Chapter

Management Practices to Enhance the Effectiveness of Substance Use Disorder Treatment

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Abstract

Managers of substance use disorder (SUD) treatment organizations face significant challenges to improve treatment effectiveness. The field has paid significant attention to the delivery of pharmacological and psychosocial treatment interventions, and the effectiveness of these interventions, with little consideration for the role of management practices that enhance the delivery of such evidence-based practices (EBPs). This chapter describes evidence-based management practices (EBMPs) that may support the effective and consistent delivery of EBPs in SUD treatment. Drawing from a socio-technical and cultural framework, we propose a management approach that relies on policies, human resources, and culturally responsive practices to directly and or indirectly facilitate the delivery of EBPs. In particular, this chapter describes EBMPs that could be widely implemented to respond to the cultural, linguistic, and service needs of racial and ethnic minority groups. We discuss implications for funding and support of management training to improve standards of care and include a case example to promote reflection.

Keywords: evidence-based management practices, effectiveness, workforce diversity, substance use disorder treatment

1. Introduction

Evidence-based management practices (EBMPs) are grounded on evidence with significant empirical support to facilitate organizational change and performance improvement [1, 2]. As such, EBMP refers to meso and macro practices that may enhance the effectiveness of micro practices (e.g., EBPs or interventions at the practitioner-client level). Emerging evidence suggest that EBMPs play an important role in the effectiveness of behavioral health services by supporting the process of service delivery [3–6]. EBMPs are therefore increasingly important to respond to the high demand for public accountability, organizational performance and implementation fidelity in health and human services [7].

The substance use disorder (SUD) treatment field has focused on clinical interventions that show effectiveness in reducing substance use. In particular, there has been significant development of EBPs in the use of medication and psychosocial interventions to reduce substance use or support abstinence. Yet, there is limited application of evidence-based management practices (EBMPs) that support the delivery and integration of EBPs into routine practice. Once an intervention is

considered effective, it is critical to understand the contextual factors that play a role in supporting effectiveness in the delivery and continued use of the intervention.

Management in SUD treatment organizations are a complex and multifaceted practice that seeks to improve the structure, technology and human resource capacity to enhance service delivery and achieve positive treatment outcomes [8]. Managers consequently play a critical role to develop, implement, and sustain EBPs [9, 10]. Although managers tend to rely on personal experience to inform practices used in their organizations, it is critical to develop management capacity to rely on EBMP to enhance the impact of EBPs in SUD treatment [5, 11].

Managers in SUD treatment organizations face significant challenges to increase access to care and ensure high rates of recovery from SUD. Among the most documented challenges to enhance access to effective care include preparing the workforce to deliver culturally responsive and evidence-based treatment [12, 13], develop a sustainable funding approach and relying on technology to track staff performance and client progress. To do so, managers need to rely on best practices in human resources, finance and staff and client progress measurement [12, 14–16]. The field of management in SUD treatment could benefit from more than 100 years of management research. Drawing from this discipline, there are at least three EBMPs that could improve the effective implementation of EBPs in SUD treatment. The management practices with significant evidentiary bases include: (1) goal setting, (2) feedback and redesign models, and (3) total quality management. Our emphasis on these practices, among the range of evidence-based management practices, is grounded on the context of social service organizations. Specifically, these practices are relevant to the organizational challenges most implicated in the effective delivery of substance use disorder treatment, and challenges where they are mostly to have impact. We select these practices in line with the unique challenges faced by managers in substance use disorder treatment programs (e.g., organizational capacity, staffing) [17]. These management practices also consider various levels of challenges, i.e., development/pre-implementation: establishing alignment between expected outcomes and goals by putting in place systems that support the outcome; testing/implementation: a double-loop approach to learning and adapting to change; and continuous/post- implementation: engaging staff at all levels of program to ensure maintenance of effectiveness and quality.

