Substance Abuse:
Administrative Issues in Outpatient Treatment

A Treatment Improvement Protocol

TIP 46

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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OT
OUTPATIENT TREATMENT

Substance Abuse: Administrative Issues in Outpatient Treatment

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Disclaimer

The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of CSAT, SAMHSA, or DHHS. No official support of or endorsement by CSAT, SAMHSA, or DHHS for these opinions or for particular instruments, software, or resources described in this document is intended or should be inferred. The guidelines in this document should not be considered substitutes for individualized client care and treatment decisions.

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What Is a TIP?

Treatment Improvement Protocols (TIPs), developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services (DHHS), are best-practice guidelines for the treatment of substance use disorders. CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private treatment facilities to include practitioners in mental health, criminal justice, primary care, and other health care and social service settings.

CSAT's Knowledge Application Program (KAP) expert panel, a distinguished group of experts on substance use disorders and professionals in such related fields as primary care, mental health, and social services, works with the State Alcohol and Drug Abuse Directors to generate topics for the TIPs. Topics are based on the field's current needs for information and guidance.

After selecting a topic, CSAT invites staff from pertinent Federal agencies and national organizations to be members of a resource panel that recommends specific areas of focus as well as resources that should be considered in developing the content for the TIP. These recommendations are communicated to a consensus panel composed of non-Federal experts on the topic who have been nominated by their peers. Consensus panel members participate in a series of discussions. The information and recommendations on which they reach consensus form the foundation of the TIP. The members of each consensus panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A panel chair (or co-chairs) ensures that the content of the TIP mirrors the results of the group's collaboration.

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have

been incorporated, the TIP is prepared for publication, in print and on line. TIPs can be accessed via the Internet at www.kap.samhsa.gov. The online TIPs are consistently updated and provide the field with state-of-the-art information.

Although each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance abuse treatment is evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. For this reason, recommendations proffered in the TIP are attributed to either panelists' clinical experience or the literature. If research supports a particular approach, citations are provided.

This TIP, *Substance Abuse: Administrative Issues in Outpatient Treatment*, was written to help administrators work in the changing environment in which outpatient treatment programs operate. The TIP provides basic information about running an outpatient treatment program, including strategic planning, working with a board of directors, relationships with strategic partners, hiring and retaining employees, staff supervision, continuing education and training, performance improvement, outcomes monitoring, and promotion of the program to potential clients, funding agencies, and government officials. More specialized sections address challenges that have emerged and gathered importance in the last decade: preparing a program to provide culturally competent treatment to an increasingly diverse client population, succeeding in a managed care-dominated world by diversifying the funding sources a program draws on, and understanding privacy and confidentiality requirements imposed by Federal legislation.

Consensus Panel

This TIP is a consensus-based document, developed by the experts listed below. Although all panelists made significant contributions in the development of the TIP as a whole, some panelists took on the additional responsibility as writers for upfront development of particular chapters. Those chapters are listed after their names.

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Foreword

The Treatment Improvement Protocol (TIP) series supports SAMHSA's mission of building resilience and facilitating recovery for people with or at risk for mental or substance use disorders by providing best-practices guidance to clinicians, program administrators, and payers to improve the quality and effectiveness of service delivery and thereby promote recovery. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and client advocates debates and discusses its particular areas of expertise until it reaches a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs' panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators who serve, in the most current and effective ways, people who abuse substances. We are grateful to all who have joined with us to contribute to advances in the substance abuse treatment field.

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Executive Summary

This volume, *Substance Abuse: Administrative Issues in Outpatient Treatment*, and its companion text, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment*, revisit the subject matter of TIP 8, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse*, published in 1994 (CSAT 1994). When TIP 8 was published, one slender volume, barely more than 100 pages long, sufficed to cover intensive outpatient treatment (IOT). The same task today requires two volumes, each of which is devoted to a distinct audience (administrators and clinicians) and is longer than the single, original volume.

The primary audience for this TIP is administrators of outpatient substance abuse treatment programs. A few words about this audience are in order. Whereas TIP 8 addressed intensive outpatient treatment, the current TIP drops the word "intensive" from its title because the consensus panel hopes that this TIP will find an audience beyond administrators of IOT programs. Most of the concepts and guidelines included in this TIP apply to the administration of *all* substance abuse outpatient treatment (OT) programs. On those rare occasions when information applies only to IOT programs, the authors have been sure to make this clear. Although the term "administrator" is used most often to describe the audience for this book, the terms "executive" and "director" appear as well and are used interchangeably with administrator. These overlapping terms emphasize the varied roles and responsibilities that administrators assume.

The Changing IOT Landscape

Arnold M. Washton (1997) points out that the first large expansion of IOT took place during the 1980s, when White, middle-class individuals with cocaine addiction, many of whom were business professionals, sought treatment and did not want to take time away from work or face the stigma of checking into a residential treatment facility. A second expansion of IOT was ushered in by managed care, with its focus on cost containment. Throughout the 1990s, IOT grew, becoming the dominant treatment for most individuals with substance use dis-

orders. This growth was spurred by the expansion of IOT's population from clients with few serious risk factors to include clients who are homeless, adolescents, and those with co-occurring mental disorders, all of whom were formerly considered too difficult for IOT programs to treat successfully. The updated information and the current volume's focus on administrators are testaments not just to the proliferation of IOT programs, but also to the greater variety of services these programs now provide to a broader client population.

Along with the increased complexity of the treatment landscape come more challenges for the administrators who oversee IOT programs. When TIP 8 was written, IOT was seen primarily as a bridge between 28-day inpatient treatment and low-intensity outpatient treatment or mutual-help relapse prevention; most clients were insured privately. IOT programs proved to be adept at filling that treatment gap, and they took on more roles. Public funding sources began to refer more of their Medicaid patients to IOT programs. This development compelled IOT administrators to adapt existing programs and develop new methods to treat diverse clients.

A second force that drove the diversification of IOT programs was managed behavioral health care. Because IOT was cheaper than residential treatment and was being used successfully to treat a wider range of clients, IOT increasingly was seen as a way for managed care organizations (MCOs) to reduce costs. As a result of IOT's successes and the cost containment it made possible, today IOT is a valuable treatment modality in its own right, in addition to being an intermediate stage in the clinical continuum.

Substance Abuse: Administrative Issues in Outpatient Treatment represents the major concerns identified by the consensus panel that relate to the development, expansion, and administration of OT programs.

Administrative and Staffing Issues

Because of this TIP's administrative focus, the authors give special attention to issues faced by directors of OT programs. A more general overview and discussion of attributes and skills required of supervisors in treatment programs can be found in the Center for Substance Abuse Treatment's forthcoming Technical Assistance Publication *Competencies for Substance Abuse Treatment Clinical Supervisors* (CSAT forthcoming *a*).

Most clinic directors were at one time counselors, and the transition from treatment to management is not always a smooth one. The skills that served the counselor well (empathy, patience) may not be those an administrator will rely on primarily. Skills that are necessary for administrators—mentoring, teaching, accounting, evaluation, leadership—often are not acquired at the supervisory level either (Gallon 2002). Administrators face the additional problem of there being little guidance available from the existing literature. So scarce were articles on the job of program administrators that members of the consensus panel for *Substance Abuse: Administrative Issues in Outpatient Treatment* drew primarily on their own experiences in writing this TIP. Coupled with the lack of information on making the transition from counselor to clinic director is the problem of high turnover in the administrative ranks. The National Treatment Center Study found 31 percent annual turnover rates in IOT administration (National Treatment Center Study 1997). With nearly a third of programs experiencing some type of administrative change each year, laying out guidelines and procedures for administrators is essential.

Turnover of substance abuse treatment counselors is also a serious problem, which means that program administrators must devote resources and creativity to hiring and retaining qualified counselors. Although this TIP discusses core staffing issues (e.g., staff mem-

ber roles, shared knowledge, clinical competence), it also addresses hiring and retaining high-quality staff members, staff supervision, training, and continuing education. An emphasis in this volume is on managing staff stressors and supporting the development of counselors and staff—practices that will help mitigate counselor turnover. Substance abuse treatment counselors' turnover rate is far above the national average for all careers and higher even than rates for occupations, such as teacher and nurse, that have notoriously high turnover (Johnson 2002). The National Treatment Center Study found that more than half the counselors surveyed had been working in their current programs for less than 4 years. Nearly 20 percent of all counselors had been working in their current jobs for less than a year (National Treatment Center Study 1999). With the proliferation of treatment programs, the job market for qualified and talented counselors has become more competitive. Given the expense that goes into recruiting and training, programs can ill afford to lose experienced and skilled counselors and staff members. In a time of tight budgets, programs may need to rely on inducements such as increased job satisfaction and opportunities for professional advancement, rather than pay increases, to retain qualified staff.

IOT's Connections to Strategic Partners

When TIP 8 was written, IOT was on the cusp of its second major expansion. The authors felt the need to offer arguments for the legitimacy of IOT and devoted a chapter to explaining how IOT fits into the continuum of care. *Substance Abuse: Administrative Issues in Outpatient Treatment* takes as a given that IOT plays a central role in the treatment of substance use disorders. Convinced that IOT is an integral part of the treatment landscape, the authors of the current volume focus on strategies for program survival and growth. Exploring ways for programs to expand their services to treat more and different clients is a major theme that emerges from this volume. The most effective way for programs to broaden services and increase the number of clients being served is through community and health care partnerships. Nearly every chapter in this TIP addresses this issue in some way.

IOT's initial positioning as an intermediate stage between residential and outpatient treatment necessitated connections with other treatment providers. The emphasis on connections—fundamental at the inception of IOT—remains a strength of the way programs are run today. One advantage of IOT is that it allows clients to receive treatment while they stay connected with and participate in the social networks that shape their lives. Family, friends, and colleagues are present as supports but also as stressors that allow clients to gauge their progress in the real world outside treatment.

OT programs also are connected to the real world of the communities in which they are located; these connections to residents, community leaders, religious and charitable groups, and civic organizations are a source of strength and support for OT programs, and they emerge as a theme in *Substance Abuse: Administrative Issues in Outpatient Treatment*. Several chapters in the book discuss the benefits of community outreach as a marketing and educational tool, a way to raise the profile of programs in communities, and a way to increase awareness of substance use disorders, their signs, and treatment. This volume urges program administrators to think of community connections as a two-way street, going beyond services provided to the community to include involvement and feedback from the community. Community surveys can help direct program efforts to meet local needs. Community members can provide valuable input on matters of racial, ethnic, and cultural diversity and can be tapped to serve on the board of directors.

This theme of connection emphasizes the links between OT programs and strategic partners. Linking with hospitals, the criminal justice system, mental health service providers, mutual-help programs, and other treatment programs in the area broadens both a program's pool of potential clients and the services it can provide. Treating health management organizations as partners can benefit a program by facilitating a positive working relationship. Robust relationships with government officials, State regulators, and State and private funding agencies can play a significant role in a program's continued survival and growth. The consensus panel members note that the sheer number of service connections a program must establish and the coordination that must take place between treatment programs and strategic partners move these multiple systems beyond interaction and toward convergence, where all partners mutually support the goals of treatment.

Program Promotion

Another theme that emerges from this volume is the variety of marketing opportunities available to programs and the importance of taking advantage of them. Making a program more available to the public and more of a presence in the community can encourage community members, funders, and officials to feel more connected to and invested in the success of the program. Observing day-to-day operations and special events such as client graduations gives people a clear picture of the work the program performs, the staff members it employs, and the clients it serves. Increasing the visibility of the program and its activities can reduce the stigma associated with substance use disorders. A program that portrays recovery in a positive light and demonstrates its effects on individuals, families, and the community may see an increase in clients and in support from State and local officials. Regular program reports sent to members of the local media, community leaders, and public and private funders can serve as both a public relations and a fundraising tool. Publicizing the successes and cost-effectiveness of a program persuades supporters that their involvement is making a difference and that the program is "a form of social investment that may deserve more attention and more funds" (Yates 1999, pp. 1–2).

Performance improvement and outcomes monitoring can serve as powerful promotional tools for OT programs, in addition to helping them meet requirements of funding and credentialing bodies. The underlying principles of performance improvement were formulated more than 50 years ago and have been influencing American business practices for a quarter century. In the 10 years since TIP 8 was released, driven by the requirements of credentialing bodies and payers, performance improvement has become increasingly important to substance abuse treatment providers.

Many States now include outcomes monitoring as a requirement for licensure and establishing permanent statewide monitoring systems. MCOs and other payers are implementing incentives and sanctions that are pegged to outcomes. And the Federal Government, through the U.S. Department of Health and Human Services and the Center for Substance Abuse Treatment, is developing performance indicators, databases, and information systems to monitor outcomes. Outcomes monitoring need not function only as a stick, driving programs to improve so that they can receive credentials or funding; it can serve also as a carrot, rewarding programs with better service delivery, more satisfied clients, and increased revenues. Program monitoring is especially important when a new service has been implemented or when the staff identifies a problem area. Data gathered from outcomes monitoring can be used to publicize the success of programs to State officials, funders, and potential clients. Enhancing program visibility in these ways can be crucial to survival. Administrators rate their program's reputation as the most important competitive advantage they have over other treatment providers, followed closely by client satisfaction (National Treatment Center Study 2002). Outcomes monitoring and performance improvement

can help increase client satisfaction and thereby enhance a program's reputation, allowing it to succeed in difficult times.

Cultural and Financial Changes That Affect OT Programs

Cultural Changes

The term "cultural competence" has come into wide use to describe treatment that is mindful of the commonalities and differences among various racial, ethnic, and religious groups and a treatment environment that encourages understanding and exploration of difference. Despite the widespread support that cultural competence enjoys in society at large and within the treatment community, some claim that, as it is implemented in substance abuse treatment, it puts ideology before evidence-based practice and passion before common sense (Weinrach and Thomas 1998). Others who support cultural competence point out that 85 percent of counselors are White, but nearly half the client population is not White. Stated flatly, "Treatment professionals are generally not from the same ethnic and racial backgrounds as the clients they serve" (Mulvey et al. 2003, p. 56). For clinicians to treat diverse client populations responsibly, attention to culture is essential. As long as a cultural disparity persists, program administrators should prepare their counselors and other staff members to understand and address the needs of diverse clients. In addition, it will be beneficial to present pragmatic information on assessing treatment and community needs, training staff to be more culturally competent, and implementing cultural competence plans. Toward that end, *Substance Abuse: Administrative Issues in Outpatient Treatment* defines cultural competence and explains its significance for treatment programs. But the bulk of the cultural competence discussion focuses on how to evaluate community needs, client satisfaction, and program capability with respect to cultural competence. Coupled with examples of surveys, assessment forms, and extensive annotated lists of resources and training materials, the practical guidelines for cultural competence assessment are a first step toward the pragmatic strategies and interventions that critics of current cultural competence efforts see as lacking (Weinrach and Thomas 1998).

Financial Changes

Financing of OT programs has changed more than any other aspect of program administration in recent years. Although changes in the funding landscape were underway in 1994 when TIP 8 was published, only in the intervening decade has the extent to which managed care dominates health care funding become clear. In 1995 less than a third of substance abuse treatment facilities had managed care contracts. Four years later, more than half the facilities had contracts (Office of Applied Studies 2001), and the growth continues. Today, more than two-thirds of Americans have their behavioral health benefits covered through an MCO (Oss and Clary 1999). Befitting the increased role of managed care in funding treatment facilities, most of the financial discussion in *Substance Abuse: Administrative Issues in Outpatient Treatment* is devoted to managed care. Working with MCOs for the good of clients is essential. Of programs surveyed, 54 percent reported that they had to negotiate with MCOs for initiation or continuation of treatment for at least half their clients (National Treatment Center Study 1997). Programs report that there is more intense competition for outpatient services than for any other substance abuse treatment services (National Treatment Center Study 2002). To assist program administrators in this competitive environment, this TIP also provides guidance on the financial aspects of starting a treatment program and on diversifying funding streams to stay in business and thrive.

1 Introduction

In This Chapter...

Challenges of the Current Treatment Environment

History of Intensive Outpatient Treatment

Notes About Terminology

Summary of This TIP

This publication addresses administrative issues in outpatient treatment (OT). A companion volume discusses clinical issues, TIP 47, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* (CSAT 2006*b*).

As with all TIPs sponsored by the Center for Substance Abuse Treatment (CSAT), this volume represents the thinking, experience, and work of an expert consensus panel. The consensus panel members are convinced that, in addition to clinical excellence, skilled program administration is vital to the success of an OT program. Today, a program with topnotch clinical therapists can struggle and even fail if it is not well managed. Despite the importance of good management, a review of the literature found almost no research specific to the administration of substance abuse treatment programs. For this reason, this TIP is based less on research than it is on the consensus panel members' many years of collective experience in administering treatment programs.

Challenges of the Current Treatment Environment

It is the consensus panel's view that OT programs face unprecedented challenges. The health care environment is undergoing extraordinary upheaval. Treatment managers are asked to handle additional demands and requirements with shrinking resources. Good clinical practice increasingly is tied to the need for more sophisticated, more comprehensive, more efficient, and larger program operations. As OT programs have grown in size and variety, their administrative complexity also has grown. To ensure that programs are effective and financially successful, OT administrators need to be skilled in managing the business aspects of treatment. As they develop strategies, plans, and professional relationships for their programs, executives also need to be efficient, creative, innovative, and future oriented, actively looking for new opportunities.

…administrators need to be resourceful and creative and need to engage in long-term strategic planning…

Few OT administrators come to this challenging job with a business or management background. Most are chosen because they have been successful counselors. As clinicians, these new administrators usually had been insulated from the practical aspects of running a program, but management requires a different focus and a different set of skills. Even more important, the skills so crucial for a successful therapist—sensitivity, empathy, insight—do not necessarily make a good administrator. While staying in touch with the work of the program's counselors, an administrator needs to focus on different matters, such as budgets, business opportunities, facilities' operations, staffing, fundraising, and reporting to funders.

Given the career path of many OT program administrators—first counselor, then clinical supervisor, then OT program executive—it is remarkable how well OT programs are managed. Most current OT program managers had to master their new executive responsibilities while on the job with little or no preparation or training. The consensus panel designed this TIP to be a resource for these managers. The turnover rate of program managers in substance abuse treatment is high, with many people assuming new administrative positions. In its survey of more than 400 alcoholism treatment programs, the National Treatment Center Study found that 31 percent of the clinics had experienced some administrative change in the previous year (National Treatment Center Study 1997). It is hoped that this TIP will be useful both for clinicians who are being promoted into executive roles and for experienced administrators. Its suggestions and strategies can help administrators in any substance abuse treatment program.

The OT field today is dynamic, pragmatic, and often chaotic, with an unprecedented number of stressors of all kinds. Managers face many challenges in this difficult environment. This TIP is designed to help administrators manage the following challenges more effectively and creatively:

- **Difficult clients.** Over the last decade, the consensus panel's experience indicates that clients entering outpatient treatment have demonstrated higher levels of acuteness and more severe mental disorders and sociobehavioral problems than in the past. For example, many persons with a substance use disorder who formerly had been treated in residential programs now are referred directly to outpatient programs. With new approaches, homeless persons have been treated effectively in intensive outpatient programs. OT programs increasingly are treating clients with co-occurring substance use and mental disorders, requiring the level of program and counselor sophistication to rise even though budgets do not keep pace. In addition, the Nation's growing diversity is bringing clients into treatment from many different cultures, each with its own special needs.
- **Human resources challenges.** Currently, there is a high turnover rate not only of managers but of staff in OT programs. Some studies cite 6-month turnover rates as high as 49 percent among substance abuse treatment staff (Carise et al. 1999, 2000). The scarcity of counselors from diverse backgrounds is particularly acute. Because of the severity of problems among OT clients, programs need to provide both highly skilled therapists and counselor continuity. OT programs report that it is difficult to recruit and retain qualified counselors. With budget constraints, administrators may need to

find ways other than salary increases to motivate and reward staff members, such as enhancing staff communication and building a supportive staff environment.

- **Extraordinary financial pressures.** Limitations on health care funding are placing unprecedented pressure on OT programs. State budgets are contracting dramatically. The behavioral health care system, including substance abuse treatment, is taking the brunt of this financial constriction. OT administrators need to be resourceful and creative and need to engage in long-term strategic planning to keep their programs financially viable. When operating under a variety of payers, an OT administrator needs to be an adroit financial manager.
- **A more complex regulatory and legal environment.** An OT program can have as many as four different regulatory inspections per year. An administrator needs to make significant shifts in policies and procedures when Federal or State regulations change. For example, the recent Health Insurance Portability and Accountability Act (HIPAA) affects OT programs that use electronic communications. HIPAA requires that administrators understand and meet these new and complex requirements while complying with the Federal confidentiality laws.
- **Emergence of the behavioral health system.** With the emergence of entities that fund mental disorder and substance abuse treatment separately from other health care, there are efforts to integrate mental disorder and substance abuse treatment (NAADAC 2002). OT administrators may find that it is crucial to set up strategic alliances with other health care providers, especially in mental health care.
- **Emphasis on performance outcomes and measurement.** The monitoring of program performance and outcomes—combined with a push for evidence-based practices—is the wave of the future. The Federal Government now requires that funding be based on performance outcomes and that States set up performance monitoring systems. States are looking for ways to implement outcomes-based funding. For example, Delaware providers will receive only 75 percent of their previous annual funding if they fail to reach certain performance indicators; if certain outcomes are attained, a provider can receive up to 15 percent above the previous funding level. Administrators need to know how to ratchet up the performance of a treatment program, a challenge requiring skills they may not have learned as clinicians.
- **Advances in information technology.** Information technology has great potential for improving program efficiency in many areas, such as streamlining counselor recordkeeping, reducing paperwork, coordinating with other providers, and simplifying transactions with payers. With the advantages of computer technology come competitive challenges. Administrators will find that programs are expected to have increasingly sophisticated technology. To be competitive, OT administrators will need to find ways to fund more advanced information technology systems.
- **Increased need for marketing and community relationships.** Program administrators need to increase their marketing efforts and build relationships in the community. Accrediting bodies now look at a program's relationship with clients and the extent to which the program is integrated into the community. Both public-sector and private providers assign a high priority to marketing and community education.

The challenges are daunting. The information in this TIP will help administrators develop the resources and capacity to meet them. But programs need more than an efficient organizational structure and a motivated staff; they need funds to support their mission. The consensus panel urges administrators to reach out to local residents and business people. Developing strategic alliances and improving community relationships are vital to

the success of a program. The needs of OT programs vary from region to region, but in all treatment settings, managing an OT program requires skill and discernment. Beset by multiple challenges, the administrator determines which ones demand immediate attention and which can wait.

