

Research Summary

Focus on Organizational Change

Special Issue

IBR Web Site: www.ibr.tcu.edu

September 2002

Organizational readiness for treatment innovations

[D. Dwayne Simpson, Ph.D.](#)

IBR Director & S.B. Sells Professor of Psychology

See Special Issue of *Journal of Substance Abuse Treatment* on "Transferring Research to Practice." [Simpson & Brown (Eds.); 2002, Vol. 22 (4)]

Although the literature identifies major factors seemingly involved in transferring drug treatment research to practice, understanding how to do it effectively needs improvement.¹ Therefore, incorporating them as elements in an integrated framework could help advance the scientific progress and practical contributions in this field, including development of a set

of assessments for patient, staff, and organizational dimensions represented. This kind of infrastructure is particularly important for conducting systematic studies of efforts to disseminate feasible and effective treatment innovations. By establishing a general "model of program change" representing major stages of change and factors that promote or inhibit success, the process involved can be more readily communicated, studied, and refined.

Influence of organizational attributes

Although "change" at both the personal and organizational level is constant and universal, making it intentional and positive requires attention. This is especially true at the organizational level, which incorporates the collective attitudes, actions, and relationships of a group of individuals. There is growing

consensus that problems in transferring research to practice are more likely to be due to organizational factors (e.g., leadership attitudes, staff resources, organizational stress, regulatory and financial pressures, management style, tolerance for change) than how materials are disseminated.

A process model of program change

There are 4 general stages of “transfer”—**Exposure, Adoption, Implementation, Practice.**

A program change model¹ that integrates findings from the literature is summarized in **Figure 1**. At the core of this heuristic framework are the four action steps typically involved in the process of technology transfer. *Exposure* is the first stage, usually involving training through lecture, self-study, workshops, or expert consultants. The second stage, *adoption*, represents an intention to try an innovation. While this might be a “formal decision” made by program leadership, it also includes subtle levels of commitments made by individual staff members about whether an innovation is appropriate at a more personal level and should be tried. *Implementation* comes next, implying that there is a period of trial usage of the new innovation to allow

testing of its feasibility and potential. Finally, the fourth stage moves to *practice*, reflecting the action of incorporating an innovation into regular use and sustaining it (even if it is in some modified form).

Stage 1 – Exposure

In regard to the first stage—exposure—the literature suggests that there must be adequate readiness for change as indicated by **motivation** (defined by perceived needs and pressures for change) from program leaders and staff members as well as sufficient **institutional resources** (staffing, facilities, training, and equipment) for realistically considering innovations. Indeed, any of these factors can operate as barriers to staff training.