2. Evidence-based management practices

Goal-setting is defined as a motivational technique that is used to set specific goals that will enhance performance, with more-difficult goals resulting in higher performance [18]. Goals help motivate individuals to accomplish challenging objectives by establishing specific and measurable targets. Research on goal-setting practice has further suggested that when team members work together towards a common goal, it helps ensure that the goal will be achieved [18]. Goal-setting as a practice has its limitations because it does not take into consideration the factor of time [19]. For instance, in an organization, accomplishing a given goal, and specifically by a certain specified time, may not be aligned with supervisors' overall assessment of when the set goal is to be realized, or the organizations expectations for the goal. This misalignment has implications for how tasks and resources are prioritized and managed over time. As a result, varying understanding and expectation of time horizons may create direct conflict between employers and employees within the organization, and thus lead to weakness in overall performance. Aligning priorities and setting realistic timelines are among the many issues that managers need to address to benefit from the goal-setting practice.

Goal setting is however an EBMP that could be implemented in SUD Treatment organizations. Although this practice requires training and persistence in the supervisor-counselor relationship, it does not require an elaborate plan, costly resources, or a complex structure. It requires managers' careful assessment of staff members' strengths and limitations, as well as the facilitators and barriers to ensure a successful service outcome. The practice is also alike the treatment planning process that counselors review with clients to support their positive treatment outcomes, such as sobriety. Considering its low-cost, simplicity and ease of implementation, this practice is highly recommended for SUD treatment settings.

Feedback and redesign model is a more comprehensive EBMP, which considers four steps: context, behavior, impact, and future steps. Context describes the situation in which the individual is allotted time to provide feedback [20]. In the next phase, the individual describes their behavior, given the context, as clearly as possible, to draw conclusions. This has an impact of the situation, and the feedback may be positive or negative. The nature of the impact then leads to discussions of specific behaviors to determine if a redesign or change should be implemented. The interconnectedness of the analysis between feedback and redesign can then be used by managers to help individuals plan, evaluate, and overcome challenges [21].

The feedback and redesign model offers managers of SUD treatment services the opportunity to comprehensively assess micro and meso level factors that play a role in accomplishing the desired goal. Managers may use this model in clinical supervision, where counselor-client context, and counselor's intervention and desired outcome are constantly the focus. This model has informed well-known interventions such as the Plan-Do-Study-Act (PDSA) cycle. The PDSA approach relies on a scientific method applied to action-oriented learning. The goal is that to test isolated changes, organizations need to plan the change, try it, observe the results, and act on what is learned. Researchers have pilot tested this intervention in several studies to enhance treatment access and retention. The Network for the Improvement of Addiction Treatment (NIATx) model [22] uses a Plan-Do-Study-Act (PDSA) cycle. This cycle is designed to identify issues and create solutions (Plan), implement new processes (Do), evaluate outcomes (Study), and establish change practices (Act) [23, 24]. In the public health system in Los Angeles County, researchers have tested the PDSA approach to improve treatment retention with positive results [25].

The Plan-Do-Study-Act can be resource intensive, particularly for small treatment organizations that lack the guidance, personnel and time to implement such rigorous cycles. But, there is increasing support from government and foundations to help small treatment organization form coalitions to support PDSAs in their communities. As such, the PDSA can be considered a EBMP that could improve the effectiveness of SUD treatment.

Total quality management (TQM) or continuing quality management (CQM) model is another model with supportive evidence to improve service effectiveness. Coined by William Edwards Deming [26], total quality management (TQM) is defined as a system of management that views every staff member of an organization as responsible for maintaining the highest standards of work within every aspect of the organization's operation. TQM is used in organizations to help improve procedures in all areas of functionality [27]. TQM has become a popular management approach because it strives to improve product quality and interactions with customers and suppliers, which are linked to organizational design and change. Subsequently, the quality of a business has become an important aspect of an organization's success. Although TQM is prevalent within organizations, it requires extensive training. This approach has been mainly used and tested in manufacturing, with little exposure to health and human services. Studies focusing

on health care have sought to integrate TQM into a continuing quality management framework applied to healthcare. Existing evidence suggests significant benefits of implementing this framework in healthcare services [28].