History of Intensive Outpatient Treatment

A brief and selective review of the history of intensive outpatient treatment (IOT) in the United States reveals that the current upsurge in outpatient services is neither new nor guaranteed to endure.

The Earliest Treatment

Since the earliest days of American history, those addicted to alcohol and drugs have been well represented among patients admitted to American hospitals. As noted by Benjamin Rush, records from Pennsylvania Hospital (the country's first hospital, founded by Benjamin Franklin) state that "the excessive use of ardent spirits" caused "madness" in one-third of the hospital's "maniacs" (Rush [1812] 1962, pp. 32–33). This large proportion is notable because at that time U.S. society strongly preferred to treat secretly individuals who were addicted and to segregate them from other patients. For the first 100 years of the Nation's history, individuals addicted to alcohol, opium, and other substances routinely were treated primarily in secluded *residential* programs, often referred to as "asylums," "sanitariums," or "sober houses" (White 1998).

> Evidence…lent support to the belief that IOT programs could treat many… clients successfully.

20th-Century Beginnings of Outpatient Treatment

Individuals addicted to alcohol and drugs were first treated on an outpatient basis early in the 20th century. In 1906, the Emmanuel Church in Boston opened a clinic that provided outpatient treatment of disorders involving "weakness or defect of character" (White 1998, p. 100). This clinic sought to integrate psychological, medical, and spiritual approaches into its work with people addicted to alcohol. The Emmanuel Clinic is particularly notable because it was one of the first clinics to employ recovering laypeople as counselors.

Soon after the turn of the century, the Massachusetts Hospital for Dipsomaniacs and Inebriates also established an important outpatient addiction treatment program. By 1916, Massachusetts Hospital had established a statewide network of 29 outpatient sites providing continuity of care following inpatient treatment. Many clinics were located in YMCAs, churches, and hospitals (Tracy 1992). These clinics offered a combination of moral counseling, medical services, and occupational therapy. With the passage of the Volstead Act (the National Prohibition Act) in 1919, this large network of outpatient providers quickly disappeared because the Massachusetts legislature assumed that the new law would end alcoholism permanently.

20th-Century Growth of the Outpatient Modality

In 1923, the Yale Laboratory of Applied Physiology (later renamed the Yale Center for Alcohol Studies) was organized to study and treat alcoholism. The Yale Center conducted an ambitious program of research, publication, training, and treatment—the first major practice–research collaborative in America. In 1944, the Yale

Center employed psychiatrists and "ex-alcoholics" who worked together and encouraged patient involvement in Alcoholics Anonymous, while providing psychodynamically oriented therapy. By 1957, clinics based on the Yale model were established in 34 States (White 1998). By the late 1950s, OT programs of varying design and intensity had opened across the country, including a number of day treatment programs designed primarily for working people (Fox and Lowe 1968).

By the 1970s, outpatient detoxification (Kolodner 1977) and modern-day treatment programs (Collins et al. 1980; Savitz and Kolodner 1977) became available. Numerous day treatment programs had opened by the 1980s; many offered ambulatory detoxification along with rehabilitation services (Washton and Resnick 1982). These programs were supported with funding provided through county or State agencies and the U.S. Department of Veterans Affairs, although some were supported through private insurance and self-payments. By the mid-1980s, admissions to residential and psychiatric treatment facilities had increased greatly because of the emergence of cocaine and then crack cocaine (Rawson et al. 1983; Washton et al. 1986).

The Recent Rise of IOT Programs

In the 1980s, in response to the surge in cocaine admissions and its related costs, there was a proliferation of IOT programs geared to treating privately insured, working individuals. Evidence regarding the efficacy of structured and intensive outpatient treatment lent support to the belief that IOT programs could treat many of these clients successfully. Nicholas Cummings, in his presidential address to the American Psychological Association in 1986, predicted the emergence of outpatient treatment as the dominant level of care for the delivery of rehabilitative services (Cummings 1986). By the mid-1990s, public funding sources began turning to IOT programs to treat Medicaid recipients, and IOT managers responded by adapting program designs to accommodate the needs of homeless clients and those with severe co-occurring psychiatric and other biopsychosocial problems.

Notes About Terminology

Just as the treatment field has yet to settle on a commonly accepted name for itself (e.g., "substance abuse" versus "addiction" versus "substance use disorder" versus "alcohol and drug dependence" versus "chemical dependence"), it is not surprising that the consensus panel has agreed to disagree on a variety of terms and concepts used by the field. Because use of the terms "IOT" and "IOP" (intensive outpatient program) varies by region, for the sake of consistency, the consensus panel agreed to use the term "intensive outpatient treatment" to refer to this level of care instead of the equally acceptable term "intensive outpatient program." As a consequence, the term "outpatient treatment" also is used. (For a more extensive discussion of the terminology associated with intensive outpatient treatment, see chapter 1 of TIP 47, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* [CSAT 2006*b*].)

Summary of This TIP

The following topics are covered in this volume:

Chapter 2—Management Issues focuses on developing and implementing the structural elements of a successful program, including strategic planning and strategic partnerships, a board of directors, bylaws, and program policy. This chapter also examines the use of strategic relationships to refer clients to programs, to enhance programs' treatment capacity, and to increase programs' visibility. Chapter 2 also addresses the day-to-day man-

agement of a treatment program: policies and procedures, staffing, budgeting, sharing new knowledge with staff, and facility management.

Chapter 3—Managing Human Resources examines the recruiting, hiring, and retaining of OT staff members and addresses the appropriate use of a program's human resources. This chapter also discusses the importance of continuing education and training, supervision, and stress reduction for counselors and staff. A client's relationship with a counselor may be the most important factor in treatment, so guidelines are provided for selection, motivation, and retention of skilled counselors.

Chapter 4—Preparing a Program To Treat Diverse Clients discusses how to prepare the staff to be understanding and competent in its treatment of individuals with diverse backgrounds. Eighty-five percent of treatment providers are White, whereas nearly half the clients are from other ethnic groups (Mulvey et al. 2003). Given the dynamic demographic changes the United States has seen in recent years, a culturally competent program will be better prepared to serve more clients. This chapter explains how to perform community, client, and program assessments of cultural competence. Chapter 4 also provides recommendations and an annotated list of resources to assist programs in cultural competence education, assessment, and training.

Chapter 5—Outpatient Treatment Financing Options and Strategies addresses a subject that is crucial in the light of funding cuts, changes in traditional funding streams, and pressure to reduce costs through managed care. Typically, program funding is derived from several sources and may change over time. This chapter discusses the different funding streams, including the complexities of managed care contracting, private sources, and State and Federal funding and how they can be used to support OT services. The chapter also discusses foundations and government grant programs. In addition, chapter 5 examines particular funding sources and the effect they have on the nature and scope of OT programs.

Chapter 6—Performance Improvement and Outcomes Monitoring explores the many facets of measuring treatment performance outcomes—a critical concern as both government and the private sector demand increasing accountability and accreditation. This chapter explores treatment performance indicators such as engagement rate and client satisfaction and the tools used to measure them. Chapter 6 also discusses outcomes measures in today's funding environment, monitoring issues, handling and use of data, and costs and funding of performance monitoring.

2 Management Issues

In This Chapter...

Roles of the Program Executive

Strategic Planning and Implementation

Board of Directors

Program Policy and Procedure Management

Relationships With Strategic Partners

Referring Clients to Services Outside the Program

Sharing New Knowledge With Those in the Field

Management and Administrative Issues

Program Visibility: Outreach and Public Relations

As outpatient treatment (OT) and intensive outpatient treatment (IOT) emerge as critical components on the broad continuum of care for people who abuse substances, executives are in pivotal leadership roles. They are skilled, informed, and involved in the business of substance abuse treatment. Today's successful executive fulfills a variety of roles while balancing diverse needs and expectations with available resources.

This chapter discusses the challenges facing executives and the opportunities for employing available resources and skills to meet program goals. The chapter includes discussions about

- Roles of the program executive: making the transition from clinician to executive
- Strategic planning and implementation
- Aspects of governance: board of directors and instituting board bylaws
- Program policy and procedure management
- Relationships with strategic partners
- Referring clients to services outside the program
- Sharing new knowledge with those in the field
- Management and administrative issues, such as staffing, policies and procedures, budgeting and monitoring, and facility management
- Program visibility: outreach and public relations

Roles of the Program Executive

The program executive juggles administrative, clinical, fiscal, policy, and political roles. It is important that the executive carry out these functions within a framework of both effective time management and priority setting. These roles require the executive to

- Provide leadership, vision, and planning for the future
- Manage the internal workings of an office
- Manage increasingly complex human resources
- Handle budgeting and fundraising issues

- Develop and manage formal agreements with other professional service providers
- Develop and maintain relationships with people and groups in the community

No individual is likely to excel in all these areas. However, an effective executive can address these major areas capably and, if necessary, can delegate and oversee the performance of some tasks.

The Transition From Clinician to Executive

It is common for executives of treatment programs to have served as clinicians before they moved to a chief executive role. This transition from clinician to executive needs thoughtful planning and preparation. Managing a program is a demanding and time-consuming job that requires an array of qualities and skills, including leadership, business sense, human resource knowledge, strategic thinking, budget management, and decisiveness. These are not necessarily the skills a clinician develops while treating clients.

Many clinicians come to their new executive jobs without any formal training in organizational theory and business management. New executives change their focus from delivering clinical services to managing the systems and group dynamics of the workplace. Because many clinicians have little training in management, they may feel uncomfortable in the new role.

Those who have enjoyed clinical careers are sometimes reluctant to relinquish the clinical role entirely (McConnell 2002). Management, however, is usually a full-time job. New executives realize that managing the program is now their first priority and primary responsibility. The demands may preclude clinical work. However, some executives deliberately maintain a few cases to keep in touch with clinical issues, maintain their clinical skills, and model behaviors and practices for clinical staff.

Strategic Planning and Implementation

Strategic planning should be thought of as a regular, periodic activity—as important when the program has been in operation for years as when setting up a program. Preparing a strategic plan is a time-consuming but necessary process that can help a program in the following ways:

- Provide direction when starting a program.
- Define or revise the program's mission and directions.
- Set clear program goals.
- Ensure that resources are invested effectively.
- Find cost savings and new resources.
- Energize the board and staff, improving morale and performance.

The discussion that follows will benefit executives of both new and existing programs. The Addiction Technology Transfer Center (ATTC) Network has compiled *The Change Book: A Blueprint for Technology Transfer* (ATTC Network 2004*a*) to help programs implement change initiatives that will improve client retention and treatment outcomes. *The Change Book* and *The Change Book Workbook* (ATTC Network 2004*b*) can be ordered or downloaded at www.nattc.org/respubs/changebook.html.

Strategic Planning Parameters

Before embarking on the development of a strategic plan, the executive should consider the following:

- **The participants who will develop the strategic plan.** A consultant can be helpful if resources are available to hire one. If potential board members and funders of the program have already been identified, their input should be sought. The strategic planning process for an existing program should involve members from every level

of staff as well as clients because these people will present different perspectives and will be the ones affected by the decisions that are made.

- **The period covered by the plan.** How far into the future should the plan project? Strategic plans can span virtually any period but generally cover at least 1 year and often extend over 3 to 5 years.
- **The amount of time devoted to the planning process.** The amount of time individual participants are able and willing to allocate to the process will vary. It is helpful to establish a schedule of activities and a target date for completing the plan.

Developing a Strategic Plan

There are many different approaches to strategic planning, but some common steps include

- **Conducting a community audit or needs assessment.** What kinds of treatment needs are going unmet in the community? Is there a special treatment niche that needs to be filled, such as treatment for adolescents or women with children? A first step is to perform a community audit or needs assessment. The Single State Agency (SSA) may have a State Needs Assessment for the area that will provide some information. However, if a program defines its targeted group too narrowly, its ability to treat a population with a substance-dependence problem may be limited, restricting the number of clients. Therefore, the program should be designed to provide a wide range of options and with the potential to broaden services.
- **Identifying comparative program strengths.** How do the program's strengths and weaknesses, scope of services, populations it serves, convenience of location, response time, cost to the client, and links to other services compare with those of other programs in the area? After analyzing the strengths and weaknesses, a program might determine it has a competitive advantage in marketing its services to managed care companies because it offers comprehensive services or can admit clients within 48 hours. Or a program might have an impressive track record treating clients who are referred by the criminal justice system. Another program might find it needs to change staff hours to be able to attract people who are employed and can attend treatment only in the evenings or on weekends.

> Th[e] transition from clinician to executive needs thoughtful planning and preparation.

- **Developing or clarifying the program's mission and core values.** Everyone in the program should understand and support a common vision of the program's goals and values.
- **Developing and evaluating goals.** An effective strategic planning process results in clear, measurable, prioritized goals. There should be discussion of whether the goals are realistic, given the program's expertise, time commitments of staff, available funding, and other resources required to reach the goals.
- **Identifying strategies to achieve the program's goals.** Planners should develop multiple strategies for reaching each goal, evaluate each strategy's merits and drawbacks, and select the strategies to pursue.

The executive can assist those participating in the strategic planning process by preparing guidelines that address the following issues:

- **Maintaining a collaborative process.** The participants need to be able to exhibit mutual respect, professionalism, openness,

and patience. The best thinking is done in a safe and supportive environment.
- **Staying on task.** The participants need to stay focused on the most important items and avoid getting lost in details or side issues.
- **Accepting consensus when unanimity cannot be achieved.** Although it is important that participants entirely support the process and its result, compromises may be required to reach consensus.

Implementing the Strategic Plan

The completed strategic plan describes the goals the program hopes to reach. The next step is to draw up an annual operating plan, which describes the actions required to meet each goal and who is responsible for performing those actions. The executive should involve the entire staff in implementation, delegating responsibility for implementing the operating plan and communicating enthusiasm and support for the vision laid out in the plan.

The executive oversees implementation of the operating plan and removes barriers to its execution. Outcome measures that reflect the strategic plan's individual goals are tracked. Progress toward each goal then can be assessed, and the operating plan can be adjusted as necessary.

Board of Directors

A program needs a board of directors to monitor the internal and external management of the organization. This level of governance is extremely important for a successful business venture. Some experienced providers believe that the selection and use of boards are the weakest areas in the administration of treatment programs. Requirements vary by State, but many jurisdictions require nonprofit organizations to have a board of directors. The board is responsible for

- Overseeing the program's operating procedures, budgets, and fiscal controls
- Approving the program's mission and long-range plans
- Monitoring the executive's performance

Board members also help with fundraising and represent the program in the community, acting as ambassadors for the organization and explaining the community to the program. (See exhibit 2-1 for a sample statement of board members' responsibilities.) Board members should be committed to the program's mission and willing to contribute the time needed to be responsible stewards of the program. The board of directors in a nonprofit program needs to work as a team with the executive and staff to support the program's mission and future success.

Nonprofit board members may be responsible financially if the program fails and debts are incurred. The executive must advise prospective board members about this liability. A program should consider purchasing liability insurance to protect board members against potential liabilities.

Choosing and Encouraging Board Members

The majority of board members should have some knowledge or understanding of substance abuse treatment. If the program is publicly funded, it is useful to have board members with connections to all important political parties at the State and local levels. If the program relies on reimbursement from insurance companies and managed care companies, it is helpful to include board members with expertise in those areas. The consensus panel suggests that boards contain at least one representative from the local community and from the program's constituency (including both clients and referral sources).

Members with fiscal and legal expertise are excellent additions. Members from the nonprofit and foundation worlds can provide perspective on management and funding

Exhibit 2-1

Sample Statement of Board Member Responsibilities

General Responsibilities

- Appoint and annually evaluate the executive director
- Attend all meetings of the board of directors
- Set organizational policy
- Approve and monitor the annual budget and plan
- Develop a mission statement, and review it periodically
- Establish a strategic plan for the program (to ensure future success)
- Evaluate organizational effectiveness in accomplishing board-approved objectives
- Serve on at least one board committee
- Become informed and educated about the program and the industry of which it is a part
- Be familiar with the program's bylaws

Fundraising Responsibilities

- Actively participate in special events sponsored by the program
- Help raise funds for the program using creative strategies
- Optional: Make an annual personal donation to the program

Public Relations Responsibilities

- Act as a sounding board for community feedback about the program
- Serve as a liaison to other community organizations
- Support the services of the program, and speak out on its behalf

issues. The board also should be diverse with respect to gender, cultural background, and sexual preference.

When recruiting new board members, the executive, along with one or more board members, should meet with prospective members to determine how well they would serve the program and whether they are willing to devote the necessary time to the board. At the meeting, the executive should be frank and honest about the responsibilities of board members and discuss the following:

- The organization's goals and needs
- The preferred skills and qualities of a board member
- The expected time commitment
- Personal-giving expectations, if any

Prospective members will need time to decide on this serious commitment. Receiving a "no" is better for a program than having a board member who is unable to give the needed time and effort.

Effective boards are the result of ongoing planning and effort, effective teamwork, and a high level of commitment. Some helpful strategies follow:

- **Orientation for board members.** New board members should be oriented individually or in small groups. They should be provided with a binder of information about the program. A helpful orientation covers such areas as (1) the organization's history, mission, services, and data on service delivery; (2) board composition, responsibilities, and meeting and committee structures; and (3) job description of the program director, schedule of the board's meetings, bylaws, budget, and current short- and long-range plans.
- **Ongoing responsibilities.** Board members become more committed when they have ongoing tasks and responsibilities. Each member needs to have a specific role, such as committee member, committee chair, or task force member. Exhibit 2-2 lists types of board committees that can be established and typical responsibilities for each.
- **Communication.** Board members need to be kept informed. They should be provided with updated fact sheets about the pro-

Exhibit 2-2

Examples of Board Committee Structure

Standing Committees

- **Executive committee.** Acts between meetings of the full board; is empowered by bylaws and can exercise all board powers, except changing bylaws; and reports on actions at each board meeting
- **Nominating committee.** Develops criteria for recruitment, selection, and retention of board members; identifies and approaches potential board members; and develops rotation provisions
- **Finance and budget committee.** Is responsible for audit and appointment of independent accountants; reviews financial statements; evaluates and approves audit; evaluates organization's ability to manage fiscal and accounting functions; and works with the resource development committee to set adequate funding goals
- **Resource development committee.** Develops and approves development plan; conducts board-giving campaign; recruits chair for targeted campaigns; oversees all fundraising activities; and educates board in fundraising responsibilities

Optional Committees

- **Personnel committee.** Sets and approves personnel policies and procedures; approves benefits and compensation policies; and ensures compliance with laws
- **Bylaws committee.** Monitors compliance with bylaws and recommends changes in bylaws
- **Program committee.** Approves program plans and activities; participates in new program development; and reviews quality assurance

gram, minutes of board meetings, and printed agendas at regularly scheduled meetings.

- **Evaluation of the board.** Some executives recommend that an outside consultant evaluate the board's performance at a minimum of 5-year intervals. As terms expire, board members can be asked to evaluate their performance (see self-evaluation form, exhibit 2-3). Self-evaluation is a tactful way of encouraging board members to retire when they are not able to make the expected commitments of time (or money, if this is part of their responsibility) to the program.

Bylaws are the instruments that nonprofit boards follow to perform their roles. Bylaws establish membership requirements, term limits or rotation schedules, governance struc-

Exhibit 2-3

Board Member Self-Evaluation Form

To be self-administered before consideration of a second or subsequent term of office as a board member.

1. Have I **attended**:	a. All board meetings?	❑ yes	❑ no
	b. A majority of the meetings?	❑ yes	❑ no
	c. Fewer than half of the meetings?	❑ yes	❑ no
2. Have I **actively participated** on at least one board committee?		❑ yes	❑ no
3. Have I **made a personal financial contribution** to the organization?		❑ yes	❑ no
4. Have I **served as an advocate** for the organization?		❑ yes	❑ no
5. Have I **kept myself informed** about the organization, its role in the the industry, and its role in the community?		❑ yes	❑ no

Scoring: How do you rate yourself? Use the following scoring chart to assist you:

For question 1, score a "yes" response as follows:

1 point for answering "yes" to a
½ point for answering "yes" to b
0 points for answering "yes" to c

Score 1 point for each "yes" response to questions 2, 3, 4, and 5.

Interpretation:

4–5 points—You are great and must continue!
3 points—You definitely should consider continuing, but please try to do a bit more.
2 or fewer points—Please consider not returning; your interests probably lie elsewhere or you're currently overcommitted.

tures of board officers and standing committees, and voting procedures. With carefully prepared bylaws, nonprofit boards are able to keep administrative and housekeeping tasks to a minimum, focus on key issues, make necessary decisions, and sustain the interest and involvement of their members.

Program Policy and Procedure Management

Licensing statutes and accreditation standards require that programs establish written policies and procedures. A key executive responsibility is to ensure that these written policies and procedures meet State licensing requirements and that they are being followed. Policies and procedures should cover the following areas:

- Client care, such as screening and assessment, treatment planning, and discharge planning
- Recordkeeping, including the content and security of clients' records
- Organizational structure, such as governance committees and staff positions
- Fiscal management, including budgeting, monitoring, and reporting
- Personnel, including hiring, evaluation, and termination procedures
- Program structure and staffing, delineating clinical and administrative functions and supervisory positions
- Clients' rights, setting forth the clients' specific rights and the program's grievance processes
- Performance improvement programs, including setting standards, monitoring performance, and using results to improve the program
- Facility, health, and safety standards, including first aid and emergency planning, and a significant disaster management policy

These policies and procedures need to reflect the program's treatment philosophy. Also, in the current funding environment, an executive may want to include the use of evidence-based or best practices as an important issue in program policy and procedures.

Accreditation

The program executive is responsible for ensuring that the program continues to meet its accreditation and State licensure standards. If the program is not accredited, the program executive decides when, and whether, to seek accreditation.

It is possible for some programs to sustain a specific treatment niche without going through the accreditation process. However, program executives need to consider the possible advantages of accreditation. Accreditation is a growing requirement in the substance abuse treatment field. The Center for Substance Abuse Treatment (CSAT) now requires that all opioid treatment programs become accredited through the Joint Commission on Accreditation of Healthcare Organizations, Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation, or other CSAT-approved accreditation entity. Accreditation places a program in a more favorable position to secure contracts and may be required for State licensure and managed care contracts.

For a program that decides to seek accreditation, the following is suggested:

- Consider forming an alliance with a larger organization that can provide support.
- Hire a consultant with documented accreditation-related experience to assist with the accreditation process.
- Visit www.jcaho.org, www.carf.org, or www.coa.net for more information about accreditation processes and requirements.