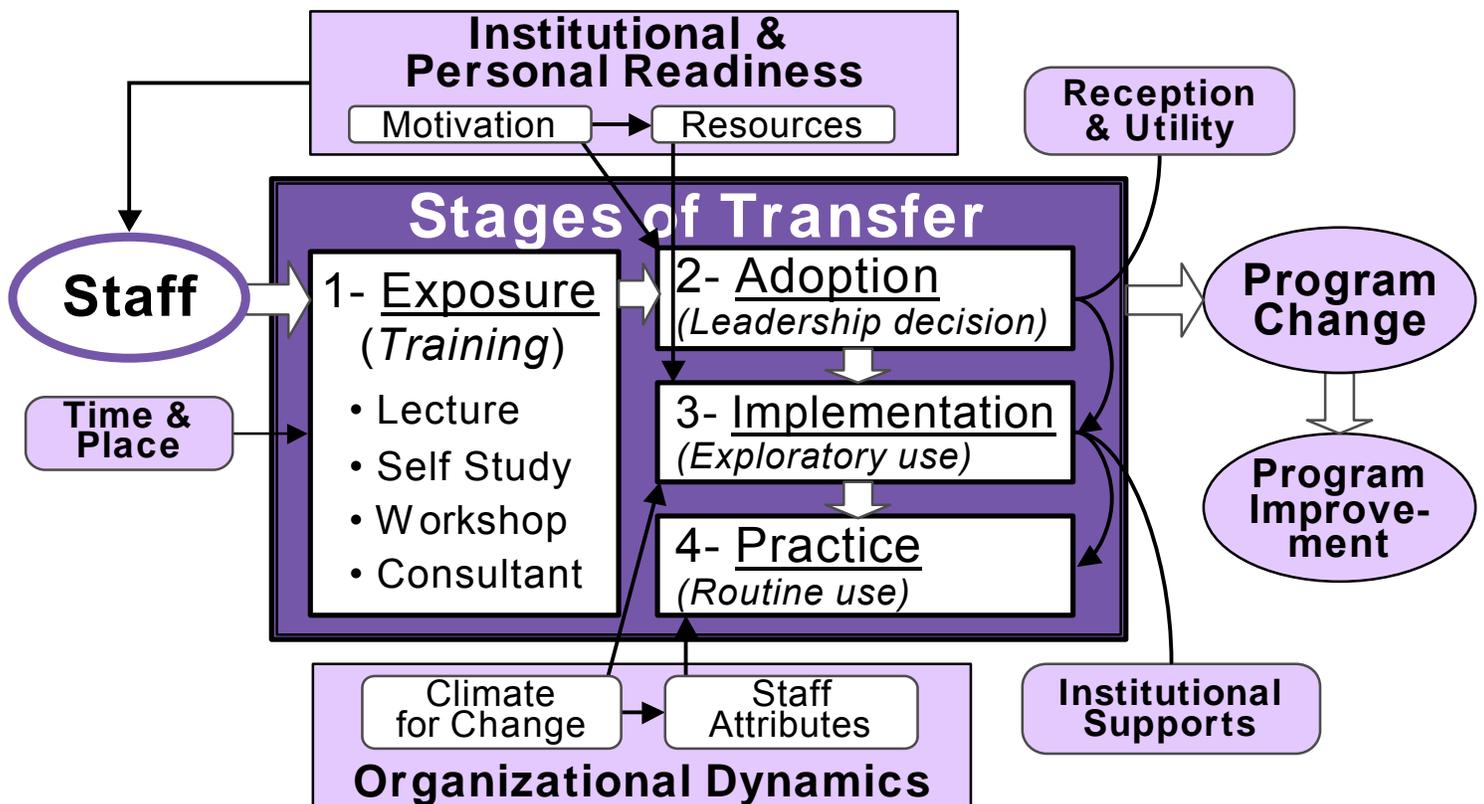


Figure 1. TCU program change model (Simpson, 2002).

Another obvious consideration involves **convenience** of the training opportunities (e.g., time and place).

Stage 2 – Adoption

Without motivation or pressures for change, it is unlikely that new innovations will be adopted. Furthermore, decisions about adoption of new techniques or procedures can be made at either the individual or group level. For instance, individual counselors may find a specialized counseling technique intriguing and worth incorporating into their personal practice, or several staff members may decide collectively to adopt an innovation. Such decisions are guided in part by **reception and perceived utility** of the innovation. This includes adequacy of the training received, perceived ease of use, and how well it fits (or has value) within the accepted therapeutic scheme and abilities of the users.

Stage 3 – Implementation

Implementation—stage 3 of transfer—calls for adequate resources and an atmosphere conducive to carrying through on decisions to adopt an innova-

tion. Important organizational dynamics include an appropriate **climate for change** (e.g., clarity of mission and goals, staff cohesion, clinical autonomy, communication, stress, and openness to change) as well as **institutional supports** that encourage and sustain an innovation. This refers to monitoring, feedback, and the provision of formal as well as informal rewards that reinforce positive program changes.

Stage 4 – Practice

And finally, whether a new innovation is incorporated into standard clinical practice—stage 4—depends on **staff attributes** (e.g., professional growth, efficacy, influence, and adaptability) and institutional supports that promote the change process. Klein and Sorra² stress the importance of fit between innovations and organizational dynamics (including staff skills), while Andrzejewski, Kirby, Morral, and Iguchi³ illustrate the value of using feedback and positive reinforcement for effectively putting an innovation into place (e.g., a contingency management intervention).