Although the TQM, or CQM perspective can be resource intensive, it may allow SUD treatment systems to examine more broadly every aspect of the process of care. This approach can be used by state or county level administrator of healthcare services to guide quality improvement efforts. For instance, TQM can be applied to each step in the process of care, which may be divided by phases—e.g., outreach, intake, assessment, treatment planning, discharge, continuing of care. The culmination of efforts within each phase would then factor into improved service delivery and effectiveness.

3. Evidence-based management in SUD treatment organizations

The SUD treatment field has gradually built a series of EBMPs informed by managers' experience, and the continuous need to respond to a complex regulatory and funding environment. For instance, under health care reform, SUD treatment organizations are expected to become more systematic in service delivery and accountable to service outcomes, requiring the use of EBMPs to support the implementation, delivery, and effectiveness of EBPs.

The concept of evidence-based health care has led to a significant shift in the way health care professionals use evidence from scientific research and practice. Managers often encourage drug treatment counselors to adopt an EBP approach to practice, yet managers in SUD treatment often lack formal education in management, or the managerial capacity to rely on EBMPs to support delivery of EBPs [11]. The increased interest in developing EBP in the management of health care organizations is mainly due to wide variation in the implementation and effect of clinical EBPs [29].

The selection, implementation, sustainment, and influence of effective EBPs depend on how health care services are financed, regulated and delivered [11]. Leaders of health and social services system have begun to call for translation of findings from behavioral economics, cognitive and social psychology, management science, and social work, among other disciplines, to inform EBMPs [30]. Communities of scientist, academicians, and practitioners have also been encouraged to work together to translate current management practices with significant evidence, as well as to invest in the development of practical responses to current management challenges [30]. As such, practitioners will not need to rely on personal experience and local knowledge to address challenges that stem from principles addressed in research and science. We extend the socio-technical framework [12] of SUD treatment systems and include a cultural aspect to respond to the cultural and linguistic service needs of racial/ethnic minority clients. This social-technical framework posits that community and organizational factors enhance access to treatment services and the use of EBPs [18]. We categorized EBMPs relevant to SUD treatment organizations into four main areas: *Policy, Social, Technical and Cultural Practices.* These practices operate at different levels to impact organizational and treatment level outcomes.

4. Management practices that rely on policy factors

The policy context of SUD treatment is critical to determine whether a policy initiative can be evidence-based to enhance access to care [11]. The Affordable Care Act (ACA) legislation abolished categorical restrictions on eligibility for Medicaid

that have traditionally limited enrollment to children, parents, and individuals with qualifying disabilities. By removing insurance restrictions and thus, reducing financial barriers, these ACA changes have the potential to improve access to substance abuse treatment [31, 32]. Hispanics are at the highest risk of being uninsured, with non-elderly adult Hispanics nearly two and half times as likely to be uninsured than non-elderly adult Whites (22 vs. 9%). Since the implementation of the ACA, the percentage of clients without insurance in predominately African-American OTPs dropped from 45% in 2014 to 20% in 2017; similarly, this percentage dropped from 49% in 2014 to 27% in 2017 in predominately Hispanic programs. Because Medicaid expansion was deemed optional after the ruling in National Federal of Independent Business *v. Sebelius*, gains in insurance access and, in turn, treatment access, has been shown only in states that chose to open program eligibility to all low-income adults [33].

Management practices that rely on policy changes or practices, such as the ACA, can significantly improve access to care for under-represented population groups, including Hispanics and African-Americans, who remain more likely to be uninsured than Whites. Medicaid expansion and program acceptance of Medicaid reduces barriers to access treatment for racial and ethnic minority groups [34]. This is because SUD treatment programs are motivated to admit individuals to treatment to the extent that they have insurance coverage. We thus highlight Medicaid expansion as evidence-based policy practice.