Relationships With Strategic Partners

Although many programs succeed as independent organizations or by providing a single level of care, there are risks to this approach. Establishing linkages, formal alliances, or relationships with other agencies can strengthen a program and can be an effective way to obtain new sources of potential clients. Strategic alliances can take many forms, such as the following:

- A program can provide intake services at the site of a strategic partner. Staff members can be placed in health clinics, welfare offices, mental health programs, emergency rooms, and criminal justice settings to perform screening or initial assessments. For example, a program that stations a staff member in an emergency room may gain new clients (see exhibit 2-4). Similarly, providing information or assessments in the criminal justice process can be effective.
- A program can provide services at a strategic partner's site. For example, a program could place staff members on the site of a mental health care provider. This alliance serves the interests of both agencies, expanding the services each offers and treating clients who have co-occurring disorders in one location. A welfare-to-work program might need a treatment provider to deliver onsite services to its clients, or a high school might be interested in having recovery groups and assessments on campus.

Marketing can be a key to establishing new alliances. Potential referral sources include managed care companies, employers, mental health services providers, employee assistance programs (EAPs), schools, hospitals, welfare agencies, religious leaders, and criminal justice agencies.

The first step in marketing is to develop a strategy based on the community audit or needs assessment performed during strategic planning. The executive should consider the following points:

- **Determine how best to reach the target market.** If the target market includes people in crisis, the program could network with other human service providers. If the

Exhibit 2-4

Example of an OT Program and Emergency Room Strategic Alliance

Emergency rooms in hospitals see many intoxicated patients. One hospital was willing to pay OT program staff to provide assessments on site. Program staff members assessed people who were intoxicated when brought in; staff found this location to be an excellent source of referrals, including patients able to pay on a fee-for-service basis. An OT program staff member

- Interviewed emergency room patients with problems such as intoxication or drug overdose, trauma, and complaints about pain, which could signal drug-seeking behavior
- Interviewed family members, asking about problems or accidents related to substance abuse
- Encouraged family members to get the patient to accept treatment

target is a managed care organization, the program's executive could meet with managed care providers and behavioral health consultants to provide information about the program's strengths. If the program is looking for additional criminal justice clients, the executive could network with prosecutors, defense counsel, court system personnel, probation and parole officers, and coordinating case management entities, such as the Treatment Accountability for Safer Communities. Often contacts need to be made at multiple levels within a referral source. It is important to follow up with referral sources; they should be treated as a major part of the program's marketing efforts.

- **Identify the person best able to connect with the target market.** The best person might be a board member, the executive, a staff member, or a program graduate.
- **Develop materials to leave behind after a meeting.**

Once a marketing strategy to identify new alliances is selected, the executive needs to continue the effort. Marketing tends to have a cumulative effect. Not every effort produces results, but some efforts meet with success, and positive results tend to generate additional opportunities. Typically, marketing efforts take 6 to 12 months to reap benefits. A program that initiates a marketing effort after a downturn in business will have a more difficult time than if it initiates its effort when business is good and visibility is high.

Marketing can be a key to establishing new alliances.

Chapter 5 includes additional information about strategic partners.

Referring Clients to Services Outside the Program

In addition to partnering with agencies that refer clients to a program, the program needs to establish relationships with agencies that supply services not provided by the program.

Identifying Outside Services

OT executives need to know what services are available in their area. Each community has distinct ways to disseminate information about services. In most places, agencies or organizations regularly publish a directory of available social services and specialty programs. These directories usually are available from local public health departments, welfare councils, Councils on Alcohol and Drug Abuse, United Way chapters, county or municipal governments, public libraries, and regional offices of Federal and State agencies. The local Yellow Pages lists many types of special services under "Human Services," "Social Services," and "Drug Abuse and Addiction." Web sites, newspapers, and professional groups are other places to look for announcements of new services or articles about the success of existing programs.

Some locales have automated directories of social services that are updated continually. Although costly, these directories let the program know immediately when openings become available in regularly used and oversubscribed services.

A program's files need to include information about the following types of services and organizations:

- Adult education programs
- Child care
- Credit counseling programs
- Faith-based institutions
- Family therapists and couples counseling
- Food banks and clothing distribution centers

- Housing resources, including U.S. Department of Housing and Urban Development Section 8 housing, homeless and battered women's shelters, and recovery houses
- Inpatient and outpatient psychiatric treatment and mental health services
- Legal assistance for civil and criminal charges
- Parent training programs
- Preventive health care and both inpatient and outpatient medical services (e.g., visiting nurses; home health aides; physicians; specialty clinics for HIV/AIDS, sexually transmitted diseases, or tuberculosis; and prenatal and pediatric care)
- Public transportation
- Recovery support groups, such as Alcoholics Anonymous
- Recreational facilities and programs
- Social service and child welfare agencies
- Vocational rehabilitation or training and EAPs
- Volunteer transportation services

Keeping Up-to-Date Files of Resources for Clients

Executives ensure that the program's counselors and case managers develop and maintain a current and accurate list of local and regional services their clients may require. Because fewer options may be available in small or rural communities, treatment programs in these settings need to be creative and assume an active advocacy role in developing new resources and sources for services.

Programs should update files of resources, including each resource's name, address and telephone number, services offered, hours of operation, proximity to public transportation, contact person, eligibility criteria, costs, numbers of persons it serves, waiting lists, and staff qualifications and titles.

The executive needs to implement a mechanism for evaluating these external services. For example, how long is the wait to receive service? Do staff members treat people with substance use problems or people with AIDS fairly? This evaluation may include feedback from clients who are referred to and use the resources. Another option is to institute an exchange program, in which program staff members trade places with their counterparts in other programs. Volunteers can be enlisted to visit community resources, obtain information, and update files.

New services continually are being established while old ones are closing; executives need to inform staff of these changes.

Developing Formal Service Agreements and System Linkages

The program executive is responsible for establishing and monitoring formal arrangements with other organizations. These arrangements can be written memorandums of understanding, cooperative service agreements, interagency agreements, or legal contracts. Because case managers will follow the formal procedures outlined in these agreements and comply with legal contracts, case managers should be involved in the development of these agreements. The program's legal counsel may need to review the documents. Formal service agreements need to specify

- The types of services offered
- The qualifications of staff members who deliver the services
- The number of slots each participating agency will make available
- The time limits or cost caps on services
- The lines of authority and accountability
- The specific procedures to be followed in making referrals

(See CSAT's TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* [CSAT 1998*b*], and *Quick Guide for Administrators Based on TIP 27* [CSAT 2001] for more information.)

The community resources that case managers use must meet the needs of the program's client population. In addition, program staff members need to have affiliations with and knowledge about other substance abuse treatment resources in the area. Clients then can be transferred to other levels of care if needed.

Sharing New Knowledge With Those in the Field

The executive needs to take the lead in informing the program staff about developments in the substance abuse treatment field. A program might plan for regular dissemination of new information through e-mail messages, a staff newsletter, or staff meetings. Some areas to monitor are

- **Legislative changes.** The Health Insurance Portability and Accountability Act—a new set of Federal regulations governing clients' privacy rights—is an important legislative change (CSAT 2004).
- **Clinical and research developments.** Research about treatment practices needs to be integrated into treatment practices. Evidence-based information is updated regularly at the Web sites of the National Institute on Drug Abuse (NIDA) (www.nida.nih.gov), National Institute on Alcohol Abuse and Alcoholism (www.niaaa.nih.gov), and the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Clearinghouse for Alcohol and Drug Information (NCADI) (www.ncadi.samhsa.gov).
- **Regulatory developments.** The CSAT Web site (www.csat.samhsa.gov) is an important resource for following such developments.
- **Developments in funding.** It is extremely important for executives to keep up to date about the companies, agencies, and grant programs that fund treatment. (See chapter 5.)

Management and Administrative Issues

Human Resources Management

No program can succeed without an enthusiastic, hard-working staff. A major function of the executive is to support the clinicians and the rest of the staff, create a culture that nurtures and brings out their best, provide the resources that will make their work easier, and help staff members become more productive. Management style is important. As one experienced executive points out, a touch of humility and a positive, supportive approach can be the executive's best assets.

Managing the human resources of a program includes the following:

- **Providing leadership.** The executive leads the board of directors in defining the program's mission and objectives and engages the staff in translating this mission into an action plan. Developing and implementing a program's action plan should be an ongoing, teambuilding process. The collaborative creation of such a plan helps transform a clinic staff into a team.
- **Setting policy.** The executive oversees the establishment of a written human resources policy, sets pay scales, and establishes benefit packages that are equitable and appropriate.
- **Supervising both clinical and administrative staff members.** The executive should give clear, decisive direction to staff. Whereas the clinician is accustomed to influencing clients by persuasion and clarification, the executive often exercises more direct means to manage staff. The executive should be prepared to mediate disputes between staff members and provide clinical guidance.
- **Providing efficient operations.** The executive needs to model efficient, effective operating methods. The ability to conduct productive meetings is particularly impor-

tant. Well-run meetings focus on agendas, goals, the people responsible for particular tasks, and deadlines.

- **Evaluating information technology.** Executives should explore updating computer systems and software to reduce costs and increase productivity.

(See chapter 3 for information on recruiting, retaining, evaluating, and providing professional development for staff members.)

Keeping in touch with clinicians

The clinician turned executive needs to acquire different skills to be a successful executive and may lose touch with the reality (including the frustrations) of counseling clients and completing paperwork. Ways to keep in touch with the experiences of front-line clinicians follow:

- **Run groups on occasion.** Executives with clinical experience can step in when a staff member is sick or on vacation and function as clinician for a group. Demonstrating clinical expertise can enhance the executive's credibility with staff.
- **Manage by "walking around."** Simply by walking around, an executive can get a good sense of how the program is functioning. For example, the executive can observe and assess how well the work flows throughout the facility. Is the space arranged to promote efficiency? Is equipment easy to use and located where people need it? Are the forms easy to fill out and practical? How comfortable do staff members and clients appear?
- **Observe and monitor all clinical duties.** The executive needs to check in and observe groups and clinical services for quality assurance, clinical integrity, and adherence to the program mission and purposes. This activity requires returning to the program from time to time to observe clinical work during evening, weekend, or early morning program hours. These observations can help an executive understand any differences that may occur among these various shifts.

Expert consultants

A good executive knows when professional advice is needed and makes use of consultants. For example, a computer consultant can design software to improve the documentation process. A human resources specialist can help design a benefits package. A lawyer can draft protocols for reporting child abuse and neglect. A grant specialist can identify funding opportunities and prepare grant applications and other proposals.

Free expert consultant services are available for nonprofit programs. These free services (e.g., through the United Way) include help with board development, strategic planning, and administrative training. The nonprofit corporation CPAs for the Public Interest assists organizations in setting up budget, fiscal, and payroll systems and helps programs prepare for audits.

Consultants can help the executive define the program's philosophy, clarify the program's mission, develop new programs, and translate all of these into written policy. They can help programs establish and plan performance improvement and quality assurance programs and "sell" the importance of the quality improvement process to staff members.

The executive needs to model efficient, effective operating methods.

For some clients, food is an incentive… to keep their appointments.

Facility Management

The executive is responsible for maintaining a facility that is in compliance with local building and fire codes and standards set by the State or accreditation bodies. The facility also should be attractive and comfortable for clients. Whether the clinic is a residential or an OT program, an inviting facility aids in client retention. To create an inviting environment, the program executive should consider the following:

- **Ensure that the interior is physically attractive.** Furnish the waiting area with comfortable chairs, attractive furniture, and colorful and informative pictures and posters. Recovery-oriented posters are an inexpensive way to decorate. Remove broken furniture, old magazines, or out-of-date announcements. Encourage staff members to decorate their offices in a way that expresses their commitment to professionalism and client care. The executive sets the tone for staff by the way in which the executive's office is decorated.
- **Maintain cleanliness.** Replace or clean any heavily stained chairs and carpets, and encourage the staff to feel responsible for the facility's appearance. All staff members can help by tidying up the waiting area, throwing away clutter as they move through the common areas, and bringing in cheerful items for display.
- **Encourage a nurturing, friendly atmosphere.** Complement the motivational clinical strategies that engage and retain clients in treatment with a warm environment. Important ways to create such an atmosphere include
  - *Friendly receptionist or office manager.* Ensure that the receptionist or others who answer telephones are trained to be supportive and welcoming. Their manner can help create a welcoming, positive experience for the client. The skill of staff members who are in initial contact with potential clients, their families, and other concerned individuals is an important ingredient of a successful outpatient program. (See chapter 3.)
  - *Comfortable seating*. Offer comfortable seating in the waiting area that is adequate for the number of clients coming in and out.
  - *Refreshments*. Provide fruit, bagels, coffee, tea, or water. For some clients, food is an incentive to visit the program or to keep their appointments. In addition, some indigent, homeless clients who have chronic illnesses may need to take their medications with food. Providing food may add to program costs, but these expenses can be kept to a minimum by negotiating with local businesses to provide food at a discount.
  - *Educational entertainment*. Provide materials that are educational and entertaining in the waiting area, such as educational videos, a selection of recent magazines, books that clients can take with them, or a computer terminal with educational programming. Programs can diversify the materials they offer in the waiting room by asking for donations from the community.

Financial Management

The executive faces the challenge of managing the program's budget while trying to increase revenue, decrease costs, and deliver the best service to clients.

Budgeting and monitoring funding resources

The executive tracks actual revenues and expenses, compares them to projections, and makes the necessary adjustments. The program executive should be prepared to seek additional support or to cut expenses during a budget cycle. Tracking accounts receivable is especially important. The executive should be aware of the current financial status of each funding source, know when any account is falling behind, and conduct whatever negotiations are needed to restore revenue quickly.

Balancing expenditures and services

The executive who exercises effective fiscal management is attuned to the fact that the program may have services and management structures that no longer serve clients' and the program's needs. The executive should review the program's services and its management structure analytically and objectively, asking these questions: Is every service essential? Is each generating sufficient revenue? Is the service worth what the program charges for it?

To maintain the most efficient, cost-effective operation, the executive may need to change the program's mix of services or restructure staff positions. A challenging task is to strike a proper balance between new opportunities and the program's financial capacity. A balance must be achieved between the following extremes:

- **Too many staff members in management roles.** If management positions have proliferated, it may be time to eliminate tasks or to consolidate positions in a way that maintains an effective management structure.
- **Too little administrative structure.** Cutbacks can result in too little management to sustain program integrity and support high-quality clinical services. When cutbacks are too severe, the remaining staff members can be overextended and assigned tasks that they cannot manage. Under these circumstances, hard decisions must be made about which services are essential and which are ideal, but unaffordable.

Some ideas for decreasing costs include

1. **Change the service mix.** Core program services should be self-supporting. Services that are not self-supporting after 6 months should be reviewed carefully and eliminated, unless they are essential to the organization's mission and other revenue streams are sufficient to underwrite the costs.
2. **Change the staffing mix.** Several strategies can be considered:
   - *Consolidate positions.* One program with four large sites originally had hired a manager for each site. When managed care began cutting back on approved treatment sessions, the program executive eliminated all but one of the four onsite management positions and upgraded other staff members to assume the additional responsibilities. A program may be able to consolidate positions by using technology. For example, instead of having individual office managers at each location, the program might have a single manager oversee work at all sites linked through a computer network.
   - "*Rightsize.*" It is always difficult to let staff members go, but from time to time financial realities make this a necessity. One way to ease the pain of this kind of decision is to give adequate notice and

provide letters of reference. Telling staff members that their positions may have to be eliminated within a certain period enables them to begin looking for new jobs while they are employed.

3. **Save staff time and labor costs by reducing paperwork.** Paperwork is a necessary part of a counselor's job, but filling out forms can take considerable time and brings little value to the client. Simplifying paperwork and eliminating repetitive forms as follows can reduce the paperwork burden for staff and improve morale:

   – *Revise the documentation process.* Eliminate any forms that require staff to enter the same information multiple times. For example, a program could use one form to establish consent to release a client's information to several different individuals or agencies. (Note that the resulting form will be valid as long as the need for or purpose of the disclosure, the kind or amount of information disclosed, and the duration of the consent are identical for each recipient and each recipient's name or title is specified [CSAT 2004].)
   – *Revise forms.* Make sure forms are up to date and collect only the information the program needs. Review all forms being used. Whenever possible, replace forms that require people to write in information with checklists that can be filled out quickly. Look at the forms used by other programs, and adopt good ideas from them.
   – *Use technology to handle client forms.* Computerize recordkeeping to save staff time. Software can be used to record and update treatment plans, progress notes, diagnosis and discharge summaries, and referral planning and progress. Completing records by computer means that many fields, such as client contact information, will be filled automatically instead of being rewritten by hand. Although there are costs associated with making a transition to a computerized system, an automated recordkeeping system can produce substantial long-term savings and efficiencies.

4. **Find savings through strategic partners.** For example:

   – *Increase buying power.* Save money on drug testing, human resource services, and supplies and equipment purchases through agreements with other human service providers.
   – *Ask a partner to provide a critical service.* Find a partner that already provides a service and is willing to serve the program's clients (see exhibit 2-5 for an example).
   – *Engage staff.* Invite staff members to suggest ways to cut costs; reward their contributions.
   – *Find free resources.* It may be possible to arrange training for staff at no charge to the program. Both SSAs and CSAT provide training free of charge. Sometimes larger treatment programs allow staff members of smaller agencies to join inhouse training programs.

Program Visibility: Outreach and Public Relations

An important part of the executive's job is maintaining the program's visibility in the community. Executives who cultivate and maintain strong relationships help ensure that when the program needs support, the program is well known.

Political Relationships

State officials can help secure funding. Even if a program is funded privately, it probably still is regulated by State officials. Officials who feel connected to the program and its executive are more likely to support a program.

Exhibit 2-5

Example of Reducing Costs for an Emergency Hotline

IOT programs need to offer 24-hour emergency coverage for their clients. Telephone answering services are often inadequate, however, because they are expensive and not staffed by clinicians. One provider found the following solution:

An urban IOT program agreed to pay a local detoxification center to handle calls from IOT clients on the detoxification center's 24-hour helpline. The center's service was less expensive than an answering service and of higher quality because it was staffed by nurses and addiction specialists who had emergency care knowledge and understood confidentiality requirements.

Both parties benefited from the agreement. The IOT program obtained 24-hour telephone coverage by skilled staff, and the detoxification center received new business because clients requiring hospitalization were admitted to its facility. In addition, a strategic partnership was created.

To establish and maintain strong relationships with State regulators and State and private funders, the executive should consider the following options:

- Spend time with officials, getting to know them (and giving them the opportunity to get to know the executive). These encounters can take place through one-on-one meetings, on the telephone, or at conferences.
- Invite officials and funders to attend program functions, such as client graduations. Observing program activities gives officials and funders a clear picture of what the program does, who its staff members are, and the clients it treats.
- Keep the program visible to officials and funders with regular mailings about program achievements. A short note is appropriate when the program wins an award, gets a new grant, joins a new coalition, or is featured in a news story.

The executive should make an effort to get to know local officials (e.g., the town executive, mayor, town council, community board) and attend community board or town council meetings regularly to cultivate relationships with local officials.

Outreach to the Community

The program has a web of community relationships with neighbors, local groups, clients, and clients' families. The program affects the quality of life in the neighborhood around it, just as the neighborhood affects the quality of the program. A potential benefit of active outreach activities is the opportunity to reduce the stigma associated with a substance use disorder. The stigma of addiction prevents people from seeking help and deters policymakers from providing adequate funding for care. Everyone benefits when a program's outreach presents a positive portrayal of recovery and its effects on individuals, families, and the community.

Neighborhood relations

Neighborhoods often do not welcome substance abuse treatment programs. Programs seeking to move to a new location or expand in their current one may encounter resistance from people in the neighborhood. Because of the stigma that substance abuse carries, landlords and communities often have the following fears about treatment programs:

- The program threatens the building's appeal to other tenants or the neighborhood's residential character.
- The building and parking lot will become unsafe. (There will be drug deals and theft.)
- Property values will decrease.

(See CSAT's Technical Assistance Publication 14, *Siting Drug and Alcohol Treatment Programs: Legal Challenges to the NIMBY Syndrome* [Weber and Cowie 1995]), for information.)

OT programs do not usually encounter as much community resistance as residential programs; however, potential landlords are often unwilling to lease space to a substance abuse treatment program. The executive should listen attentively to the landlord's concerns and address each directly. The executive should emphasize that clients are not permitted to loiter at the office entrance or smoke in front of the building. References from current landlords also can be helpful. A treatment site should be chosen carefully so that clients feel safe, comfortable, and welcome.

Educate potential clients

One way to reach the community is to educate potential clients (and their parents, spouses, and employers) about substance abuse treatment in general and publicize the program and its services. This kind of community outreach can reduce the stigma of substance abuse and present a positive image of recovery. Many people believe that they are not touched by substance abuse. They need basic information about its impact, signs and symptoms, methods of prevention, and treatment options.

Other opportunities for outreach

The program should have ongoing relationships with other local groups. Presentations can be given by the program executive, staff, or former clients and might include the following formats:

- An informational event for faith-based institutions, schools, lawyers, physicians and other health care providers, and community organizations (e.g., Lions Clubs, Optimists Clubs) about substance abuse in the area, followed by a question-and-answer period.
- A multisession "understanding addiction" course with slides. These sessions can be promoted to local employers for presentation to their workforces or to EAPs. The presentation can be accompanied by educational slides developed by the program or procured from NIDA (www.nida.nih.gov) or SAMHSA's NCADI (www.ncadi.samhsa.gov).
- A 3- to 4-hour course that combines addiction education with stress management. One program charged $350 each time it presented this material to groups of 30 employees working for a local company.
- Presentations for parent–teacher groups or parents of middle and high school students about substance abuse, including drug paraphernalia and inhalants available in the household. In one community, a program provided each family with a booklet called "A Guide to Winning the Beer Battles." This guide was designed to help parents respond when their children insisted that "all the kids are doing it."

Public Relations—Promoting the Program

Promotional materials

A stand-alone brochure with an engaging format is an effective public relations item. It could feature an attention-getting heading, such as "Does someone you know have a drug or alcohol problem?" Often, a checklist of signs that indicate a substance use disorder is an effective public relations tool. Many informative brochures, booklets, and posters are available from SAMHSA's NCADI (www.ncadi.samhsa.gov). One program executive repackages NCADI materials regularly and sends them to local media and community organizations. The name, address, and telephone number of the treatment program should be printed on all promotional materials. The program can coordinate distribution of promotional materials with national events, such as SAMHSA's Recovery Month activities every September.

Program brochures can be illustrated with photographs of the program's facility and list program services and links to other organizations, as well as the name and telephone number of a contact person.