A TCU Project on “Transferring Drug Abuse Treatment and Assessment Resources” is funded by NIDA to study the process of technology transfer.

Organizational-level assessments

Evaluation and refinement of the model of program change proposed in Figure 1 depend on having appropriate assessments. Organizational-level assessments are perhaps the most challenging because they require data to be taken from individuals within an organization (e.g., leaders, staff, patients) and then aggregated in ways that represent “the organization.” Selection of appropriate scales, data collection format, reliability and validity of measures, selection or sampling of individuals to properly represent the organization, and methodological

alternatives for aggregating data are issues that must be addressed. A set of TCU assessments designed to address these needs are summarized in our *Research Summary on Treatment Assessments* and are available for downloading without charge from our Web site at www.ibr.tcu.edu.

TCU Program Training Needs (PTN)

The [TCU Program Training Needs \(PTN\)](http://www.ibr.tcu.edu) survey is used for identifying and

Assessment instruments are available through our Web site at www.ibr.tcu.edu in the [Forms](#) sections.

prioritizing treatment issues that programs believe need attention. Program directors are asked for a brief description of their program and staffing, followed by ratings of program training needs and pressures as well as diagnostic and billing procedures. In a separate but parallel form, individual staff members are asked about facilities and climate, satisfaction with training, preferences for training contents and procedures, computer resources, and barriers to training. Collectively, this type of information should help guide overall training efforts as well as predict the types of innovations that participating programs are most likely to seek out and adopt.

TCU Organizational Readiness for Change (ORC)

The [TCU Organizational Readiness for Change \(ORC\)](#) assessment focuses on motivation (program needs, training needs, and pressures for change), program resources (offices, staffing, training, and equipment), staff attributes (growth, efficacy, influence, adaptability, and orientation), and organizational climate (mission, cohesion, autonomy, communication, stress, and change). Parallel versions are available for the program director (or clinical supervisor) and the counseling staff.⁴ It focuses on organizational traits that predict program change, and can serve as a diagnostic tool for planning interventions to improve organizational functioning.

Comments

The successful transfer of evidence-based innovations to real-world applications requires careful planning, implementation, and on-going evaluations of the progress being made.⁵ The TCU Program Change Model suggests general principles for practice and

research, but it is should be emphasized that each situation is somewhat unique and all innovations are not equally complex. Systematic study of the process is therefore needed in order to provide guidance for maximizing the effects of training. ■

References

1. Simpson, D. D. (2002). A conceptual framework for transferring research to practice. *Journal of Substance Abuse Treatment*, 22(4), 171-182.
2. Klein, K. J., & Sorra, J. S. (1996). The challenge of innovation implementation. *Academy of Management Review*, 21(4), 1055-1080.
3. Andrzejewski, M. E., Kirby, K. C., Morral, A. R., & Iguchi, M. Y. (2001). Technology transfer through performance management: The effects of graphical feedback and positive reinforcement on drug treatment counselors' behavior. *Drug and Alcohol Dependence*, 63, 179-186.
4. Lehman, W. E. K., Greener, J. M., & Simpson, D. D. (2002). Assessing organizational readiness for change. *Journal of Substance Abuse Treatment*, 22(4), 197-209.
5. Addiction Technology Transfer Centers. (2000). *The change book: A blueprint for technology transfer*. Rockville, MD: Center for Substance Abuse Treatment.

RESEARCH SUMMARY: Focus on Organizational Change is published by: **Institute of Behavioral Research, Texas Christian University**, TCU Box 298740, Fort Worth, TX 76129. Phone: (817) 257-7226; FAX: (817) 257-7290; E-mail: ibr@tcu.edu Web site: www.ibr.tcu.edu. Prepared by Dwayne Simpson and Charlotte Pevoto.

Copyright © 2002 Texas Christian University, Fort Worth, Texas. All rights reserved.