5. Management practices that rely on social factors

5.1 Staff to client ratios

Prior work shows that staff to client ratio is an important predictor of the use of evidence-based practices in the nation's SUD treatment programs [35]. As this ratio increases, clients are more likely to receive medical and social services [12]. The likely mechanism in this relationship is staff time devoted to clients. That is, when caseloads increase, staff member simply does not have the time to respond adequately to clients' service needs, including, for example, making referral arrangements to link clients to needed services that are often located off-site [36]. Effective management of staff to client ratios can be considered an EBMPs that may support quality of care, particularly for vulnerable clients that need integrated care services.

6. Management practices that rely on technical factors

Resources available to SUD treatment programs are likely to play an important role in their behavior. Workforce, (staff-client ratios) technology (use of electronic health records), and quality improvement initiatives (accreditation) as resources, are therefore catalysts for the use of EBPs.

6.1 Financing models

Due to fewer financial resources, programs that serve higher percentages of minority clients are less likely to have or use electronic health records (EHRs). Prior work shows that EHRs play an important role in managing and coordinating client care, especially linking clients in substance abuse treatment to mainstream health care providers [37, 38]. For example, programs with high percentages of minority clients rely heavily on public funds (Medicaid reimbursement and state block grants) which provide lower levels of financial support to cover expenses for their

operations—including payroll for staff salaries; funds to purchase and maintain information technology systems for electronic health records; and funds for staff training and quality improvement programs. In comparison, programs that serve higher percentages of white clients might have, on average, more funding from private insurance, client self-pay, and donations. These funding sources might enable support for the integration of more EBPs like medical and mental health services, as well as the linkage with social services and the provision of aftercare services. Having EHRs may also be considered a management practices to enhance quality of care [35]. Hence, diversifying funding streams and increasing revenue from private insurance, self-pay and donations can be considered a management practice that can directly enhance the delivery of EBPs.

6.2 Professional accreditation

Prior research shows that SUD treatment programs that hold accreditation from the Joint Commission (TJC) are more likely to provide higher quality of care [12, 39]. Attaining accreditation from TJC is resource-intensive but programs with TJC are held accountable to provide EBPs. Program efforts to respond to accreditation standards seem to play a significant role in supporting the effectiveness of EBPs. Through the gaining and sustaining professional accreditation, managers may be able to invest in processes that support effectiveness. Having the necessary technical resources to improve the quality of care may contribute to the effectiveness of SUD treatment.

7. Management practices that rely on cultural factors

7.1 Workforce diversity

Growing evidence suggests that clients from racial and ethnic minority backgrounds respond more favorably to treatment staff who share their cultural and linguistic background [40–47]. Although cultural humility and respect for clients' cultural background is critical for services, most of the literature has examined provider-client matching as an initial condition to improve treatment engagement. Workforce diversity is one of the most concrete practices that represent organizational cultural competence. Workforce diversity generally indicates whether treatment staff, including directors, supervisors and counselors are reflective and representative of their client population, i.e., members of a minority group (e.g., African American or Hispanic) [42, 48]. Prior research on workforce diversity shows that SUD treatment programs identified as culturally competent are much more likely than other programs to have clinical supervisors and staff who are African American [49]. Supervisors and directors of culturally competent programs may have important attributes that may help engage minority clients. Research shows that those managers working in programs with high cultural competence also report graduate education and significant work experience. Hence, workforce diversity may also bring highly skilled, educated, trained, and experienced managers and staff who can competently respond to the cultural service needs of clients.