Promotional gifts

Creative promotional gifts can be an effective public relations tool. One executive noticed that clients in the driving-while-intoxicated program who smoked tended to have higher blood alcohol levels than nonsmokers. He had matchbooks made with covers advertising the program and distributed them where cigarettes were sold. To food vendors, he gave napkins printed with 10 self-assessment questions and the program's contact information. When staff members gave public presentations, they distributed business cards with the telephone numbers of the presidents of the United States and Russia, the Israeli prime minister, and the Pope, as well as the program's telephone number, local numbers for Alcoholics Anonymous and Narcotics Anonymous, and a suicide hotline. The card was so popular that the program had to print 10,000 at a time.

Post-It® Notes printed with the program's contact information are another useful promotional tool. One program included a pad of notes in each envelope it sent to a referral source.

> A treatment site should [help] clients feel safe, comfortable, and welcome.

Newspaper and bulletin publicity

The program executive can write columns for and supply news about the program to the local community newspaper, bulletins of faith-based organizations, newsletters of human service agencies, elected officials' letters to constituents, and community listservs. The executive can take information from activity reports to funders or from professional journals in digest form and rewrite it for the general public.

Television and Radio Access

The executive can create public service announcements for local radio and television stations, appear on interview programs and panel discussions, and produce programming for community-access TV channels. A board member or community leader with expertise can help with these projects.

One way to get free "advertising" is to provide a public service. In one community, a lawyer sponsored a free ride service on New

Year's Eve; an IOT program provided the dispatching service. The program was mentioned on the radio, helped the community, and reached people who could benefit from its services.

Yellow Pages Telephone Directory

Telephone directories often feature free listings in the "Human Services" section. The executive should ensure that the program's service is listed in all relevant sections. If the program has a 24-hour telephone coverage, it can be listed as a 24-hour helpline, which may significantly increase the number of calls. The executive might consider listing the program under "Addiction Services," which will appear in the beginning of the directory—an advantage that may be more valuable than an expensive advertisement.

3 Managing Human Resources

In This Chapter...

Policy Issues and Guidelines

Guidelines for Staffing

Selection of Qualified and Competent Clinical Staff

Staff Supervision

Continuing Education and Training

Motivating and Retaining Staff

Outpatient treatment (OT) and intensive outpatient treatment (IOT) programs work with profoundly compromised clients. The challenge may be greatest in the public sector, where the usual needs of clients with substance use disorders are compounded by poverty, illiteracy, co-occurring mental disorders, discrimination, HIV and hepatitis C infection, and histories of abuse, homelessness, and isolation. Moreover, unlike many other health care providers, IOT programs are expected to provide this care to clients without the controls of residential care and in groups instead of individually because funds are scarce. Working in IOT programs requires a highly developed set of skills, which makes managing human resources especially important.

The consensus panel recommends that, to be effective, programs attract, train, and retain skilled staff members who are dedicated to providing competent and compassionate care. This chapter is designed to help programs meet some of the challenges that administrators face, including the following:

- **A scarce supply of experienced staff.** Because IOT is a relatively new level of care, few clinicians have long-term experience working in IOT programs. This shortage is particularly acute for counselors from ethnic and minority groups.
- **Increasing demand in other systems for trained counselors.** Programs face competition from other systems such as criminal justice and social services, which are adding counselors.
- **Low pay.** In some areas, counselors in treatment programs are paid less than food service and janitorial workers. In 2002, the average starting salary for counselors surveyed in the National Treatment Center Study was $28,000, the equivalent of $13.50 per hour (National Treatment Center Study 2002). In 1999, more than half of the counselors surveyed were making $30,000 or less annually. Nearly one in five counselors was making $20,000 or less (National Treatment Center Study 1999).
- **Long hours and inconsistent work schedules.** Clinical coverage often demands evening and weekend hours, which can result in staff members' feeling isolated from their colleagues and support services. Sometimes staff members are required to work broken day shifts,

which, like evening and weekend schedules, can interfere with family life.
- **Paperwork.** The consensus panel estimates that up to 40 percent of providers' time is spent completing paperwork.
- **Stressful demands of the treatment population.** Unpredictable client behavior, high risk of crisis, and "secondary trauma" (resulting from listening to clients recount their traumatic experiences) place extra demands on staff.
- **Time required to handle complex client issues.** Programs address client retention, relapse, employment problems, psychosocial issues, and family problems, but they also must devote time to case management, networking with employee assistance programs (EAPs), employers, social service agencies, mental health care providers, and the criminal justice system.
- **Limited community resources.** In some areas, treatment is complicated further by a lack of community resources. The clinical staff is required to put extra effort into nontraditional substance abuse treatment tasks, such as providing assistance with vocational placement, housing, and transportation.

A program should employ and retain clinical staff members who are empathic, caring, and able to function in this stressful environment. It is important that clinicians be autonomous, while functioning as part of a multidisciplinary team.

This chapter covers the following key issues:

- Policy issues and guidelines
- Guidelines for staffing
- Selection of qualified and competent clinical staff
- Staff supervision
- Continuing education and training
- Motivating and retaining staff

Policy Issues and Guidelines

Establishing formal written policies and procedures provides guidelines for staff members, ensures that they understand their roles and responsibilities, provides security and stability for them, and outlines the ethical and behavioral standards expected of them. Administrators should consider having all staff members sign copies of policies to document that they have read and understand them.

Program Philosophy

The program philosophy should express a clear vision and mission, consistent with the daily operations of the program. The philosophy statement defines performance expectations, standards for effective and ethical treatment interventions, and the relationship between clinician and client. It also specifies standards that encourage high-quality care, professionalism, and a commitment to the well-being of clients and staff. This document should refer to the specific treatment theories and evidence-based practices used by the program. It should be reviewed and amended regularly. (For more information on developing strategic and operating plans, see chapter 2.)

Shared Staff Attitudes and Knowledge

It is helpful when staff members have similar treatment orientations. If one program philosophy does not hold sway, clients may find themselves caught between clinicians with different approaches and conflicting treatment recommendations. Staff and management should work together to develop the program philosophy. Treatment beliefs about which staff should agree include

- Addiction is a biopsychosocial and spiritual disorder, best treated by multidisciplinary approaches; it cannot be treated effectively or exclusively by any one discipline or orientation. For some clients, this may include medication in combination with counseling and behavioral therapies.

- Recovery is possible, and together staff members can treat people with addiction successfully.
- Recovery support groups, such as mutual-help programs, are vital aspects of treatment and recovery.

Policies and Protocols on Professional and Ethical Responsibilities

Management is obligated to ensure that all staff members, and counselors in particular, are knowledgeable about and adhere to accepted professional and ethical standards of conduct.

Professional code of ethics

Treatment providers come from many different professions, each of which has its own professional code of ethics. These codes are the basis for identifying and managing ethical issues, and staff should adhere to them.

Staff members also should be held accountable for maintaining professional standards and client safety. A program might wish to adopt the code of ethics used by its State board of counselors. Exhibit 3-1 lists professional standards that should be discussed with staff. A source of information is the code of ethics developed by NAADAC, The Association for Addiction Professionals, downloadable at naadac.org/documents/display.php?DocumentID=11.

Exhibit 3-1

Issues Regarding Professional Standards

A counselor should demonstrate the following:

- Familiarity with mandatory reporting requirements
- Adherence to professional standards and scope of practice
- Knowledge of the difference between a clinical relationship and that of a peer counselor or sponsor to a client
- Willingness to use clinical supervision and peer assessments to gain insights into clinical deficiencies
- Awareness of current research and trends in addiction and related fields
- Involvement in professional organizations
- Respect for clients from diverse backgrounds
- Recognition of the effect that personal bias toward other cultures and lifestyles can have on treatment
- Understanding of personal recovery and its effect on the provision of treatment
- Capacity to conduct self-evaluation
- Participation in regular continuing education
- Use of self-care strategies

Conflicts of interest

The policy about conflicts of interest should be clear to staff members, particularly part-time staff members who often have affiliations with other agencies. For example, a senior-level person who works part-time in the program also may run the best recovery house in the area. This staff person will benefit personally from referring clients to that facility. Clinic policy should ensure that all referrals are based on the client's need and choice—not on personal benefit of staff members. Ethical guidelines protect both the clinic and the client.

Guidelines to protect staff safety and health

Policies and procedures to safeguard staff safety and health should be framed according to the program's client population. For example, counselors' personal safety may be at risk with severely impaired clients. The consensus panel recommends that at least two staff members be on site whenever clients are present.

Standards for staff–client relationships

The program should have clearly stated ethical standards that delineate boundaries for staff–client relationships. Because staff members may see clients in the community, clear guidelines are needed about staff contact with clients outside the program, including policies on romantic relationships between staff and clients and on protecting client confidentiality. Such guidelines should address specifically the issue of staff members who participate in recovery support groups.

Review of complaints and incidents

Counselors sometimes work in isolation and may be susceptible to charges of misconduct. Programs should have clear policies about sexual harassment, sexual relations, and other violations of professional conduct and have a protocol for reviewing and documenting incidents and complaints. These incidents should be handled immediately.

Guidelines for Staffing

An OT program needs a core full-time staff that is responsible for maintaining continuity of care. The program should be run by this core of clinical staff members who consider the program their primary employer. Although many programs depend on part-time employees, an OT program should not be run exclusively with part-time staff unless it serves a very small or specialized population.

Staff Roles and Responsibilities

In large programs, some clinical services may be provided by specialists. In small programs, some staff members might need to be trained to provide comprehensive services. IOT programs that offer distinctive treatment, such as medically managed detoxification, family therapy, and recreation and leisure activities, may require physicians, physician's assistants, family therapists, or certified recreation therapists. OT program personnel fall into four categories:

1. **Core clinical staff** provides such direct client treatment services as assessment, counseling, case management, crisis interventions, and clinical supervision; OT-based detoxification programs also need appropriate medical staff.
2. **Clinical management** includes clinical supervisors with certified supervisory status and relevant clinical experience, as well as case managers.
3. **Specialized services** may include the multidisciplinary team psychologist, psychiatrist, social worker, vocational counselor, family therapist, and outside consultants who provide education, case management,

and transition and discharge planning; medical staff provides examinations, assessments, and medication management.

4. **Administrative, clerical, and support staff** performs such administrative functions as program planning, quality assurance, fiscal management, logistical support, information management, contracts management, and regulatory compliance. Outreach workers are becoming increasingly important for some OT programs. Security guards also may be part of support staff.

Multidisciplinary teams

Staff members should be hired with an eye toward building a multidisciplinary team. The multidisciplinary team may include full-time, part-time, or consultant workers whose skills overlap. For example, nurses and social workers also may serve as addiction counselors. As the treatment field grows, less attention is being given to a person's training or discipline and more attention is being paid to the person's competence in addiction treatment and in the treatment of co-occurring disorders. The size of teams varies according to the facility, but each team should be able to address

- Medical services
- Counseling
- Case management
- Family services
- Social services
- Psychological services
- Psychiatric services
- Liaison with criminal justice, child welfare, and other agencies
- Other ancillary services

The consensus panel realizes that this type of robust staffing is possible only with adequate funding. Programs may not be able to supply all these services. Setting up linkages and a system for collaborating with other agencies is imperative.

Specialized services

Core staff members often are able to provide many specialized services needed in a program. Some services include

- Vocational rehabilitation
- Recreational therapy
- Art, music, and dance therapy
- Nutrition counseling
- HIV/AIDS counseling
- Spiritual counseling
- Literacy and general equivalency diploma preparation

Clerical and administrative staff

Clerical staff members are often the first individuals to have contact with potential clients and their families. The nature of this initial interaction can help determine whether the client successfully enters treatment. Administrative staff members are responsible for communicating information about the program to potential clients and referral sources. Outreach workers who know the community can play a crucial role in engaging clients in treatment. Security guards can be a welcoming, protective presence. These individuals are valuable team members and should receive training about substance use disorders, the nature of the program, positive client relations, and confidentiality regulations. They also must be appropriately supervised and supported.

> Clinic policy should ensure that all referrals are based on the client's need and choice…

Interns and trainees

Recruiting students or program alumni to be interns is a good way to train qualified staff. A program can form a partnership with the department of psychology or social work at a local university or community college. Interns and trainees can perform many clinical and nonclinical functions. These trainees may include

- Physicians and medical students who are participating in addiction medicine internships
- Undergraduate and graduate students in clinical psychology, counseling, social work, and addiction studies
- Nurses preparing for a specialty in addiction

Trainees and interns can be valuable adjuncts to the program and should be incorporated into staff planning. The consensus panel recommends that programs develop policies pertaining to the recruitment, oversight, and granting of clinical privileges to intern staff members and develop written policies and procedures for notifying clients that their care may be provided in part by interns and trainees. The qualifications of interns and trainees affect reimbursement. Some addiction treatment trainees may be qualified as counselors and be eligible for reimbursement.

Staff in Recovery

Many programs recruit and hire counselors who are in personal recovery. According to the National Treatment Center Study, which surveyed 400 programs, 60 percent of counselors were in recovery (National Treatment Center Study 1999). Counselors and staff members in recovery bring a valuable perspective to the treatment of clients with substance use disorders. The consensus panel recommends that program staffs include both professionally trained clinicians who are in personal recovery and those who have no personal addiction experience. The balance of perspectives is valuable for programs, regardless of the treatment model. A policy about the length of time counselors must be in recovery before being hired is needed (see exhibit 3-2). For example, programs generally do not hire applicants who have less than a year in recovery, although they may hire people in early recovery for noncounseling positions. A written policy protects the program if someone challenges its hiring policy for counseling positions.

Personnel policies regarding staff misuse of alcohol or drugs

Programs should maintain a drug-free workplace. Clinics should explore the use of drug testing for employees. Drug testing should follow the program's written policies and might consist of preemployment testing and testing for cause. Programs can ask applicants for counseling positions about their recovery status if the job description and employment policies make clear that abstinence is job related. (For information on a drug-free workplace, visit workplace.samhsa.gov/home.asp.)

Programs need to address the issue of staff drug use. A member of the professional staff who is impaired as a result of substance use may affect adversely the recovery of his or her clients, exposing the program to liability for malpractice. A program's reputation and standing in the community may be damaged by a counselor who is abusing substances. Personnel policies should detail expectations and rules of conduct for professional staff and should explain disciplinary procedures and consequences of staff misuse of alcohol or use of drugs. Integrating job descriptions, personnel policies, and policies regarding relapse and substance use by staff will make it easier to implement or enforce action in difficult or ambiguous situations. Establishing these policies is complicated because Federal (and many State) laws that prohibit employment discrimination treat alcohol abuse differently from drug abuse (see exhibit 3-2). Programs drafting policies for

Exhibit 3-2

Laws Regarding Hiring and Employing Staff in Recovery

Two Federal laws protect certain individuals with substance use disorders from discrimination in employment: the Federal Rehabilitation Act (29 United States Code [U.S.C.] § 791 *et seq.* [1973]) and the Americans with Disabilities Act (ADA) (42 U.S.C. § 12101 *et seq.* [1992]). These laws protect individuals who have histories of substance use disorders, some people who currently abuse substances, and individuals who currently are receiving treatment. Some States also provide protection to individuals who formerly abused or currently abuse substances. Not all programs are subject to these laws.

1. **The laws generally regard people with substance use disorders as individuals with disabilities** but distinguish between individuals who are in recovery and those who currently abuse substances and between alcohol abuse and illegal drug abuse.
   a. **Individuals in recovery.** The laws protect people who abused alcohol and drugs in the past and are in recovery.
   b. **Individuals who abuse alcohol.** The laws provide limited protection against employment discrimination to people who currently abuse alcohol but who can perform the requisite job duties and do not pose a direct threat to the health, safety, or property of others in the workplace.
   c. **Individuals who abuse illegal drugs.** The laws do not protect people currently abusing illegal drugs, even if they are qualified and do not pose a direct threat to others in the workplace.
   d. **Individuals in treatment.** Individuals who are participating in a supervised rehabilitation program and no longer are engaged in drug or alcohol abuse are protected.
2. **The laws protect only individuals who are "qualified" for employment.** The ADA defines a "qualified individual with a disability as an individual . . . who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires. [C]onsideration shall be given to the employer's judgment as to what functions of a job are essential, and if an employer has prepared a written description before advertising or interviewing applicants for the job, this description shall be considered evidence of the essential functions of the job" (42 U.S.C. § 1211(8)).
3. **The laws prohibit the use of standards or other selection criteria that screen out individuals with a disability** unless the standards or selection criteria are shown to be job related to the position and are consistent with business necessity (42 U.S.C. § 12112(b)).
4. **The laws prohibit preemployment medical examinations or inquiries about applicants' disabilities (or the severity of disabilities)** "unless such examination or inquiry is shown to be job-related and consistent with business necessity" (42 U.S.C. § 12112(d)(4)).

It is important to note that laws can differ from State to State and that Federal laws change. Providers are advised to consult their human resources department or legal counsel for the most up-to-date laws and statutes.

relapse and substance abuse by employees should consider the following issues:

- **Distinguishing between alcohol abuse and use of illegal drugs.** The law does not protect staff members who use illegal drugs but does protect employees abusing alcohol if they can perform the essential functions of their jobs and do not pose a direct threat to health and safety. Programs must decide whether to treat relapse involving illegal drugs the same as relapse that involves alcohol or legal drugs.
- **Job performance of impaired professional staff.** Written job descriptions should include abstinence and drug-free status as a requirement. Moreover, staff members who have relapsed or begun abusing alcohol are likely to be unable to perform the essential functions of their jobs and may well pose a direct threat to clients' health and safety.
- **Whether to provide incentives for employees to come forward.** Programs should consider establishing incentives for employees who are experiencing a relapse to come forward voluntarily and obtain help.
- **Treatment for a staff member who returns to work after regaining abstinence.** The program needs to determine how much time must pass before an employee may return to work. The program also should decide how much increased supervision will be provided and for how long.

Staffing To Meet Diverse Needs

Culturally diverse staff

A program will benefit from a culturally diverse staff. This diversity needs to encompass all levels in the organization, including the administrative, clinical, and support staff members, as well as the board of directors. A challenge facing treatment programs is how to recruit, attract, and hire sufficient people from different groups. Chapter 4 suggests a number of recruiting and hiring strategies.

Special staffing needs for affinity groups

Affinity groups are clients with common characteristics that affect treatment; they include women, adolescents, and clients with co-occurring disorders. Women-specific programs are concerned about setting up a supportive environment in which female clients can feel empowered, learn coping skills, and address issues of physical, emotional, and sexual abuse. Such programs employ primarily women at all levels, which can create an environment that allows female clients to feel more comfortable discussing their lives and that provides role models of responsible, professional women (Weissman and O'Boyle 2000).

Staff Structure

Carefully formulated staffing structure, clear organizational relationships, job expectations, and a staff communication system are important to a supportive work environment. Management should provide staffing that is tailored to the clients the program serves and accommodates the personal lives of the staff members.

Issues to consider when formulating staff structure include the following:

- Some clients come from highly supervised inpatient settings to the less restrictive OT environment. Staff may face resistance and acting-out behavior as clients adjust to treatment. Some clients may test the limits of the program and their counselors. Staff members need to be prepared for and equipped to treat recalcitrant clients.
- Clients benefit from continuity with the same staff members from assessment through completion of treatment. Clients tend to drop out when they are transferred from one clinician to another. One study found that pregnant women in an outpatient program benefited when continuity

was provided in both counseling staff and group membership from the time of the women's inpatient assessment through the IOT and stepdown phases of treatment (Weisdorf et al. 1999).
- Program staff often may provide services during evening and weekend hours. The program needs to be flexible enough to accommodate the personal and family needs of individual staff members.

Staff size

What is an appropriate staff-to-client ratio? Because programs vary widely, it is impractical to state specific guidelines for staffing levels. However, the consensus panel reports having IOT staff-to-client ratios ranging from 1-to-8 to 1-to-15. Factors to be considered in establishing counselor caseloads include

- State regulations that govern staff-to-client ratios
- The type of care provided
- The availability of auxiliary services
- The amount of work that staff members can accomplish given their schedules (e.g., a part-time employee should not be given caseload responsibilities requiring 40 hours per week)

Organizational Relationships and Job Expectations

The program's organizational structure should be articulated clearly, and staff members should have the assurance of knowing exactly what is expected in their roles, job responsibilities, and reporting relationships. The following elements of an organizational structure are recommended:

- **An organizational chart.** This chart displays current reporting relationships among staff. Management ensures that the chart is fair and monitors it for compliance.
- **Job descriptions.** Each position has a job description that outlines its responsibilities and functions. The description identifies the knowledge, skill, certifications, and any other necessary qualifications required. The job description is the basis for performance evaluations, with clearly defined expectations and performance levels. These performance indicators are measurable and change as the responsibilities of the job, activities of the program, and the capabilities of the staff change.

> Staff members need to be prepared for and equipped to treat recalcitrant clients.

- **Established evaluation process.** The process for evaluating job performance should be identified clearly and followed. This process includes formal assessment and review of a staff member's skills, knowledge, strengths, and weaknesses. Other evaluation measures include
  - Direct observation of clinical sessions by the supervisor
  - Documentation of the training sessions attended
  - A plan for future training and professional growth
  - Formal notification of areas for correction
  - Formal and informal processes for staff review of management

Staff Communications System

A program needs a comprehensive plan for communicating information among all staff members. The multidisciplinary team approach necessitates good communication among all team members, so they are knowledgeable about each client and can work

together. Also, all staff members need to be kept up to date on protocols in a crisis, emergency, or disaster.

Staff meetings

Convening routine, structured meetings is recommended. These regular meetings can address the concerns of staff members and provide training on clinical and administrative issues. Staff meetings should focus on reviewing the therapeutic effects of the current treatment plan and determining the need for service adjustments.

As frequently as circumstances permit, case reviews should be conducted to review client progress. Regular meetings bring all involved staff members together to assess each client's status, brainstorm treatment strategies, and coordinate services. Through these meetings, the team can discuss and plan for ancillary services such as housing, employment, health care, mental health care, and family counseling.

Unstructured team meetings and informal "huddles" are valuable in maintaining continuity of care. Staff members should be encouraged to ask for brief meetings whenever there is a need. For example, holding a meeting at the end of a stressful day allows staff members to discuss their feelings, problems, and complaints before another workday begins. Nightly huddles also give staff members a chance to discuss followup plans for clients who did not show up that day and to work through clinical events or client problems that require immediate attention.

> …the ability to be an effective counselor may be more the result of experience than of academic training.

Administration feedback to staff

In many organizations, administration has knowledge that is not passed along to staff. Issues that should be shared with staff, but often are not, include program performance, policymaking, competitive status, and finances. Counselors benefit from involvement in negotiations or discussions with managed care organizations (MCOs) and from participation in required authorizations, case reviews, utilization reviews, and social or educational events with MCO staff. Increasing the information available to the clinical staff translates into better care for the client.

