or worse, is largely a product of what staff *perceives* about the organization and its culture. Regardless of what leadership *says*, culture will be defined by *how staff experience organizational culture*.
- This requires every-day practice by staff in empowering clients. *Repetition in modeling to staff is key!*
- If we want meaningful, positive organizational culture, leadership must model it every day, in every way.

ACHIEVING STAFF BUY-IN

- To achieve and sustain cultural change, *staff must buy into the process*. Their day-to-day involvement is crucial in setting the tone, nurturing and supporting the developing culture, and living the organizational values with every client interaction.
- For that to happen, *staff must be willing to look at their own wounds as well as their own biases and beliefs*. Perceptions held about particular disorders, behaviors, or traits (or even the best way a client should approach them) can negatively influence quality of client care.

AVOIDING THE "STATUS QUO"

- The SUD field in particular is used to labeling clients ("the borderline in room 8" or "the schizophrenic in room 12" or even "I'm an alcoholic" or "I'm an addict.")
- This dehumanizes clients in the staff's mind. It is also disempowering to clients; the client is not their diagnosis. Each client is on a unique journey. Our role is to guide them. We can't do that if we label and devalue them.
- When staff members use "What worked for me" as a "go-to" for clients, this is often not what's best for the client. Intellectual curiousity, openmindedness, and flexibility must be developed and nurtured. Staff can support clients regardless of whether their path to healing is the same or completely different than the staff member's path.

SUPPORTING STAFF IN MAKING CHANGE

- Resistance is a normal part of change. If we aren't seeing resistance in our staff, we likely are not facilitating change.

- The key is "rolling with the resistance."
  - Listen to staff concerns with a supportive ear.
  - Acknowledge that change can be hard.
  - At the same time, hold firm to new policies and redirect.
  - Consistency from management will help staff adapt to new policies.

CHALLENGES WITH STAFF RESISTANCE

- No matter how beneficial, some staff will be resistant to learning new or different approaches or accepting cultural shifts.
- Leadership must be patient and encourage these staff to be openminded.
- Some staff members may ultimately find that a different organization is a better fit for them.
  We may have to help them make this decision.
- Keeping even one staff who is openly resistant or negative can undermine the entire cultural change.

RULES AND BOUNDARIES

- Some rules and boundaries are *necessary*, but those established for staff convenience, not excellence of care, they should be reconsidered.
- When considering policies that impact clients, the *least invasive approach* will most empower clients. Removing barriers help clients lead.
- This isn't quite a peer-led model, but has greater autonomy than a traditional model. It is collaborative rather than directive. (Deagan, 1997). Authenticity is crucial.

RULES AND BOUNDARIES

- Boundaries and rules must be consistent. Would you give every client your cell number? How do we teach and model consistency to our staff?
- Client autonomy and choice is important, but must be balanced against the needs of other clients and necessary (usually regulatory) policies.

ORGANIZATIONAL INVESTMENT

- Prioritizing corporate culture requires significant investment. It requires training, follow-up, and constant nurturing for at least the first year.
- Why do this when so many other values are competing?
  - Investing in culture helps *set your organization apart* from others.
  - More empowered clients means greater client satisfaction and success.
  - Innovatiion and evolution enables us to serve a constantly changing clientele. We must be willing to constantly "reinvent" in order to remain relevant.
  - Many programs successfully grow to serve a larger portion of the community by offering a mix of services and payors/funding sources, to best address the needs of the served community

CHALLENGING CURRENT THINKING: THE NAUGHTY THINGS

- Much of what we do is about convenience or familiarity rather than what's best for clients.
- The peer-led model is effective but flawed. It is often "Monkey See, Monkey Do." Peer-led models *often overlook the client's unique experience*.
- Due to lived experiences, it's common for a peer workforce to have more biases and judgments. Many don't have the training needed to widen perspectives, or have not had the chance to work on their wounds. They may be triggered or otherwise have difficulties. This is especially true In the SUD/MH workforce.
- Labeling clients In SUD treatment is still status quo. Stigma still exists, especially when it comes to mental health diagnoses. Many front-line SUD workers are afraid of, or biased against, those with personality or thought disorders.

CHALLENGING CURRENT THINKING: THE NAUGHTY THINGS

- "Crisis management team" team has a specific meaning.
- Though substance abuse is a crisis, it is often not seen that way.
- SUD clients in early recovery can't manage their emotions, thoughts, interactions, and behavior. It is these crisis stabilization services that are the "first line" in helping these SUD clients manage early recovery.
- This is where the "Traveler/Guide" model is so valuable. We address the crisis not from a place of power, but from a perspective of service and guidance.

TAKEAWAYS

- How does your program define itself?
- What is your current culture?
- Is your current culture what you want it to be?How do staff verbalize culture?
- If it's not what you want, how do you change?
- Are you prepared to invest? Not just a one-day training, but ongoing training and support?
- Consider challenging your perceptions, your leadership's perceptions, and looking for ways you can innovate.

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