The extant literature on SUD treatment systems across the country show that when minority counselors provide services, minority clients enter treatment faster than when serviced by White counselors [47, 49–52]. For instance, culturally responsive policies, management and service practices are associated with greater retention in treatment; and treatment completion [42, 53]. The organizational

context underlying practices that are responsive to the cultural diversity of the population served, especially in social service organizations, cannot be understated. Specifically, the multidimensional aspect of factors that facilitate effective response to diverse population, at the program level, include: a multicultural service delivery philosophy (e.g., partnerships with local agencies, reducing duplication of services that are costly); responsive organizational processes (e.g., collaboration with agencies with similar goals, considering limited resources); responsive organizational procedures (e.g., managerial support for policies that illustrate mission statement and service standards); continuous organizational renewal (e.g., ongoing needs assessments); and effective agency-community relations (e.g., the establishment of relationships that are not grounded on power dynamics) [54]. Thus, culturally responsive practices can be considered EBMPs when used in management to enhance client outcomes. These results have informed policy interventions to invest in translation of materials, diversification of the workforce and counselors' Spanish language proficiency [53]. Despite this evidence, workforce diversity national initiatives require more financial, legislative and social support to improve the treatment conditions for members of racial and ethnic minority groups entering the SUD treatment system.

8. Implications for managers in SUD treatment organizations

EBMPs described in this chapter are not exhaustive of all practices available, nor are they fully described for training purposes. They are however some of the most significant practices based on the current context of healthcare reform in the United States and the increasing participation of racial and ethnic minority clients entering the SUD treatment system. Our goals for this chapter was to bring awareness to policy makers, health care administrators, program managers and other stakeholders of a series of evidence-based practices that can improve the effectiveness of SUD treatment.

Because most managers of SUD treatment are generally promoted from direct service provider (i.e., counselor) to middle manager (clinical supervisor) and sometimes to program director, it is critical to train them on the job. These managers also have limited formal education in the latest management theories and practices that makes them effective as managers of healthcare services. Federal, State and Foundations should require and financially support comprehensive management training for all SUD treatment programs, nationwide [55]. Such trainings should focus on a package of training that focus on, but not limited to the transition to management and leadership, role identity, and the necessary knowledge and skills, in order to solidly prepare former clinicians on astute implementers of EBMPs. The extent, as well as implementation of a comprehensive training agenda will in turn make progress on the ongoing efforts to professionalize the field. Treatment programs would accordingly function with evidence-based practices at the core of their operations. This will be reinforced by the knowledge and experiences of providers, which would benefit clients who demand high quality, efficient, effective, and cost-effectiveness care to address their substance use disorder.

9. Case example

Lorena Perez was one of the most popular, active and friendly managers in her human service organization. She managed their substance use disorder treatment

division, which included several inpatient and outpatient treatment programs in the suburbs of a large city on the East Coast. Ms. Perez did not receive any formal training in management. In fact, she started as a client in one of the inpatient programs 30 years ago. After completing the program and maintaining her sobriety from alcohol, Ms. Perez first volunteered as a sponsor to many Latino women in recovery. After a few years, she completed her Bachelors' degree in Psychology and addictions and became certified as a substance abuse counselor. She was given a full-time job in the same program that helped her recover. During her 10 years as a counselor, she became one of the most effective counselors engaging hundreds of women in the process of recovery. Although she relied heavily on her recovery experience and 12 step approach, she incorporated this approach with the latest evidence-based interventions to her individual and group counseling. Ms. Perez was always eager to attend trainings to improve her skills and competencies in all areas of the treatment process. After a few years, her personal commitment to effectiveness, was noticed by the organization's leaders, and Ms. Perez was promoted to clinical supervisor.