Staff teambuilding

Regular retreats can help promote teamwork. At a retreat, clinicians are away from the stress of the job and can concentrate on teambuilding. A retreat reinforces the idea of employees as stakeholders of the program, involved in management and decisionmaking. Retreats should have a clear agenda, objectives, and anticipated outcomes. Often, programs try to accomplish too much during a retreat. The consensus panel recommends that the agenda for a retreat focus on one or two program planning issues.

Selection of Qualified and Competent Clinical Staff

Research shows that the therapeutic alliance is a critical factor in treatment (De Weert-Van Oene et al. 2001). Counselor empathy can have a profound and positive effect on client outcomes (Miller and Rollnick 2002).

Research also suggests that the ability to be an effective counselor may be more the result of experience than of academic training. In a National Institute on Drug Abuse (NIDA) study of collaborative cocaine treatment, individual and group drug counseling by experienced treatment counselors was more effective

in reducing overall drug use than two types of professional psychotherapy conducted by trained therapists who had less experience treating clients who were substance dependent (Crits-Christoph et al. 1999).

Qualities of Effective Counselors

Arnold M. Washton (1997), a pioneer in the early design of IOT programs, listed the following qualities of effective counselors:

> Skilled clinicians who can be warm, empathetic, tolerant, nonjudgmental, flexible, focused, firm, and clear will be the most effective. Choose counselors who are good motivation mobilizers and change facilitators. These are people who like doing counseling and know how to talk to the patients with empathy and concern. They focus on patients' strengths rather than weaknesses. They are eternal optimists and not easily frustrated. They maintain clear boundaries, but do not come across as distant. (pp. xxvi–xxvii)

Personal qualities

To work in a stressful, changeable environment, staff members need to be emotionally mature, adaptable, and creative. They should have the capacity to relate effectively to others and to confront and resolve their own personal difficulties, show self-respect and respect for others, and be willing to learn about and understand people with backgrounds different from their own. They should be capable of taking advantage of mentorship, learning from criticism, and adapting to new approaches. They should be eager to examine their prejudices and able to avoid overidentification with clients.

Addiction knowledge

All treatment professionals, regardless of professional identity or discipline, should have a basic understanding of addiction that includes knowledge of evidence-based practices, pharmacology, and the biological bases of addiction.

Certification and credentialing

Programs need to recognize one or more certifying bodies for their professional staff. When hired, clinical staff members should be certified, licensed, or working toward certification or licensure in their discipline, with attention given to training in the addiction field.

Staff members should obtain credentials in addiction treatment and have a professional development plan to ensure compliance with internal privileging standards and those of credentialing bodies such as NAADAC and the American Society of Addiction Medicine.

Clinical competence of counselors

Clinical staff should meet counselor standards established by the International Certification Reciprocity Consortium and by State addiction counselor certification boards. In addition, staff members should be aware of best treatment practices as determined by research-based evidence. Programs should have counselors who are licensed or certified to treat co-occurring (substance use and mental) disorders.

Programs that have no affiliations with providers of ancillary services benefit from having staff members who are capable of providing a wide range of services. Staff should be able to demonstrate competence in the following areas (CSAT 2006*a*):

- Clinical evaluation
- Treatment planning
- Referral
- Services coordination
- Counseling
- Client, family, and community education
- Documentation
- Professional and ethical responsibilities

Appendix B in *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (CSAT 2006*a*) lists the competencies that form the foundation for professional treatment of substance use disorders.

Clinical evaluation skills. Staff members should have a clear understanding of how to evaluate a client clinically, including screening and assessment. They should understand that the diagnostic process is a framework for identifying appropriate treatment. To perform diagnostic functions, staff members need to establish rapport with clients, manage crisis situations, and determine when additional assistance is needed. Staff members also need to identify their own biases and understand how their values and beliefs may affect both communication with clients and their treatment recommendations. Clinical staff also should be knowledgeable about

- The use of current screening and assessment instruments and the interpretation of their results
- The effect of cultural diversity on information gathering and on the assessment of client needs
- Mental status assessment criteria
- Confidentiality requirements

Staff members should know the symptoms of intoxication, withdrawal, and toxicity for all psychoactive substances, as well as the physical, pharmacological, and psychological implications of substance use and abuse. Staff members should be able to assess client readiness for treatment and accept the client's assessment, even if the client is not ready. The clinical staff is expected to use appropriate matching and placement criteria, as well as the current *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association 2000) or other accepted diagnostic standards.

Counselors should be familiar with theories about how clients change their substance abuse behavior, as well as how to assess their readiness for the treatment process. Motivational interviewing techniques can help increase the readiness of clients for treatment (CSAT 1999*b*; Prochaska and DiClemente 1986). Using assessment data and other information gained from interactions with the client, counselors determine the client's readiness for change and what will help the client use treatment effectively. Counselors also identify barriers to treatment and recovery.

Treatment planning skills. The following competencies are needed to plan treatment well:

- **Effective communication and collaboration skills.** The counselor communicates effectively with the client, the client's family, and colleagues. It is important for the counselor to explain treatment implications to both the client and the client's significant others, working with them in a collaborative effort.
- **Planning, priority setting, and evaluation skills.** The counselor works with clients to define and prioritize their needs. For each need, the counselor formulates a measurable outcome. These outcomes are the basis for treatment evaluation.
- **Knowledge of treatment options and resources.** The counselor develops an individualized action plan, in collaboration with the client. To design the best plan, the counselor should understand all available treatment modalities and community resources consistent with the client's diagnosis and demographic background (e.g., race, age, gender, ethnicity, ability, and sexual orientation).

Referral skills. Many clients need referral for social services. To provide adequate service, clinical staff should use community support systems and other providers effectively; this activity involves understanding the continuum of care. Many clients have been involved in the legal/medical/treatment network previously and may have complicat-

ed histories. Some clients may need to be referred for crisis intervention related to mental disorders, for indepth mental status examination, for medication assessment, or for other reasons.

Services coordination. Services coordination depends on the counselor's ability to manage cases, advocate for clients, coordinate community resources and treatment services, and work within managed care systems.

Counseling skills. Several fundamental counseling skills are common to individual and group counseling:

- The ability to establish rapport and engage with the client. Counselors and other clinicians should be direct and nonjudgmental and treat clients with respect.
- The ability to recognize whether counseling and other therapeutic interventions are working. Counselors should have an awareness of the client's reaction to the therapeutic process and of their own reaction to the client.
- The ability to integrate therapy with events occurring in the client's life. Staff members should be comfortable becoming involved with the client's family, employer, and community if permission is granted.
- The ability to know when to seek help from other professionals or a supervisor.
- The ability to educate clients about addiction and recovery.
- The ability to help clients build and practice recovery skills.

Counseling family members of clients requires counselors to understand how substance use affects family dynamics. Counselors should also be adept at engaging family members in the treatment process.

Family involvement is an important but often overlooked component of treating a family member who abuses substances. Staff members who provide family therapy should have supervised experience with family therapy. Family specialists working with clients who abuse substances should have a thorough knowledge of family support in the community and social services, such as Al-Anon and Nar-Anon. Strategies that support clients in recovery and improve family communications and functioning are also valuable.

> …us[ing] community support systems and other providers effectively…involves understanding the continuum of care.

Client, family, and community education. Education is an integral part of a treatment program's activities, whether the audience is clients, family members, or the local community. Suitable topics include

- Factors that increase the likelihood of substance use disorders
- Signs, symptoms, and course of substance use disorders
- Continuum of care resources that are available
- Principles and philosphy of prevention, treatment, and recovery

Documentation. Substantial documentation is required for most agencies to be in compliance with regulatory and funding agencies. Clear documentation also serves important clinical goals essential to the treatment process. Because of time constraints, counselors need to balance requirements for thoroughness and accuracy with pressures to be productive.

Professional and ethical responsibilities. All staff members, and counselors in particular, have access to extremely sensitive personal information about clients. Because of their knowledge of the client and their professional

role, they hold significant power over clients, who may be vulnerable because of their criminal justice or employment status. Consequently, staff members need to adhere to their professional and ethical obligations.

Recruiting and Hiring Staff

The hiring of qualified staff is critical to the successful treatment of the client, and this responsibility is best shared by several members of the treatment team. Skilled, capable staff members keep the program running effectively and efficiently. Ill-prepared, incompetent, and dysfunctional staff members will compromise client care and the existence of a program.

Programs face a shrinking pool of applicants because of the increasing demand for trained counselors. Just as clients need to be matched to the most appropriate treatment modality, so do staff members need to be matched to an appropriate type of treatment setting and service delivery system. Some questions to consider include

- Does the applicant have experience in the program's treatment modality?
- Does the applicant have experience working with the types of clients served in the program?
- Does work experience suggest that the applicant will be able to function competently with all the program's potential clients? A staff member should be able to treat a diverse client population and prevent personal assumptions and biases from affecting outcomes.
- Is the applicant knowledgeable about addiction, recovery, and the maintenance of a therapeutic alliance?

Recruiting applicants

The consensus panel recommends that programs be forward thinking in their search for new staff.

Advertise the position broadly. Many candidates are identified by word of mouth, so programs should network with people who may know candidates both locally and regionally. They should be sure to consider Internet job sources, such as Monster.com and Hot Jobs. Some potential resources include

- National sources such as the Addiction Technology Transfer Center (ATTC) Web site (www.nattc.org)
- An ad placed in the NAADAC Career Classified Ad Program (www.naadac.org)
- Ads in local newspapers, including neighborhood papers
- An ad in any Single State Authority (SSA) newsletter or Web site
- State certification boards
- An announcement through the State provider association
- Announcements to pertinent local and State chapters of professional societies
- Announcements to the psychology and social work departments of local colleges and universities

Use special efforts to find ethnically diverse staff. To counteract the shortage of trained counselors from minority groups, the consensus panel suggests the following:

- **Plan to train young candidates.** Programs may need to hire young candidates; a young person will require more training than will an experienced candidate.
- **Acknowledge that competent minority candidates are highly marketable.** Trained minority counselors, especially those who are multilingual, are in high demand. These candidates should be recruited creatively. If the program cannot pay a high salary, administrators should provide a sign-on bonus and try to retain these counselors.
- **Identify special resources.** Some States now provide funds to train counselors from minority groups. The SSA can provide more information.

Interviewing and assessing the candidate

When interviewing candidates, a program should look for the qualities of effective counselors mentioned earlier in this chapter.

A team assessment process. A recommended way to be sure that a candidate can work as part of a team is to have the clinical staff participate in the selection process. Here is a sample interview process.

1. Staff members interview candidates before the clinical director meets with candidates. Part of this interview can be a role play of a counseling session to give staff a sense of how candidates would work with clients. The clinical director can set up the framework for staff to use in evaluating candidates, including
   - Objective criteria for evaluating a candidate.
   - An interview form to score candidates (see exhibit 3-3). This interview form can be modified to reflect the characteristics that the clinical director and staff would like to see in the new hire.
2. The clinical director interviews the candidates recommended by staff.

Checking applicant credentials. An applicant's references should be contacted to verify prior employment and elicit comments on the person's qualities as a counselor. Educational achievements can be verified. Some States require that agencies verify the credentials of their staff and obtain checks for criminal and child abuse convictions. In addition, it is important to run background checks on all employees being hired for drug and alcohol treatment programs.

Applicant's recovery status. Individuals who are not in recovery may claim to be in recovery, thinking that it will enhance their chances of being hired. Rather than asking applicants whether they are in recovery, it is better to ask questions designed to assess their knowledge of mutual-help recovery. For example, the prospective counselor might be asked, "If a client tells you she is having a tough time with the Third Step, what might her issues be and how might you respond?" Knowledge-based questions provide important information about how the candidate will perform as a counselor, and they avoid discrimination based on recovery status, real or feigned.

Staff Supervision

Clinical supervision needs to be integrated fully into program management. Ongoing clinical supervision benefits programs by improving care and staff performance. Evidence suggests that clinical supervision is the most appropriate way to reduce staff stress, increase motivation, mobilize for crisis intervention, and provide ongoing evaluation of skills and knowledge bases (Powell and Brodsky 2004).

Responsibilities of Supervisors

Ongoing supervision that is responsive to staff needs should be provided regularly. Supervisors need training in supervisory techniques and adequate time to supervise. Senior counselors can share in supervisory duties if their caseloads are adjusted to allow them time for both duties.

Supervisors perform the critically important role of educating, encouraging, guiding, and monitoring staff. Supervisors in small clinics

Suggestions for Supervisors

1. Praise publicly.
2. Criticize privately.
3. Listen.
4. Ask questions.
5. Focus on solutions and on best practices.
6. Work to improve supervision skills.

Exhibit 3-3

Counselor Interview Form

Before scheduling an interview, review the following over the phone:

1. Working hours (e.g., three evenings a week plus Saturday)
2. Salary range for the position
3. Whether the candidate has transportation to get to work

Candidate's Name:_____

Date and Time:_____

Credentials:_____

Scoring Key: 0 = Poor; 1 = Fair; 2 = Good; 3 = Excellent

Characteristic	Score	Comments
Years of IOT experience		
Years of OT experience		
Total experience with drug and alcohol treatment		
Professionalism		
Interpersonal skills		
Understanding of mutual-help groups		
Addiction treatment training		
Computer skills		
Experience with managed care		
Mental disorder treatment experience		
Enthusiasm		
Other		

Total Score: _____ Additional Comments: _____

Availability (Hours? Start date?): _____

Interested in: ___ Full time ___ Part time ___ Either

Experience Using Addiction Severity Index: ___ Yes ___ No

Salary Requirements: _____

may maintain a caseload, whereas those in large clinics may have little or no direct client contact. Supervisors may serve as leaders on performance improvement teams (see chapter 6) and help staff members focus on the organization's mission, goals, and objectives.

Supervisory issues with addiction counselors

Powell and Brodsky (2004) suggest that supervisors be particularly concerned about the following:

- Relationships between recovering staff and clients
- Professional credibility
- Cultural bias and unfair treatment
- Staff performance evaluations
- Liability concerns
- Impaired counselors

Supervision of specific team members

Medical staff. Physicians and nurses need to be supervised by peers in the medical profession. If the organization does not employ anyone qualified to supervise medical staff, a peer review can be arranged. Clinic directors supervise medical staff on administrative issues, but not on medical care.

Part-time staff. Part-time staff members should meet regularly with either their supervisor or the team. Supervision should be part of the employees' paid work plan; approximately 1 hour of supervision should be allotted for every 40 hours of service. Suggestions for supervision include the following:

- Be flexible so that supervisory hours vary as the person's work hours increase or decrease.
- Schedule supervision intermittently, planning for about 30 minutes every 2 weeks.
- Assign part-time staff to work with particular clients; the primary therapist for those clients then becomes the part-time person's de facto supervisor.
- Allow full-time staff members to supervise senior part-timers who carry their own caseloads. In some cases, a part-time staff member also may have a private practice or an affiliation with another agency. Supervision and program policy should address any resulting conflict of interest regarding referrals.

When more than one part-time staff member works with a client, frequent and regular communication is essential. Good progress notes should serve as the main means of communication among the clinical team.

Peer extenders. A peer extender is a noncredentialed paraprofessional, such as a recovering program alumnus. The peer extender assists clients by acting as a "temporary sponsor" for them in Alcoholics Anonymous (AA) or other mutual-help groups and by taking them to support meetings. Peer extenders also may work as cotherapists or assistant therapists and need to be trained and supervised. Using recovering peers in a clinical setting has legal implications in terms of both confidentiality and professional boundaries. Peer extenders should receive training as follows:

- **Confidentiality.** Confidentiality requirements apply to both staff members and volunteers. Peers may see clients at mutual-help group meetings and should avoid violating confidentiality. For example, when seeing a client at an AA meeting, the peer should not say, "I'm so glad to see that you're out of detox." The client may volunteer particulars, but the peer is bound by the same confidentiality laws as clinical staff.
- **Professional boundaries.** It is important to set clear professional boundaries for peer volunteers regarding clients. A program needs to set up policies that prohibit peer volunteers from becoming romantically involved with clients. One director recommends that peer volunteers sign ethical guidelines specifying no romantic

involvement until a client has been out of treatment for at least 3 years.

Methods of supervision

The supervisor should meet with all the clinicians to review cases on a regular basis, at least monthly. The overhead cost of these group supervision meetings can be built into the program's budget. Individual supervision, no matter how brief, also should occur regularly.

It can be both interesting and informative to use a variety of supervisory methods. Options include case studies, chart reviews, presentations by outside experts, and videotapes and audiotapes.

Group supervision. The basic group supervision/case review format is cost effective and efficient because the entire team learns together. This format allows clinicians to ask for input from their colleagues, with the whole team solving specific problems or reviewing current cases or issues. A clinician presents a difficult case, describing the problem, diagnosis, treatment history, and course of treatment. Case review sessions increase the team members' skill in working with clients and promote consistency and quality control in treating clients. Other activities for group supervision sessions include a brief presentation on a treatment resource or evidence-based practice.

Individual supervision. It is important for each clinician to meet regularly and privately with his or her supervisor. These meetings can be brief. Regular supervision sets up a climate of learning and inquiry concerning cases—much preferable to the common practice of holding clinician–supervisor meetings only when there is a problem. Individual supervisory sessions should be an ongoing dialog about how best to treat clients and how to manage pressing treatment issues. However, these individual sessions also should focus on staff development and plans for continual improvement.

Other Roles of Supervisors

Supervisors may fill in for sick counselors, recruit new staff, and review and complete paperwork. A thorough description of the roles and responsibilities of the clinical supervisor is beyond the scope of this chapter. Other activities of supervisors are discussed in chapter 6 on performance improvement.

Continuing Education and Training

An environment of learning and inquiry is appropriate for substance abuse treatment—a field now driven by the push to adopt evidence-based practices. A spirit of learning and ongoing professional improvement motivates staff and boosts morale.

It is recommended that treatment providers, regardless of their specific discipline or amount of experience, participate in continuing education and training. The consensus panel recommends that programs offer educational and training incentives to their staff members.

All counselors and supervisors should assess their own knowledge and skills and then develop an individualized professional development plan. Professional goal setting is a vehicle for improving staff skills and competence, motivating staff, and counteracting stress (see exhibit 3-4).

Carrying out these plans is challenging because, in many programs, staff cannot get away more than one or two times per year. A program should support education and training for staff by

- Identifying resources needed for an individual's development plan. The adminis-

Exhibit 3-4

Sample Plan for Staff Education and Training

Staff Assessment and Planning Form

In the interest of your continuing professional development, we'd like you to take a minute to complete the following form.

Name: _____ Date:_____

1. Have you completed at least 6 hours of HIV/AIDS education? Yes ❑ No ❑
   If yes, when? _____
2. Have you completed at least 4 hours of tuberculosis/sexually transmitted disease and related subject training? Yes ❑ No ❑
   If yes, when? _____
3. Have you been certified in CPR and first aid training? Yes ❑ No ❑
   If yes, when? _____
4. Review the following topic list and rank each topic on a scale of "1" (no need for more training) to "10" (significant need for training).

Educational Topic	Your Rating	Supervisor's Rating	No. of Hours in Last Year's Plan
a. Supervision and employee evaluation			
b. Confidentiality			
c. Fiscal management			
d. Program administration			
e. Program planning			
f. Performance improvement			
g. Program licensure			
h. Personnel management			
i. Cultural and diversity issues			
j. Sexual harassment and related issues			
k. Computer skills			

What other topics (or specific issues within the above topics) would you like to learn more about? (Use other side for additional space.) _____

_____ _____

Director's Signature Date Employee's Signature Date

tration can inform staff about available resources (see exhibit 3-5 for suggested resources). For example, the administrator may arrange for staff to attend training sessions sponsored by local programs or find out about scholarships for courses.

- Encouraging staff members to be assertive about identifying their education and training needs.
- Being flexible with staff members in negotiating education and training opportunities. Individuals may be willing to exchange their vacation time for inservice training paid by the program. Some programs may be able to support staff members financially in gaining academic credits.
- Tying financial or other rewards to the attainment of an individual's education or training goals, such as academic degrees or professional credentials.
- Making training available on an ongoing basis to all staff members.

Exhibit 3-5

Resources for Staff Education and Training

- Professional courses offered through the 14 regional ATTCs funded by the Center for Substance Abuse Treatment (www.nattc.org). ATTCs have provided millions of hours of academic, continuing education, professional development, and practicum training to tens of thousands of individuals.
- Summer institutes. Many States offer extensive programs for staff training.
- Professional conferences.
- Online education and training.
- Web sites offering training:

  1. www.motivationalinterview.org lists trainers, as well as an extensive bibliography of abstracts, clinical demonstration videos, training events, and training videotapes in English and Spanish.
  2. www.tgorski.com lists training and consultation services, publications, workbooks on relapse prevention and denial, and links.

- Distance education courses. A link at www.nattc.org provides a list of online courses from sponsors approved by the ATTCs, NAADAC, and the International Certification and Reciprocity Consortium. This site lists audio/video teleconferences, CD-ROMs, and correspondence, e-mail, and online courses. Courses are listed by topic and language.
- Home-study course books offering continuing education credits. Online booksellers offer the following courses from Red Toad Road Company (qualityfilmvideo.com/smyth), with continuing education credits for psychologists approved by the American Psychological Association:

  1. *Addictions Motivational Interviewing* with distance supervision available, 12 continuing education units (CEUs), based on the work of Miller and Rollnick (2002).
  2. *Addictions Coping Skills*, 10 CEUs, a cognitive–behavioral approach based on a training guide by Monti and colleagues (2002).

Onsite Training

The program's training plan needs to account for the entire staff, including outreach workers, receptionists, and security guards. The entire staff needs to have some understanding about clients with addiction problems.

Training for nonclinical staff

Training for nonclinical staff can be brief but should be tailored to individual roles:

- **Security guards.** Guards need training in screening people who enter the building. They should have a protective, not intimidating, presence.
- **Reception and clerical staff.** Training for clerical or administrative staff should include
  - Positive, "customer service" orientation
  - Telephone and reception skills development, using people who have had retail training to teach customer service techniques
  - Role plays of first contact and other interactions with clients
- **Outreach workers.** Training for outreach workers should focus on setting boundaries between the outreach worker and client.

Training about confidentiality laws should be included for all security guards, clinical staff, and others associated with the program. It is recommended that programs have staff members sign statements of confidentiality that are maintained in personnel folders.

Training for clinical staff

Training and professional growth have been associated with increased counselor motivation, improved performance and morale, and decreased stress (CSAT 1999b; Miller and Rollnick 2002). Staff training programs should focus on topics or approaches appropriate for the client mix (e.g., cognitive–behavioral approaches, co-occurring disorders, relapse prevention, motivational techniques) as well as the identified population served by the agency (e.g., cocaine specific, women's programs, criminal justice).

Manuals and training documents are available for program use in skills development. Many manuals and curriculums have been tested and validated empirically. The lesson plans included in these resources are an asset that can be put to greater use by those in the field. The consensus panel recommends that programs use the materials listed in exhibit 3-6 for training sessions.

Additional training topics

In addition to having knowledge of resources that build counselors' therapeutic skills, administrators should be aware of the following training topics:

- **Multicultural awareness.** All staff members need to appreciate how their underlying biases and attitudes affect client treatment. Training is required to maintain cultural competence and unbiased clinical service (see chapter 4).
- **Aggression management techniques.** All staff members need to know how to manage aggression in clients and defuse volatile situations.
- **Crisis management.** Training in crisis management gives staff members the skills necessary to handle crisis situations. Skills include sound judgment, the ability to assess and respond appropriately, understanding personal limitations, and the ability to stabilize a psychological, social, or medical crisis.

A program needs to train clinicians in recordkeeping, legal matters, and service purchasers' requirements.

Documentation skills. Good recordkeeping is more than a bureaucratic obligation. A program must document its case records effectively for the sake of licensure, utilization review, quality assurance, reimbursement, and program evaluation. The records track

Exhibit 3-6

Selected Training Documents

Motivational Groups for Community Substance Abuse Programs (Ingersoll et al. 2000) can be ordered at www.motivationalinterview.org/news/groupguide.html.

Enhancing Motivation for Change in Substance Abuse Treatment (CSAT 1999*b*) contains motivational exercises, illustrating how to enhance motivation for treatment in both clients and their family members.

The Matrix Institute on Addictions (visit www.matrixinstitute.org) offers IOT therapist and client manuals as well as other manuals. The institute also offers 2-day IOT training on the Matrix Model for continuing education units.

Managing Your Drug or Alcohol Problem: Client Workbook (Daley and Marlatt 1999) and *Managing Your Drug or Alcohol Problem: Therapist Guide* (Daley and Marlatt 1997) focus on teaching clients how to manage cravings and reduce the risk of relapse.

A wide range of training documents and client workbook materials is available from the Hazelden Foundation at www.hazelden.org/bookplace.

National Institute on Alcohol Abuse and Alcoholism manuals from the Project MATCH Monograph Series can be ordered at www.niaaa.nih.gov/publications/match.htm. The series includes

- *Cognitive–Behavioral Coping Skills Therapy Manual* (National Institute on Alcohol Abuse and Alcoholism 1994)
- *Motivational Enhancement Therapy Manual* (National Institute on Alcohol Abuse and Alcoholism 1995*a*)
- *Twelve Step Facilitation Therapy Manual* (National Institute on Alcohol Abuse and Alcoholism 1995*b*)

The NIDA Clinical Toolbox contains science-based materials for drug abuse treatment and can be downloaded at www.drugabuse.gov/TB/Clinical/ClinicalToolbox.html. The NIDA Therapy Manual Series includes the following volumes that can be downloaded from the URLs listed:

- *A Cognitive–Behavioral Approach: Treating Cocaine Addiction* (manual 1), www.drugabuse.gov/TXManuals/CBT/CBT1.html
- *A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Dependence* (manual 2), www.drugabuse.gov/TXManuals/CRA/CRA1.html
- *An Individual Drug Counseling Approach To Treat Cocaine Addiction* (manual 3), www.drugabuse.gov/TXManuals/IDCA/IDCA1.html
- *Drug Counseling for Cocaine Addiction: The Collaborative Cocaine Treatment Study Model* (manual 4), www.drugabuse.gov/TXManuals/DCCA/DCCA1.html
- *Brief Strategic Family Therapy for Adolescent Drug Abuse* (manual 5), www.drugabuse.gov/TXManuals/BSFT/BSFT1.html

program changes, client progress, case planning, and hours of service. They help treatment providers communicate with one another, which is especially critical when a client is transferred.

It is essential that staff be trained comprehensively to document assessments, interventions, treatment plans, transitional notations, and discharge plans. This recordkeeping is both a fundamental responsibility of treatment staff and a requirement for certification. Staff members should receive training in how to document treatment outcomes, using accepted methods and instruments. The training also should cover the following specific elements and skills:

- Regulations about client records
- Essential components of the client records, including release forms, assessment instruments, treatment plans and revisions, progress notes, and discharge summaries
- Client rights
- How to analyze, synthesize, and summarize information, with guidelines for documenting cases in a timely, clear, and concise manner
- Clinical terminology and the practice of objective recording

Confidential and legal requirements. A program needs to ensure that all clinical staff members completely understand program, State, and Federal confidentiality regulations, including when and how to use the appropriate release forms (CSAT 2004). Staff members should understand the basic ethical standards regarding client confidentiality.

Requirements of service purchasers. Clinical staff members need training in meeting the data requirements of purchasing entities, such as MCOs.

Motivating and Retaining Staff

Staff turnover is disruptive to clinical service delivery and represents a substantial cost in time taken to recruit, select, and orient the replacement staff. High turnover rates may be symptomatic of an unstable, poorly performing program.

Human Resources Policies

Written policies that show understanding and support for the challenges involved in treatment can be a major factor in staff morale and retention. Following are suggestions for developing thoughtful policies that encourage staff satisfaction.

Look at pay scales

Pay scales should be appropriate and reasonable. A program needs to provide fair and competitive compensation that is commensurate with the staff person's responsibility and qualifications. When a valuable staff member receives another job offer, managers should consider making a counteroffer to retain him or her.

One provider reports that salary was the number one reason that IOT, OT, and residential treatment staff members gave for leaving their positions. The average annual salary increase in the new position was $6,000.

Recognize challenges

Administrators should acknowledge the stressors and challenges faced by the staff—such as working odd hours in isolation and with limited resources—and establish emotional and structural supports.

Managers should explore opportunities for staff members to do special project work, which can enhance their skills, increase their commitment, and reduce burnout. Such opportunities are possible through staff rotations or through a training swap with

other agencies. Business mechanisms that assess performance and award incentives (e.g., 360-degree feedback, in which staff members are evaluated by all their colleagues) are also important. These mechanisms should be connected with both the individual's and the agency's goals. (See chapter 6 for detailed information about using performance measures to enhance staff competence and motivation.)

Support Within the Work Environment

Part of a program manager's job is to encourage and mentor staff, as well as promote excellence. Managers should function as role models in terms of attitudes and performance. To ensure that treatment staff avoid overwork, burnout, and isolation, managers might

- **Use clinical teams** so that decisionmaking about clients is a group endeavor, with input from various disciplines. The team assesses and charts progress, plans treatment, and functions cooperatively, putting the best interests of clients first. A supportive, team approach can help reduce staff stressors because responsibility is shared among all staff members. No individual will feel isolated and overwhelmed. It is imperative that staff members have a full spectrum of clinical support services available on short notice and that clinicians know when and whom to ask for help.
- **Encourage team building, cooperation, and conflict resolution** at staff meetings and retreats.
- **Promote a culture of mutual respect** by including team members in the decisionmaking process. Replace subjective performance evaluations with objective ones. (See chapter 2 on administration and chapter 6 on performance improvement.)

EAP services

Programs should explore contracting with an EAP for their employees. A full-service EAP provides stress management, referral, brief counseling, and critical incident debriefing, if indicated, for staff. Alternatively, program management should have EAP-like policies in place. Such policies should encourage employees to use their mental health benefits if they are having personal difficulties and provide referrals for employees who have problems that interfere with job performance.

Flexible and individualized personnel practices

Flexible work schedules can help in recruiting and retaining good staff. It is possible to establish flexible schedules that meet the needs of program operations and accommodate the needs of staff members. Work sharing also may ease caseload problems. Program policy should state clearly which employees are not available for overtime work.

The program needs to have clearly stated policies that demonstrate the administration's concern for staff well-being (e.g., support for time-off requests to reduce stress). Such policies cover mental health days to reduce stress, vacation and sick time, compensatory time, and time to pursue continuing education.

Recognition, incentives, and rewards

One cause of burnout is the lack of praise and recognition. The work environment should offer unbiased recognition, reward, and promotion. Supervisors and administrators should look for opportunities to praise the work being done by staff. Some examples are

- **The "story" box.** Staff members at one program created "stories of ourselves." Staff members record good things about

other staff members and put them in a box. At staff meetings, the stories are drawn from the box and read aloud.

- **Performance improvement initiatives.** It is helpful to provide objective indicators of accomplishment so that high performers are recognized and those who need to improve can be provided with objective feedback and appropriate direction.
- **Incentives.** Managers should consider providing incentives for superior performance.

If left unchecked, burnout will adversely affect staff members' commitment to the treatment program and its clients. In addition to recognizing employees' innovations and accomplishments, administrators can mitigate the effects of burnout by giving employees autonomy, communicating openly and clearly, and ensuring an equitable work environment (Knudsen et al. 2003).

4 Preparing a Program To Treat Diverse Clients

In This Chapter...

Understanding Cultural Competence

Learning About Cultural Competence in Organizations

Preparing for Cultural Competence Assessment

Understanding the Stages of Cultural Competence

Performing Cultural Competence Assessment

Implementing Changes Based on Cultural Competence Assessment

Developing a Long-Term, Ongoing Cultural Competence Process

Undertaking Program Planning

As the 2000 census makes clear, the United States is a diverse multicultural society. Minority groups make up roughly one-third of the Nation's population, up from one-quarter in 1990. Minority groups are the fastest growing segment of the U.S. population (U.S. Census Bureau 2001). Foreign-born people now constitute more than 11 percent of the population—an alltime high (Schmidley 2003).

This chapter provides the consensus panel's recommendations on how to improve the cultural competence of treatment programs by

- Understanding cultural competence
- Learning about cultural competence in organizations
- Preparing for cultural competence assessment
- Understanding the stages of cultural competence
- Performing cultural competence assessment
- Implementing changes based on cultural competence assessment
- Developing a long-term, ongoing cultural competence process
- Undertaking program planning

Understanding Cultural Competence

What Is Cultural Competence?

Cultural competence is

- The capacity for people to increase their knowledge and understanding of cultural differences
- The ability to acknowledge cultural assumptions and biases
- The willingness to make changes in thought and behavior to address those biases

Cultural competence is an ongoing process of examination and change, not a goal to be attained once.

A culturally competent program demonstrates empathy and understanding of cultural differences in treatment design, implementation, and evaluation (Center for Substance Abuse Prevention 1994). According to *Cultural Issues in Substance Abuse Treatment* (CSAT 1999*a*), culturally competent treatment is characterized by

- Staff knowledge of or sensitivity to the first language of clients
- Staff understanding of the cultural nuances of the client population
- Staff backgrounds similar to those of the client population
- Treatment methods that reflect the culture-specific values and treatment needs of clients
- Inclusion of the client population in program policymaking and decisionmaking

It is important for administrators to understand that moving their program toward cultural competence requires a personal commitment and significant involvement from the entire staff. Cultural competence is an ongoing process of examination and change, not a goal to be attained once. To move toward cultural competence, staff members will have to contemplate on an ongoing basis what life is like for people different from themselves. Administrators should encourage program staff members to adopt an inquisitive and open-minded attitude toward other cultures.

Why Cultural Competence Matters

The Nation's diversity has important implications for treatment programs. The percentage of minority clients in substance abuse treatment is much greater than the percentage of minority treatment counselors (Mulvey et al. 2003). Administrators need to consider whether their organizations provide competent, sensitive treatment for individuals from minority groups. Following are compelling reasons for undertaking this effort:

- **Individuals from minority groups can be a significant—even majority—sector of potential clients.** In 2000, 59.0 percent of those admitted to treatment were Caucasian, 24.0 percent non-Hispanic African-American, 12.0 percent Hispanic, 2.3 percent American Indian and Alaska Native, and 0.8 percent Asian and Pacific Islander (Office of Applied Studies 2003*b*).
- **Understanding and appreciating a client's cultural background expand treatment opportunities.** Every culture has specific values that can be used in treatment, such as the support of extended families and of religious or spiritual communities. By appreciating a client's culture, staff can tap into the most effective treatment strategies—those based on the personal and social strengths of each individual.
- **Enhancing the sensitivity and capacity to treat clients from other cultures improves a program's ability to treat all clients.** The consensus panel believes that the competent handling of diversity is a basic issue underlying good treatment. The empathy and trust that a program's staff needs to practice to move toward cultural competence are an extension of the qualities that make a good counselor.
- **Cultural competence is increasingly a requirement of funding and accreditation bodies.** Attention to cultural competence is a requirement for accreditation by the Joint Commission on Accreditation of

Healthcare Organizations (JCAHO). JCAHO currently is reviewing and is expected to adopt some form of the national standards for culturally and linguistically appropriate services (CLAS) in health care, developed by the U.S. Office of Minority Health. The CLAS standards were published in 2001 and are available at www.omhrc.gov.

- **The ability to attract and serve ethnic clients is a financial issue.** Improvements in cultural competence may contribute to improved client retention (Campbell and Alexander 2002).

Learning About Cultural Competence in Organizations

Administration's Attitude Toward Cultural Competence

Cultural competence starts with the program's administration. The more flexible and adaptable the program's organizational structure is, the more it will be able to incorporate the kind of changes cultural competence calls for. Rigidly hierarchical organizations are resistant to change and are hampered particularly when minority viewpoints need to be included (Administration for Children and Families 1994).

Cultural competence requires that people at all levels of the program learn to value diversity. The administration can demonstrate the seriousness of its commitment to cultural competence by investing human and financial resources in the effort and providing incentives for cultural competence training just as it would for other forms of continuing education. A culture of learning, where self-assessment and staff development are regular program activities, lends itself to cultural competence.

Becoming culturally competent means expanding the perceptions and the worldview of all staff members. The reassessment can result in fundamental changes for both individual staff members and program policy and structure. When staff members are asked to undergo serious self-examination and change, there may be resistance and varying degrees of success. Administrators should anticipate staff objections and reassure staff members that no one is being singled out for being insensitive—everyone can strive to be more culturally competent.

Defining Diversity

The consensus panel recommends that administrators define diversity broadly. Programs often assume that diversity applies only to specific ethnic and racial groups. But cultural diversity includes many groups of clients and many important factors that affect treatment—a client's gender, age, sexual preference, spiritual beliefs, socioeconomic status, physical and mental capacities, and geographic location. Program staff members should be aware of the many dimensions of diversity and how these factors can be used to motivate and assist clients in treatment—or how they can be barriers to engagement, treatment, and recovery.

The glossary in exhibit 4-1 defines common terms in the context of cultural competence.

Background Resources

An administrator may want to explore materials and resources on cultural competence and organizational change. Information on how to support staff members in changing attitudes and behaviors is available in Thomas (1999). (See appendix 4-A on page 68 for articles, books, and Web sites on educating staff and preparing programs for cultural competence.)

Federal agencies and academic centers offer information to assist administrators in determining the steps to take in planning, implementing, and evaluating culturally competent service delivery systems. One

Exhibit 4-1

Glossary of Cultural Competence Terms

Cultural diversity. Differences in race, ethnicity, nationality, religion, gender, sexual identity, socioeconomic status, physical ability, language, beliefs, behavior patterns, or customs among various groups within a community, organization, or nation.

Culture. Social norms and responses that condition the behavior of a group of people, that answer life's basic questions about the origin and nature of things, and that solve life's basic problems of human survival and development.

Discrimination. The act of treating a person, issue, or behavior unjustly or inequitably as a result of prejudices; a showing of partiality or prejudice in treatment; specific actions or policies directed against the welfare of minority groups.

Ethnicity. The beliefs, values, customs, or practices of a specific group (e.g., its characteristics, language, common history, and national origin). Every race has a variety of ethnic groups.

Ethnocentrism. The attitude that the beliefs, customs, or practices of one's own ethnic group, nation, or culture are superior; an excessive or inappropriate concern for racial matters.

Multiculturalism. Being comfortable with many standards and customs; the ability to adapt behavior and judgments to a variety of interpersonal settings.

Prejudice. Preconceived judgments, opinions, or assumptions formed without knowledge or examination of facts about individuals, groups of people, behaviors, or issues. These judgments or opinions usually are unfavorable and are marked by suspicion, fear, or hatred.

Race. The categorizing of major groups of people based solely on physical features that distinguish certain groups from others.

Adapted from Administration for Children and Families 1994, pp. 108–109.

resource is the National Center for Cultural Competence at Georgetown University's Child Development Center (www.georgetown.edu/research/gucdc/ nccc/index.html). The Health Resources and Services Administration (2001) also offers materials.

Research on treatment

Little research exists on practical ways for programs to deliver culturally competent substance abuse treatment to specific populations. Beutler and colleagues (1997) found that matching clients with counselors of the same race improved engagement and retention for some clients but for others it had no effect. Some ethnic groups (e.g., Asians) place such a strong emphasis on community that it is often easier for them to discuss problems with a counselor who is outside their group.

Further complicating the picture, clients' engagement with counselors and retention in programs also can be improved if such race-blind attributes as socioeconomic class, acculturation, and education are used to match clients with counselors (Chinman et al. 2000). Increased retention does not translate necessarily into increased client engagement in the treatment process (Chinman et al. 2000). In the mental health field, evidence that matching clients with counselors based on race improves treatment outcomes is inconclusive (Chinman et al. 2000). Administrators should not overlook the potential benefits of treating diverse clients together, where they can learn from one another across, instead of within, racial and cultural boundaries.

The Center for Substance Abuse Treatment's (CSAT's) forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT forthcoming *b*) provides both the latest research and expert advice from practitioners on clinical issues and treatment of diverse populations. Administrators also should consult TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*d*), and *Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence* (Center for Substance Abuse Prevention 2001). *Cultural Issues in Substance Abuse Treatment* (CSAT 1999*a*) contains population-specific discussions of treatment for Hispanics, African-Americans, Asian and Pacific Islanders, and American Indians and Alaska Natives, along with general guidelines on cultural competence.

Preparing for Cultural Competence Assessment

An administrator should consider the following issues before undertaking the various cultural competence assessments described below:

- **Take advantage of staff knowledge.** Counselors and nonclinical staff members should serve as resources; administrators should find out what staff members have learned from their experience with clients from diverse backgrounds.
- **Educate and motivate staff.** Staff members can learn from resource materials on substance abuse treatment and culturally diverse groups that the administrator has collected. Involving the entire staff in the cultural competence effort promotes self-assessment as a program priority and helps secure the staff's commitment and participation.
- **Establish a cultural competence task force.** This group will lead the cultural competence assessment and will be responsible for planning, carrying out, and evaluating the program's cultural competence initiatives. It should have representation from throughout the program—board members, administrators, clinicians, nonclinical staff members, and clients. The task force can be divided into work groups to focus on different aspects of assessment (e.g., community, client, program; see "Performing Cultural Competence Assessment" below). An administrator also should try to involve members of the community in the self-assessment process.
- **Network with other groups.** It will be beneficial for the administrator to talk to other programs that have developed culturally competent service delivery systems and to solicit input from diverse groups in the community.

Understanding the Stages of Cultural Competence

The administrator and staff might find it useful to think of cultural competence occurring along a continuum that includes six stages, ranging from cultural destructiveness to cultural proficiency (see exhibit 4-2). Without attention to cultural issues, most organizations are at cultural incapacity (stage 2) or cultural blindness (stage 3). Agencies that begin to look at competence issues will be at cultural precompetence (stage 4). Even when a program reaches cultural proficiency (stage 6), there is still room for growth and improvement.

Performing Cultural Competence Assessment

Agency self-assessment is valuable in planning for culturally competent service delivery. To capture all useful information relating to a program's cultural competence, the self-assessment must survey the community, the clients, and the program itself. This assessment has two key goals: to determine how culturally competent the program's services are and to provide information for a long-term improvement plan. Assessment focuses on the following questions:

- What is the composition of the local population? Are all those who need care being served in the program?
- What is the level of satisfaction with the program among clients from minority groups?
- How prepared and competent is the program to meet the treatment needs of the diverse groups in the community?

Community Assessment

An administrator needs to identify the culturally, linguistically, racially, and ethnically diverse groups in the program's locale. Appendix 4-B on page 71 provides a matrix that can be used to determine the demographics of a local area, using 2000 census data. These data can be accessed at www.census.gov. The information is useful for assessing

- The percentage of minority and ethnic individuals residing in the catchment area
- The extent to which individuals from various ethnic groups are accessing services
- The underrepresented groups that may need targeted outreach

The census data also allow a program administrator to compare community demographics with those of the program staff. Does the staff reflect the makeup of the community? Does the board of directors include individuals who represent local population groups? Does the program have caseworkers, outreach workers, or other personnel who have links to all groups in the community?

Cultural competence has different emphases depending on the makeup of the local community. Each program establishes what cultural competence means with respect to the clients it serves. People from the community and members of the board and the staff who represent diverse groups can provide useful information about the program's level of cultural competence and needed services.

Assessment by Clients

Important information about a program's level of cultural competence can be supplied only by the clients it serves. How satisfied are clients with the services they receive? Surveys help determine the accessibility and sensitivity of the program and are an effective method of program assessment. It is recommended that a program survey clients at the time of discharge (or dropout) from the

Exhibit 4-2

Stages of Cultural Competence for Organizations

Stage 1. Cultural Destructiveness

- Makes people fit the same cultural pattern; excludes those who do not fit (forced assimilation).
- Uses differences as barriers.

Stage 2. Cultural Incapacity

- Supports segregation as a desirable policy, enforces racial policies, and maintains stereotypes.
- Maintains a paternalistic posture toward "lesser races" (e.g., discriminatory hiring practices, lower expectations of minority clients, and subtle messages that they are not valued).
- Discriminates based on whether members of diverse groups "know their place."
- Lacks the capacity or will to help minority clients in the community.
- Applies resources unfairly.

Stage 3. Cultural Blindness

- Believes that color or culture makes no difference and that all people are the same.
- Ignores cultural strengths.
- Encourages assimilation; isolates those who do not assimilate.
- Blames victims for their problems.
- Views ethnic minorities as culturally deprived.

Stage 4. Cultural Precompetence

- Desires to deliver quality services; has commitment to civil rights.
- Realizes its weaknesses; attempts to improve some aspect of services.
- Explores how to serve minority communities better.
- Often lacks only information on possibilities and how to proceed.
- May believe that accomplishment of one goal or activity fulfills obligations to minority communities; may engage in token hiring practices.

Stage 5. Cultural Competence

- Shows acceptance of and respect for differences.
- Expands cultural knowledge and resources.
- Provides continuous self-assessment.
- Pays attention to the dynamics of difference to meet client needs better.
- Adapts service models to needs.
- Seeks advice and consultation from minority communities.
- Is committed to policies that enhance services to diverse clientele.