With no formal management experience, Ms. Perez struggled to provide counselors with effective support. She treated counselors under her direction as clients, spending a great deal of time processing their emotions and supporting their decision making. Even though staff felt emotionally supported, which had a positive effect on their view of the relationship with Ms. Perez, they did not have a sense of what they were working towards, both at a personal and program levels. They knew that with more guidance, they could better serve their clients, and further improve the functioning of the organization. With these looming gaps, the treatment staff became increasingly frustrated with her supervisory and approach to management. These dynamics were compounded by resource constraints that Ms. Perez had to operate within. She finds herself managing a program and team, but did not have the necessary resources to meaningfully engage her staff. This meant that she often had to reschedule or cancel one-on-one review meetings and program-wide meetings. These missed opportunities for engagement meant that staff did not get needed critical feedback on their performance or ways in which they may improve their performance. It also meant that she did not get to learn about and address challenges faced by staff in the care delivery process. Within the broader organizational context, Mrs. Perez also had fewer touch-points with clients. These interactions, she has also found to be invaluable to her experience and knowledge as a practitioner and manager. Because of her lessened presence, with respect to client-facing interactions, she began to lose track of the changing patient demographic and did not always consider alignment between the population that the program is serving, and the staff. In the end, although the staff felt emotionally supported, they requested practical guidance on how to become more effective in the process of care (e.g., screening, intake, assessment, counseling, discharge) and improve performance. Ms. Perez also knew that changes were necessary, for her to be successful in her role as a manager, and improve performance.

Ms. Perez requested help from upper management. She wanted to either go back to counseling clients, which she knew well and was clearly effective, or to receive training to become an effective manager for her team.

Discussion questions:

1. Why was Ms. Perez not successful in helping her team become more effective?

2. What evidence-based practice are available to Ms. Perez, as a manager to help her team achieve their performance goals?

3. What can Ms. Perez do to help her team follow an evidence-based process that leads to better treatment results, i.e., how the process be operationalized to comprehensively improve performance?

4. What may be other approaches to improve the diversity of the program and improve cultural competency?

10. Conclusion

The field of SUD treatment has focused on delivery of evidence-based pharmaceutical and psychosocial interventions with little attention to the management practices that support the implementation of such EBPs. The field can benefit from evidence-based management practices (EBMP) to increase the effectiveness of EBPs. SUD treatment organizations could benefit from EBMP with different degrees of investment. For instance, goal setting is an easier practice to implement and generally with low cost, while the feedback and redesign model requires more resources and organization but may improve system functioning. The total quality management, also referred as continuing quality management model is the most resource-intense EBMPs presented here, but one that can result in significant and sustained system change. Managers of SUD treatment programs with the appropriate training on these models, can apply these concepts to their context and improve treatment effectiveness.

Instead of solely relying on managers' experience and common sense, the field seeks to improve managers' decision making by relying on many of the practices described in this chapter. Although this was not intended as an exhaustive list of EBMPs, we selected practices that seem to benefit the SUD treatment field, because they are either analogous to existing treatment practices (e.g. goal setting in treatment planning or in development) or easily implementable.

Other EBMPs that have developed as a response to the funding and regulatory context of SUD treatment are policy initiatives like accepting Medicaid payments and obtaining premier professional certifications. Although most SUD treatment programs in the United States are small, with 3 to 5 counselors and less than 1 million dollars in revenue yearly, these programs are now considering forming coalitions to guide, support and maintain premier certification standards and implement system wide continuing quality management.

Standalone EBMPs are also available for managers of SUD treatment services. Implementing an Electronic Health Record system is critical to track progress and show improvement in quality of care and effectiveness. Managers could consider again the benefit of having their own EHR system, or collaborating with larger treatment organizations to benefit from their systems. Similarly, applying innovative human resources practices, managers can overcome staff recruitment, retention and promotion with the right guidance and resources. Finally, developing a culturally responsive treatment program requires astute management practices to diversify, train and support their staff on culturally responsive care. Although these practices are often singularly implemented, managers can rely on the EBMPs framework to support their efforts to improve treatment effectiveness.

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Conflict of interest

The author declares no conflict of interest.

Abbreviations

EBMPs	evidence-based management practices
EBPs	evidence-based practices
NIATx	Network for the Improvement of Addiction Treatment
OUD	opioid use disorder
OTP	opioid treatment program
SUD	substance use disorder
TJC	the Joint Commission

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