Stage 6. Cultural Proficiency

- Holds all cultures in high esteem.
- Seeks to add to knowledge base.
- Advocates continuously for cultural competence.

Source: Cross et al. 1989, pp. 13–18.

program. Programs then can analyze by gender, race, ethnicity, religion, and physical ability the feedback received from clients about services.

Program Self-Assessment

Self-assessment of the treatment program's cultural competence should include the following areas:

- Administration policies
- Physical facility
- Staff diversity
- Staff training
- Screening and assessment methods and tools
- Program design

To be effective, cultural competence self-assessment should be undertaken in a supportive environment; involve the entire program, including board members and volunteers; include a formal review in which all who were involved in the assessment learn the results; and culminate with the decision to take specific actions (Gonzalez Castro and Garfinkle 2003; McPhatter and Ganaway 2003).

> Hiring ethnic or minority staff members... is important for programs that serve diverse populations.

The results of an agency self-assessment should be used to develop a long-term plan that includes measurable goals and objectives and may indicate changes to be made in the mission statement, policies, administration, staffing patterns, service delivery practices and approaches, and outreach and professional development activities.

Several assessment tools are listed in appendix 4-A on page 68.

Implementing Changes Based on Cultural Competence Assessment

Most programs can benefit from administrative-level changes that can be accomplished quickly. These changes can be made in program mission, program policy, board membership, community input, staff diversity, and facility appearance. The more attention the administration pays to diversity, the more positive and supportive all staff members will be about expanding their cultural competence.

Mission statement. The program should ensure that its mission statement incorporates cultural competence as a core value. The cultural competence committee should be involved in developing or modifying the statement.

Program policy. The program policy should endorse explicitly and respect the cultural diversity of program clients, staff members, and the community. Respect should be reflected in the development and enhancement of the program's philosophy, outreach activities, staffing, and client services.

Support for cultural competence should be included in staffing policies. Some suggestions follow:

- The ability to work sensitively with people from other cultures can be a criterion for evaluating staff performance.
- Program policy can encourage staff members to pursue continuing education in cultural competence, focused on groups served by the program.

A diverse board of directors. As a result of the agency assessment, an administrator may want to add board members from groups not represented. A diverse board is extremely

important and can help provide a broader perspective. Having board members from diverse groups helps establish the program's credibility with members of those groups.

Input from diverse groups. An administrator can identify knowledgeable persons from the community and involve them in the program. Their advice can help develop new interventions and services that affirm and reflect the values of the various cultures in the community.

Diverse staff and management. The administrator needs to make clear, through policy and action, the value of recruiting staff members from diverse groups. Hiring ethnic or minority staff members to work in management, policymaking, and clinical positions is important for programs that serve diverse populations.

Facility appearance. The decor of a treatment facility can make an inclusive or exclusive statement. The program's walls should reflect cultural openness, with posters and pictures showing people representative of the client population. Clients feel welcome when they see pictures of people like themselves. (See appendix 4-A on page 68 for Web sites that have appropriate posters.)

Developing a Long-Term, Ongoing Cultural Competence Process

To move toward cultural competence, programs need a long-term, ongoing commitment to change, including staff selection and training.

Steps To Take

Based on results of the cultural competence assessment, an administrator might take the following steps:

- **Obtain new screening and assessment instruments.** Identify and acquire screening and assessment materials for the diverse groups in the client population (e.g., translated or orally administered materials). Both foreign-born clients who are learning English and those with cognitive impairments may benefit from oral screening methods. Train staff to use these materials and methods.
- **Open a dialog with staff.** Convene brown-bag lunches to engage staff members in discussions and activities that offer an opportunity to explore attitudes, beliefs, and values related to cultural diversity and cultural competence.
- **Explore staff development needs.** Ask staff members what resources would help them serve culturally, linguistically, racially, and ethnically diverse groups. Use this information to develop ongoing staff training programs.
- **Revise the budget.** Allocate funds to support staff in attending conferences, seminars, and workshops on cultural competence and treatment issues relevant to the program.
- **Investigate funding opportunities.** Explore resources that are available to provide special services needed by potential clients. Many Federal grant programs are designed to fund services for underrepresented and underserved populations.
- **Remove barriers.** Address any special barriers to treatment for diverse groups identified in the assessment phase. For example, foreign-born clients may need vocational help, translation services, or English-as-a-second-language classes.
- **Inform staff and clients of resources on diversity and substance use disorders.** Provide information about the resources that are available to support clients from diverse groups.

Appendix 4-A on page 68 contains population-specific information that can help staff better understand and treat clients from diverse backgrounds.

Staff Selection and Training

The program's openness to differences in background among clients and staff members should be communicated clearly both to potential clients and to referral sources in the surrounding community. The more diverse the staff is with respect to age, gender, physical ability, race, religion, and ethnicity, the more able the program will be to treat all types of clients. A program needs to make special efforts to hire culturally competent staff.

Selecting a diverse staff

Programs need to recruit staff members whose backgrounds are similar to those of the clients being treated. Unfortunately, the substance abuse treatment field has a shortage of trained counselors from diverse backgrounds. Administrators report that bicultural and bilingual counselors are hard to recruit. A recent survey done by CSAT showed serious disproportion between the demographic backgrounds of clients and those of treatment staffs (Mulvey et al. 2003). In this survey of 3,276 randomly selected facility directors, clinical supervisors, and counselors, only 6 percent of treatment providers were Hispanic and only 11 percent were African-American. Yet the survey showed that Hispanics made up 14 percent and African-Americans 25 percent of the treatment population.

…the substance abuse treatment field has a shortage of trained counselors from diverse backgrounds.

The study concludes that "treatment professionals are generally not from the same ethnic and racial backgrounds as the clients they serve. This situation presents a tremendous challenge for the field" (Mulvey et al. 2003, p. 56). The following planning approach may be helpful in increasing the number of counselors from different backgrounds:

- Target specific ethnic and cultural groups served by the program, and assess the barriers to finding and hiring clinical staff with the same backgrounds. In areas where these groups constitute a small percentage of the population, hiring qualified counselors from the same backgrounds may be difficult.
- Tap into State and national recruiting sources, such as the Single State Agency and job search and recruitment Web sites.
- Establish a file of recruitment resources, and seek their help.
- Develop a plan to encourage potential counselors to enter the treatment field through internships. Look at providing incentives for promising candidates, including training.
- Recruit diverse candidates from local colleges; consider granting fellowships to assist advanced students in completing their degrees.

Interviewing and hiring culturally competent staff

Cultural competence is not merely a set of skills; it is also a desire to use those skills to understand others. Programs will move more easily toward cultural competence if they hire individuals who have a genuine interest in cultural diversity. The process of hiring culturally competent staff need not differ much from hiring good counselors. The same qualities are common to each: empathy, use of individualized treatment approaches, willingness to look beyond assumptions, and ability to establish trust.

In interviews, applicants should be asked to discuss what diversity means to them. Administrators should rate more highly applicants who speak of diversity in terms that go beyond race to include religion, physical ability, sexual preference, age, and gender.

Applicants also should be asked to speak in detail about their experiences working with diverse colleagues and clients. Administrators also may arrange for prospective counselors to run a group session to see how they interact with diverse clients.

Training staff

All counselors have cultural blind spots. It is important for counselors to acknowledge their beliefs and assumptions, even if they are misguided or based on stereotypes. Learning about the nuances of other cultures, particularly as they affect treatment, is not intuitive. Counselors should be willing to learn from their clients. Counselors should be trained to ask questions to learn what substance abuse and addiction mean in the client's culture. Staff members should not make assumptions about clients based on their physical ability, gender, ethnicity, or religion but approach and treat each client as an individual.

Training can be undertaken by the program itself, can focus on the particular groups being treated in the program, and can be done inexpensively. Knowledgeable people representing the diverse groups in the community can be invited to meet with staff and discuss issues affecting treatment. Training of staff members needs to focus on

- Self-assessment of cultural biases and attitudes
- Sources of cross-cultural misunderstanding
- Sources of social or psychological conflict for bicultural clients
- Strategies for clinical cultural assessment of individual clients
- Guidelines for clinical encounters

Appendix 4-A on page 68 lists tools for cultural competence training and evaluation, including Web links to trainers and consultants.

Undertaking Program Planning

A core set of administrative and structural principles is important for every program providing treatment to diverse groups. Treatment planning and goal setting should be sensitive to the individual client's recovery goals. The client's values and cultural traditions should be accepted and respected in establishing expectations and making the treatment plan. Program staff members should be sensitive to cultural, ethnic, and regional variations in family structures and in the way that clients define their families.

Criteria for Types of Programming

What type of programming will be provided for clients from minority groups in the community? A program can decide to serve diverse clients

- Within a nonspecialized treatment program, providing one-on-one counseling as needed
- Within a nonspecialized treatment program, adding specialized group meetings or tracks
- In a specialized treatment program designed for members of a particular group

Programs should consider whether they can address diverse clients' needs within a nonspecialized treatment program or whether it would be preferable to set up a specialized program serving only these clients. If people are ill at ease outside their own culture, they generally are more comfortable and trusting with others who are like them. Specialized treatment programs consisting of clients from a particular group, such as immigrants from a particular country or women, offer the chance to design program strategies for individuals who share a common background and common concerns.

However, because treatment resources are limited, administrators may face difficult choices about integrating diverse clients into general programs. Some questions to answer include

- Is the potential volume of clients sufficient to support a specialized program?
- Is financial support available for these clients?
- Will treatment goals of the specialized services fit into the program?
- Are counselors available who are sensitive to the group?
- Will there be access to training regarding the special needs of this population?
- Are links and referrals to other service providers possible for this target population?

When the answers to these questions do not support the development of a separate specialized program, administrators may want to consider enhancing their program's general outpatient treatment services with special groups and tracks.

Administrative Support for Counselors

When clients from diverse groups are to be treated in a general program, the counselor who works with them should be experienced and supportive. Such clients may need additional time in individual counseling, as well as the counselor's help to integrate them into the treatment group.

Clients from diverse groups may need ongoing, long-term social support. The available peer support groups in the community may not serve some of these clients adequately. Programs should identify and maintain a list of local mutual-help groups. If appropriate support groups cannot be identified for a particular group (e.g., Hispanic clients who abuse alcohol), the treatment program should consider sponsoring a specialized alumni support group. Bonding with a long-term support group can be a significant factor in recovery.

Specialized Treatment Programs

If a specialized program is deemed necessary, administrators should be aware that the program must follow mandatory State requirements and meet the same licensure regulations as other treatment programs. These requirements need not hamper treatment of minority clients. Directors of ethnocentric treatment programs note that, although State and accreditation requirements are the same for all programs, culturally sensitive treatment can deploy the required program elements to serve culturally diverse clients.

Identified special client populations

Clients for whom specialized programs are highly recommended include

- **Foreign-born clients.** The special language needs of some immigrant groups may be met best through specialized programming. Bilingual counselors need to be available when treating clients who speak a language other than English. Specialized programs for recent immigrants also may require focusing on U.S. laws that pertain to substance abuse and on available social support systems. For clients with limited English-language skills, important documents (e.g., confidentiality, grievance, and complaint forms) need to be translated or explained.
- **Clients benefiting from an ethnocentric approach.** Individuals from minority groups may have problems with identity, self-esteem, and cultural alienation. Ethnocentric programs that build on the individual's strengths and ethnic roots can be empowering. Treatment programs developed for Native Americans and Alaska Natives—using both Western and traditional healing methods—represent an example of the enhanced effectiveness that ethnocentric programs can achieve.

- **Clients who are disabled**, including those from the Deaf community.

Components of specialized programs

Specialized programs for a particular group should include

- **Staff members, supervisors, and administrators representing backgrounds similar to those of the clients.** Although it is important that program staff members reflect the diversity of the client population, it should not be assumed that counseling staff members will be competent simply because they share the clients' ethnicity or culture. For example, middle-class African-American counselors may not share the life experiences of African-American clients who live in inner-city poverty. Native-American programs may find that their Western-trained Native counselors need training and support before they can treat clients effectively using Native healing ceremonies and traditions.
- **Staff training and supervision.** Cultural training is important for counselors in an ethnocentric program. Programs serving foreign-born clients need to employ staff members who are multilingual and multicultural. It is important to be aware that a counselor from the same culture as the client may still need cultural sensitivity training. Culture changes within a country over time. A counselor whose family immigrated during his or her childhood may not be attuned to the culture of the recent immigrant. Also, the level of acculturation can change drastically between immigrants and their children born in this country.
- **Unbiased assessment tools.** Program staff should be sensitive to issues of cultural bias in assessment procedures. To ensure appropriate test interpretation, programs should use standardized and program-based instruments that have norms for the ethnic or cultural groups that are being treated.
- **Special programming components.** Treatment programs that serve a particular group should be culturally relevant for the particular group in content, delivery of services, and philosophy. Before designing a specialized program, administrators should seek help and advice from other providers who have developed programs for the same population. Focus groups comprising recovering members of a specific minority population, drawn from program alumni, also can be valuable.

Bonding with a long-term support group can be a significant factor in recovery.

Clients With Disabilities

Clients who are deaf

One-half of one percent of the American population is deaf, but people who are deaf are underrepresented among the population that seeks treatment (McCrone 1994). It is important for administrators to be aware of potential barriers to treatment, some of which come from within the close-knit Deaf community. Because people who are deaf socialize primarily with one another, a fear exists that personal information shared in treatment will become public via the Deaf community's communication grapevine. The Deaf community's desire to present a positive image also may deter some members from admitting to substance use problems (Guthmann and Blozis 2001).

Individuals who are deaf are reluctant to enter treatment if they think they will encounter barriers to communication. For this reason, most people who are deaf and seeking treatment for a substance use disorder prefer to be in a program with other people who are deaf (CSAT 1998*d*). Because having a separate group often is not feasible, most programs treat individuals who are deaf with hearing clients.

Deafness is defined as a disability by the Americans with Disabilities Act (ADA) of 1990; clinics are required to provide accommodations to individuals who are deaf and seek treatment. In most cases, the accommodation will consist of hiring an individual fluent in American Sign Language (ASL) to interpret during sessions. Family members of the individual who is deaf should not be used as interpreters. Administrators should not assume that all individuals who are deaf are proficient in ASL; some use other manual languages. Written materials might be difficult to understand for some individuals who are deaf; the average adult who is deaf reads at the fourth grade level (Crone et al. 2003).

Recovery can be particularly difficult for individuals who are deaf. Because there may be few people who are deaf in the area, people who are deaf and in recovery who want to sever ties with substance-using friends may have to turn their backs on nearly everyone they know. Also, support groups that include ASL interpreters are rare (Guthmann and Blozis 2001). Programs should maintain a list of resources that can be accessed by individuals who are deaf and in recovery (Guthmann and Sandberg 1998). The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals offers resources and training for treating this population. Its Web site (www.mncddeaf.org) includes articles on assessment and treatment, as well as information for ordering manuals for individuals in recovery and videotapes of mutual-help programs interpreted in ASL.

Other clients with disabilities

Individuals who are disabled have higher rates of substance use disorders than the general population (Moore and Li 1998). The higher rates can be attributed to increased risk factors, such as chronic pain, a feeling of entitlement to drugs, and access to prescription drugs. Administrators should know that the presence of a physical or mental disability may conceal signs of substance use (Li and Ford 1998).

ADA guarantees equal access to treatment for clients with disabilities. If the building that houses the program does not permit equal access to people with disabilities, administrators should consider making the necessary changes. Physical barriers include not just stairs, but narrow hallways, conventional doorknobs that prevent access to people with limited manual dexterity, deep pile carpet that interferes with wheelchairs or crutches, and water fountains and telephones that are located too high on walls (CSAT 1998*d*). People who use wheelchairs or crutches may need help arranging transportation to and from the treatment facility. While there, they may require extra time to get from place to place.

Administrators should be aware of local programs and services that are equipped to help individuals with disabilities. TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*d*), contains information about screening and treating this population; chapter 5 of TIP 29 focuses on administrative tasks, appendix B lists resources, and appendix D discusses the implications of ADA.

Designing Ongoing Outreach Efforts

Community involvement and outreach are critical parts of any long-term, cultural competence plan. Providers need to think about how they can recruit clients from cultures not adequately reached by the program.

Programs should reach out to minority individuals who are in need of treatment but may be reluctant to seek it.

Programs will benefit greatly from drawing on the cultural experience and expertise of diverse members of the community. Administrators should involve the diverse groups in developing program goals, designing networking, and ensuring client entry and retention.

The following steps can be taken:

- **Network with appropriate organizations.** Contact organizations concerned with the culturally diverse groups the program serves. Solicit their involvement and input in the design and implementation of service delivery initiatives with these groups.
- **Work to identify and remove barriers to treatment for diverse groups.** Address clients' need for transportation services, limited free time to participate in treatment, and the need for childcare services.

Although there is widespread agreement that understanding of and sensitivity to the increasingly diverse cultural groups in the United States are positive developments, it is unclear how these developments should affect treatment. McFadden (1996) observes that "simply knowing about a culture is not sufficient. The counselor must use this new information obtained through experience and incorporate it into the counseling process" (p. 234). Studies conducted to date on the implementation of culturally specific elements in substance abuse treatment have been inconclusive.

The consensus panel believes that cultural competence is a worthwhile goal for programs and recommends that it involve the entire program—from the board of directors to the part-time staff members, from the mission statement to outreach efforts. When administrators commit program resources to train and support staff members in their efforts to improve their cultural competence, the program as a whole benefits.

Appendix 4-A. Cultural Competence Resources

Background Information on Diversity and Cultural Competence

- The Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Clearinghouse for Alcohol and Drug Information (NCADI) (www.ncadi.samhsa.gov)—The NCADI Web site provides access to publications on specific populations. Click on Audience to access information on African-Americans, American Indians, Alaska Natives, Asians and Pacific Islanders, disabled individuals, Hispanic and Latino populations, and lesbian, gay, and bisexual individuals.
- Hawaii AIDS Education and Training Center (www.hawaii.edu/hivandaids/links_culture.htm)—This Web site provides links to resources on clients who are homeless, have disabilities, or are members of minority groups. The information and links provided discuss more than just HIV/AIDS and health care.
- "Effective Therapies for Minorities: Meeting the Needs of Racially and Culturally Different Clients in Substance-Abuse Treatment" (Beatty September/October 2000; www.counselormagazine. com)—This journal article includes basic steps that programs can take to move toward cultural competence.
- Cultural Competence in Substance Abuse Treatment, Policy Planning, and Program Development (www.attc-ne.org/pubs/ccsat.pdf)—This annotated bibliography of resources has sections on African-Americans, Asian and Pacific Islanders, Native Americans, and Latinos, compiled by the Addiction Technology Transfer Center of New England, at Brown University's Center for Alcohol and Addiction Studies.
- The Provider's Guide to Quality and Culture (erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English)—This Web site provides descriptions of attributes and beliefs of many cultural groups, with links and references, as well as information on cultural diversity and self-assessment tools.
- *Cultural Competence Standards in Managed Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups* (Center for Mental Health Services 1997; www.mentalhealth.org/publications/allpubs/SMA00-3457)—This book discusses guiding principles for cultural competence in the context of treatment for African-Americans, Asians and Pacific Islanders, Hispanic populations, Native Americans, Alaska Natives, and Native Hawaiians.
- "Develop Your 'Ethnocultural Competence' and Improve the Quality of Your Practice" (Straussner November/December 2002; www.counselormagazine.com)—This journal article provides a good introduction to ethnicity and culture and how both affect treatment.
- *Cultural Diversity in Health and Illness* (Spector 2003)—This book includes chapters on traditional views of health in African-American, Hispanic, American Indian, and Asian and Pacific Islander communities and appendixes that list population-specific resources.

Preparing for Cultural Competence Assessment

- *Managing Multiculturalism in Substance Abuse Services* (Gordon 1994)—This book focuses on developing a multicultural framework for treatment, program evaluation, and leadership. It includes tools to evaluate the needs of the community and the effectiveness of cultural competence training.
- Planning, Implementing and Evaluating Culturally Competent Service Delivery Systems in Primary Health Care Settings:

Implications for Policymakers and Administrators (www.georgetown.edu/research/gucdc/nccc/nccc8.html)—This checklist from the National Center for Cultural Competency helps organizations implement policies and practices that support cultural competence.

- "Evaluating Outcomes in a Substance Abuse Training Program for Southeast Asian Human Service Workers" (Amodeo and Robb 1998)—This journal article explores the challenges that cross-cultural substance abuse training programs face.
- *Culture, Race, and Ethnicity in Performance Measurement* (Philips et al. 1999)—This is a compilation of resources and readings on providing and evaluating culturally competent mental health care.

Assessment

- *A Guide to Enhancing the Cultural Competence of Runaway and Homeless Youth Programs* (Administration for Children and Families 1994; www.ncfy.com/pubs/culguide.htm)—This guide presents tools for assessing and enhancing cultural competence in youth-serving organizations. Assessment questionnaires that focus on the community, clients, and the program itself are included in appendix A. The tools and information can be adapted for drug treatment programs.
- *Cultural Competence Self-Assessment Instrument* (Child Welfare League of America 1993; www.cwla.org/pubs)—This resource provides tools for assessing cultural competence of policies, programs, and staff and guidelines for strengthening cultural competence.
- Health Resources and Services Administration. Study on Measuring Cultural Competency in Health Care Delivery Settings: A Review of the Literature (www.hrsa.gov/culturalcompetence/measures)—This report details a comprehensive review of the cultural competence theoretical and methodological literature.

Training

- Cultural Competency Tool (order forms at www.ahaonlinestore.com)—Available from the Society for Social Work Leadership in Health Care for $15 for members and $20 for nonmembers, this instrument assists in evaluating the cultural competence of staff and can be used for performance assessment, evaluation of prediversity and postdiversity efforts, or compliance with Medicaid/Medicare conditions or JCAHO cultural competence standards.
- Toolkit for Cross-Cultural Communication (www.awesomelibrary.org/multiculturaltoolkit.html)—These materials compare patterns of communication across diverse groups and discuss myths that impair cultural competence, including a table of communication norms and values across cultures.
- *Handbook for Developing Multicultural Awareness*, 3d edition (Pedersen 2000)—This book employs a three-stage model of multicultural training, focusing on culturally learned assumptions, accurate information, and counseling skills; it also discusses ethical dilemmas and conflict management.
- *Developing Intercultural Awareness: A Cross-Cultural Training Handbook* (Kohls and Knight 1994)—This book contains training activities, including preplanned 1- and 2-day workshops.
- *Figuring Foreigners Out: A Practical Guide* (Storti 1999)—This workbook focuses on interactions with people from outside the United States. Lessons can be used for group training or self-instruction and are designed to teach new attitudes and behaviors for interacting with people from diverse cultures.
- *Culture and the Clinical Encounter: An Intercultural Sensitizer for the Health Professions* (Gropper 1996)—This book presents cross-cultural health care scenarios with possible outcomes from which the reader chooses. Each choice is discussed

in a separate answer key. The question-and-answer format makes this a useful training tool.

- Intercultural Communication Institute (www.intercultural.org)—This organization conducts an annual Summer Institute for Intercultural Communication.
- The National Center for Cultural Competence (www.georgetown.edu/research/gucdc/nccc)—Web site lists links for trainers.
- Diversity Training Associates of Portland, OR (800-484-9711, ext. 8250)—This organization provides consultants and trainers.

Posters

SAMHSA's NCADI stocks posters and office materials that can be viewed and ordered at www.ncadi.samhsa.gov.

Population-Specific Information

For information and resources that address specific populations, see TIP 47, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* (CSAT 2006*b*).

Appendix 4-B. Community Diversity Form

Total City Population: _____

Total County Population: _____

	Characteristic	Total City	% of Total	Total County	% of Total
Age Distribution	15 to 19				
	20 to 24				
	25 to 44				
	45 to 59				
	60 to 74				
	75 and Older				
	Total				
Sex	Female				
	Male				
Hispanic Origin	Mexican				
	Puerto Rican				
	Cuban				
	Other				
Citizenship	Birth				
	Naturalization				
	Not a Citizen				
Ethnicity	American Indian/Alaska Native				
	Asian or Pacific Islander (API)				
	Asian Indian				
	Black or African-American				
	Chinese				
	Filipino				
	Guamanian or Chamorro				
	Hawaiian				

	Characteristic	Total City	% of Total	Total County	% of Total
Ethnicity (continued)	Japanese				
	Korean				
	Samoan				
	Vietnamese				
	White				
	Other API				
	Other Race				
	Two or More Races				
Income	<$10,000				
	$10,000–$14,999				
	$15,000–$24,999				
	$25,000–$34,999				
	$35,000–$49,999				
	$50,000–$74,999				
	$75,000–$99,999				
	$100,000–$149,999				
	$149,000–$199,999				
	$200,000+				

Source: Administration for Children and Families 1994, pp. 84–85.

5 Outpatient Treatment Financing Options and Strategies

In This Chapter...

Planning and Developing a Program

Funding Streams and Other Resources in the Substance Abuse Treatment Environment

Working in Today's Managed Care Environment

Contracts Are Primary Tools in Managed Care

Elements of Financial Risk in Managed Care Contracts

Networks, Accreditation, and Credentialing

Organizational Performance Management

Utilization and Case Management

Strengthening the Financial Base and Market Position of a Program

Preparing for the Future

Planning and Developing a Program

Developing an outpatient treatment (OT) program is a major financial challenge, whether the program is entirely new or is part of an existing treatment entity. The process of program development requires careful planning and extensive work to ensure adequate financial support. The decision to develop a program should be based on a well-developed strategic planning process (see chapter 2) and a clear understanding of what an OT program entails. Because a new program incurs extensive costs for office space, furniture, staff, computers, and other equipment before it provides services to clients and can receive payments, significant amounts of upfront capital are needed.

Once the administrator or planner identifies a need for treatment services, potential financial support and other resources should be identified and secured to provide for both implementation and initial operating costs. Strategic partners may provide resources, work with the program planner, provide office space, or help obtain funding. Community organizations that see a need for establishing treatment services are likely partners. Locally based foundations and businesses also may be approached for assistance in developing a program. Potential funders are more likely to contribute startup money if they are convinced that the program can cover costs once it is operating.

Documented assurance is necessary from major referral and payment sources that they will provide information on potential payment sources for clients they refer. Signed contracts with expected payers ensure adequate cashflow and establish a budget for the new program's fee structure.

Identification and recruitment of these strategic partners are important steps in the program development process. Before and during the program development process, administrators and planners should work closely with potential referral and payment sources to determine their needs and whether the program will fit those needs. Programs

also need to learn whether referral sources will consider new partners, the types of contracts they use, their timeframes for reimbursement, and the process for negotiating contracts. Holding focus groups and strategy meetings with individuals from potential referral sources allows these groups to suggest services they need and for which reimbursement is available. Potential referral sources are more invested in a program if they are involved throughout the planning process. All potential stakeholders should be informed regularly of the development plans and milestones achieved.

Program planners should follow up all potential leads for both funding and referral sources to build and maintain relationships with these sources. Potential sources of funding and referrals include the contacts made during a focus group process, public-sector payers and planners, private insurance plans, contracting agents for private insurance (e.g., managed care organizations [MCOs]), and local employers that have employee assistance programs (EAPs) or managed behavioral health plans and that offer substance abuse treatment coverage. Direct contact with EAPs or managed behavioral health plans may be necessary to ensure both private-sector demand and appropriate reimbursement for services.

All potential stakeholders should be informed regularly of the development plans and milestones achieved.

Strategic alliances with other treatment providers and with social service agencies can be both important sources for referrals and resources for clients with needs in addition to substance abuse treatment. Alliances with providers to which an OT clinic can refer clients for step-up and stepdown care are vital. Chapter 3, of TIP 47, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* (CSAT 2006*b*), provides a discussion of continuum of care. An alliance with a larger organization can strengthen a program's negotiating position with an MCO.

Funding Streams and Other Resources in the Substance Abuse Treatment Environment

Substance abuse treatment in the United States is financed through a diverse mix of public and private sources, with most funding coming from the public sector. Public sources account for 64 percent of all substance abuse treatment spending, a much higher percentage than public expenditures for the rest of health care (Coffey et al. 2001). The existence of diverse funding streams in substance abuse treatment funding presents both opportunities for and challenges to program independence and stability. However, a program with only one major funding source is financially vulnerable if its funder's budget or priorities change; dependence on one source should be avoided. Diversification of funding sources should be a major goal.

Each funding stream usually has its own approval and reporting requirements. Therefore, substance abuse treatment programs require a fairly sophisticated management and accounting system to meet the reporting and performance needs of each purchaser, to provide information that fulfills all funders' requirements, and to generate the appropriate invoices. OT administrators must be knowledgeable about efficient business practices, the use of data-based performance measures, accounting, budgeting, financing, and financial and clinical reporting.

Other potential sources of support are foundations, OT program board members, and local or national corporate donation programs that reduce costs, increase revenue, or improve productivity and effectiveness. Searching for support does not end with ensuring initial funding; planners must continue to secure cash and in-kind donations that can supplement the funding sources discussed below.

Benefits paid to individuals covered by public and private insurers often vary according to whether the services are facility based. Readers should note that the terminology referring to facility-based services may vary by State, especially in public programs. Facility-based services often are eligible for higher payment rates than office-based services because of their greater overhead and capital costs. Sometimes, client copayments or coinsurance rates may be lower for facility-based services than for office-based services. This situation is true for Medicare and other health insurance plans. An OT program that is part of a hospital, affiliated with a hospital, or considered a licensed facility may be eligible for higher rates of reimbursement than one considered to be an outpatient program with no facility license. However, often barriers to obtaining a facility license exist, and a program that is part of or affiliated with a hospital is restricted by cost allocations from the hospital and by oversight from hospital administrators who may not know or care much about substance abuse treatment.

Some health insurance plans may exclude coverage for facility-based OT programs, and others may subject admissions to such programs to more intensive review than admissions to non-facility-based programs. Program planners should consider carefully all alternatives; decisions concerning affiliation with a hospital or pursuit of a facility license should be made with as much information as possible.

The following sections provide discussions about the key funding streams and resources that are available for OT programs providing substance abuse treatment.

Substance Abuse Prevention and Treatment Block Grant

The Substance Abuse Prevention and Treatment (SAPT) Block Grant program is the cornerstone of Federal funding for substance abuse treatment programs. These funds are sent to Single State Agencies (SSAs) to distribute to counties, municipalities, and designated programs. Some funds are set aside for special populations. A program should determine whether the clients it intends to serve are eligible for block grant funding, either from set-asides or from other funds. Each State maintains criteria for eligibility, and these criteria and definitions vary greatly among States. Multistate providers need to check eligibility in each State in which they operate.

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides funding for substance abuse prevention and treatment through these State block grants as well as through a variety of other mechanisms, including both discretionary grants and contracts. A portion of the SAMHSA Web site (www.samhsa.gov/funding/funding.html) is devoted to various funding opportunities.

The most recent data available indicate that in 2001 the SAPT Block Grant accounted for approximately 40 percent of public funds expended nationally for substance abuse prevention and treatment (U.S. Department of Health and Human Services n.d.). Sixteen States reported that more than 50 percent of their total funding for substance abuse prevention and treatment programs came from the Federal block grant, either from the SSA or channeled through regional or county intermediary agencies (U.S. Department of Health and Human Services n.d.). Services may be paid through grants, contracts, fee-for-service, or managed care arrangements.

The Children's Health Act of 2000 mandated a gradual transition from SAPT Block Grants to Performance Partnership Grants (PPGs). Providers should track this transition through their SSA, such as

- **Changes in reimbursement.** Treatment purchasing systems may evolve over time; managed care arrangements and utilization review are increasingly common.
- **Performance outcome data.** In accordance with Federal legislation, PPGs eventually will replace SAPT Block Grants and will provide more flexibility for States as well as require more accountability based on outcomes and other performance data. The Center for Substance Abuse Treatment (CSAT) and States are establishing performance outcome measures for funding programs under the block grants. All data for core measures are collected from States receiving PPG dollars.

Medicaid

Medicaid, administered by the Centers for Medicare and Medicaid Services (CMS) in conjunction with the States, provides financial assistance to States to pay for medical care of eligible persons: low-income children, pregnant women, the elderly, and people who are disabled, including those who are blind. Medicaid has been used by many States as a vehicle for expanding medical coverage for the uninsured through the use of different types of public-sector managed care. About 2 percent of total Medicaid expenditures nationally are for substance abuse treatment services (Mark et al. 2003), but this represents about 20 percent of national expenditures for such services (Coffey et al. 2001). The level of expenditure varies greatly by State. Some programs may want to target the Medicaid population; if the State's coverage and payment rates are minimal, however, other funders may pay a larger share.

State Medicaid expenditures and coverage vary substantially because substance abuse treatment and rehabilitation are optional benefits under Medicaid, left to the discretion of the States. Recent State budget problems have resulted in discontinuation of Medicaid benefits in some States. In many States, managed care arrangements provide some or all substance abuse treatment benefits for Medicaid enrollees, usually administered by private vendors. In 2002, 58 percent of the Medicaid population was enrolled in managed care arrangements (Centers for Medicare and Medicaid Services n.d.). State Medicaid offices or the CMS Web site (www.cms.gov/medicaid) can provide more information.

Medicaid may pay for substance abuse treatment either directly through fee-for-service arrangements or through a managed behavioral health care organization (MBHO) or other MCO with which it contracts. More than one type of arrangement may exist in a State, which can mean that rates of payment vary in the State. Rates of payment are determined by each State. The services provided under managed care may differ from those under fee-for-service arrangements. Even if a State decides to include benefits for substance abuse treatment in its Medicaid program, it may choose the precise services and levels of care it reimburses. Therefore, a State Medicaid program may not cover OT program services.

Even if some types of substance abuse treatment are covered, OT, as a relatively new form of treatment, may not be covered or may not be covered in the setting in which a program plans to provide services. Some States have included OT services successfully under the Medicaid Rehabilitation Optional services.

Medicaid excludes coverage for services provided in an institution for mental disease (IMD), defined as a facility with more than 16 beds that treats mental disorders, including substance use disorders, for individuals between ages 21 and 64 (Rosenbaum et al. 2002). Although services furnished by partial hospitalization and day treatment programs

are not excluded, OT providers should be aware of the IMD exclusion in their program planning process.

The Medicaid Early Periodic Screening, Detection, and Treatment (EPSDT) mandate requires States to screen all Medicaid children and adolescents for physical and behavioral health disorders. Furthermore, EPSDT requires that any needed medical treatment be provided to children, even if the treatment is not in the State's Medicaid plan. Although the procedures and screening tools vary by State, and only slightly more than half the States perform any screening (Bazelon Center for Mental Health Law 2003), the EPSDT program is an important entrance to substance abuse treatment for children and adolescents.

When available, Medicaid offers the following advantages to substance abuse treatment programs:

- It can provide significant treatment funding for certain high-risk groups, such as low-income mothers and adolescents.
- Client copays traditionally have not been required so the program receives the entire negotiated fee without having to collect funds from clients. However, some States have changed this provision recently because of budget crises.
- A Medicaid contract can provide a useful lower limit for rate negotiations with commercial payers by essentially prohibiting acceptance of a contract with another purchaser at rates lower than those established for Medicaid.
- Certification as a Medicaid provider can position a program to receive clients from other public-sector referral sources, making it possible to obtain clients from sources such as indigent care funds, social service agencies, and criminal justice systems.
- Criminal and juvenile justice systems and drug court administrators typically favor providers that are eligible for Medicaid reimbursement because some States permit treatment of offenders to be billed to Medicaid.

Medicaid Link to Supplemental Security Income

Supplemental Security Income (SSI) is a program financed through general tax revenues. SSI recipients automatically qualify for Medicaid coverage, but provisions vary by State. SSI disability benefits are payable to adults or children who are disabled or blind, who have limited income and resources, who meet the living arrangement requirements, and who are otherwise eligible. A primary substance use disorder diagnosis has been excluded by Congress as a qualifying disability under the Social Security Administration's programs. But if another primary disability qualifies a person for SSI, a secondary substance use disorder diagnosis is acceptable. Many SSI recipients with a mental disorder diagnosis have a co-occurring substance use disorder diagnosis.

Medicare

Medicare provides coverage to individuals ages 65 and older, people younger than 65 who have certified disabilities, and people with end-stage renal disease. Medicare supports about 8 percent of national expenditures for substance abuse treatment services. Medicare may provide Part A coverage to clients in OT programs that are in hospitals certified by Medicare. However, OT that consists solely of psychosocial programs and provides only a structured environ-

…a State Medicaid program may not cover OT program services.

Most IHS funds are appropriated for American Indians who live on or near reservations.

ment, socialization, or vocational rehabilitation is not covered by Medicare. Medicare imposes strict review requirements for OT programs in hospitals and those considered partial hospitalization programs, as well as for their clients. Alternatively, Medicare may provide Part B coverage to clients in OT programs with Medicare-certified medical practitioners; however, clients whose services are reimbursed under Part B must pay 50 percent of Medicare-approved charges. Medicare recipients are eligible for a prescription drug benefit that covers medically necessary medications used for substance abuse treatment in an outpatient setting. This new benefit for Medicare recipients is called Medicare Part D. This is a new program as of January 2006. More information about how this Medicare benefit could impact clients in substance abuse treatment is available at the CMS Web site (www.cms. gov/medicare). Additional information is also available from the Social Security Administration, the Medicare provider enrollment department, or State Medicare services.

Medicare Link to Social Security Disability Insurance

The Social Security Administration provides Social Security Disability Insurance (SSDI) to individuals and certain members of their families if they have worked long enough and paid Social Security taxes. SSDI is a program financed with Social Security taxes paid by workers, employers, and self-employed persons. To be eligible for a Social Security benefit, a worker must earn sufficient credits based on taxable work. Recipients of SSDI benefits are covered by Medicare following a 2-year waiting period. Disability benefits are payable to disabled workers, widows and widowers of disabled workers, or adults disabled since childhood. A substance use disorder diagnosis was excluded by Congress as a qualifying disability under SSDI, but if a person qualifies under another diagnosis, secondary substance use disorder diagnoses are acceptable. Often a qualifying primary mental disorder diagnosis co-occurs with a secondary substance use disorder diagnosis.

State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP) provides funds for substance abuse treatment of children and adolescents in many States. This program provides low-cost health insurance for children of low-income families who are not eligible for Medicaid. States may provide SCHIP benefits under their existing Medicaid programs or design a separate children's health insurance program. If the program is part of Medicaid, the substance abuse treatment benefits mirror those under Medicaid. If the State designs a program, CMS has promulgated a set of rules to ensure that coverage meets minimum standards. More information is available from CMS (www.cms.gov/schip) or SCHIP offices. State alcohol and drug abuse agencies may be able to provide information on resources available for treatment of transition-age youth (often defined as youth between ages 14 and 21) who have exceeded the maximum age for SCHIP.

TRICARE

TRICARE is a regionally managed health care program for active duty and retired members of the uniformed services and their families and survivors. TRICARE supplements the health care resources of the Army, Navy, and

Air Force with a network of civilian health care professionals. It consists of TRICARE Prime (in which military treatment facilities are the principal source of health care), TRICARE Extra (a preferred-provider option), and TRICARE Standard (a fee-for-service option that replaced the program formerly known as CHAMPUS). TRICARE Extra and Standard benefits include treatment for substance use disorders, subject to preauthorization requirements. TRICARE is run by managed care contractors, each of whom may have different authorization procedures. More information is available at www.tricare.osd.mil.

Indian Health Service

The Indian Health Service (IHS) is an agency in the U.S. Department of Health and Human Services that operates a comprehensive health service delivery system for approximately 1.6 million of the Nation's estimated 2.6 million American Indians and Alaska Natives. Most IHS funds are appropriated for American Indians who live on or near reservations. Congress also has authorized programs that provide some access to care for Indians in urban areas. IHS services are provided directly and through tribally contracted and operated health programs. Health services also include health care purchased from more than 9,000 private providers. The IHS behavioral health program supports substance use disorder prevention, treatment, and rehabilitation services for individuals and their families. More information is available at www.ihs.gov/MedicalPrograms/Alcohol/index.asp.

U.S. Department of Veterans Affairs

The U.S. Department of Veterans Affairs provides the Civilian Health and Medical Program of the U.S. Department of Veterans Affairs to eligible beneficiaries. Medically necessary substance abuse treatment is a covered benefit; beneficiaries are entitled to benefits for three substance use disorder treatment periods in their lives. More information is available at www.va.gov/hac/forbeneficiaries/champva/champva.asp.

Social Services

Funding for substance abuse treatment also may be available through arrangements with agencies funded by the U.S. Departments of Labor (DOL), Housing and Urban Development (HUD), and Education (ED). Some Federal sources for substance abuse treatment funding under these programs may prohibit use of funds for medical services. However, services performed by those not in the medical profession—such as counselors, technicians, social workers, and psychologists—and services not provided in a hospital or clinic—including 24-hour care programs—may be considered nonmedical. What constitutes medical treatment under some Federal programs may be determined by each State, so administrators need to check with State authorities to determine which services are funded through these sources. If needed services are not funded through these programs, providers can link clients to services that enable them to initiate and complete treatment successfully. Opportunities include the following:

- **TANF.** Under the Temporary Assistance to Needy Families (TANF) programs, each State receives a Federal block grant to fund treatment for eligible unemployed persons and their children, primarily women with dependent children. Services that overcome barriers to employment (e.g., substance abuse treatment) are eligible for formula grants, with one-quarter of the money allocated to local communities through a competitive grant process. The funding channels vary by State. Funds may be directed through Private Industry Councils, Workforce Investment Boards, Workforce Development Boards, and similar bodies at the State and community levels. TANF funds cannot be used for medical services, but States have considerable

latitude in determining which services are deemed medical and have used TANF funds to support the following substance abuse treatment services: screening and assessment, detoxification, OT, nonhospital residential treatment, case management, education and prevention, housing, employment services, and monitoring (Rubenstein 2002). Even if TANF funds are unavailable for substance abuse treatment, clients may be able to access assistance for employment training, child care, and other support. More information on TANF is available at www.acf.hhs.gov/programs/ofa.

- **Welfare-to-Work Initiatives.** DOL funds nonmedical substance abuse treatment services through the Welfare-to-Work program. More information is available at www.doleta.gov.
- **Social Services Block Grant.** Under Title XX of the Social Security Act, the Administration for Children and Families provides a block grant to each State to supply social services. Funds may not be used for medical services (except initial detoxification). In 2001, the block grants provided $16 million for substance abuse treatment in 12 States (Administration for Children and Families 2001). More information is available at www.acf.hhs.gov/programs/ocs/ssbg/index.htm.
- **Public housing.** HUD funds substance abuse treatment for public housing residents under the Public Housing Drug Elimination Program. HUD awards grants to public housing authorities, tribes, or tribally designated housing entities to fund treatment. Funds are channeled to local public housing authorities, which contract with service providers. In addition, special housing programs are available for people who are homeless and have substance use disorders. More information is available at www.hud.gov/grants/index.cfm.
- **Vocational rehabilitation.** ED funds support services that help people with disabilities participate in the workforce. Treatment of substance use disorders is eligible for funding. Funds are channeled to the State agencies responsible for vocational rehabilitation. More information is available at www.ed.gov.
- **Children's protective services.** Title IV of the Social Security Act provides funding for foster care and services to prevent child abuse and neglect. Eligible services include substance abuse treatment for parents who are ordered by a court to obtain treatment and are at risk of losing custody of their children. Furthermore, children in foster care must receive Medicaid coverage. More information is available at www.acf.hhs.gov/programs/ cb/index.htm.
- **HIV/AIDS resources.** The Federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, enacted in 1990, provides health care for people with HIV disease who lack health insurance and financial resources. Under Title I of the Ryan White CARE Act, which provides emergency assistance to Eligible Metropolitan Areas that are most severely affected by the HIV/AIDS epidemic, funds are available for substance abuse treatment. More than 500,000 people are served through this program each year. More information is available at www.hab.hrsa.gov/programs.htm.

Criminal and Juvenile Justice Systems

Both State and local criminal and juvenile justice systems purchase substance abuse treatment services. The manner in which these systems work varies across locales. The following are common aspects of these systems:

- **State corrections system.** This system may provide funds for treatment of offenders who are returning to the community through parole, halfway houses, or residential correctional facilities.

- **Community corrections.** Community corrections provides a system of presentence diversion or parole services, including drug courts, that may mandate substance abuse treatment in lieu of incarceration.
- **Community drug court.** Drug courts may send low-risk, nonviolent offenders to substance abuse treatment in lieu of incarceration. Programs can be under contract to provide this treatment.
- **Correctional residential facility.** These facilities serve offenders returning from a State correctional system; programs may enter into contracts for substance abuse treatment to prevent relapse of treated offenders.
- **Juvenile court system.** Treatment programs with expertise in treating adolescents can obtain contracts to provide treatment in a juvenile correctional facility or for juveniles in the justice system.

Providers need to understand the culture, values, and needs of the criminal and juvenile justice systems to develop responsive services for this special needs population. TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT 2005); TIP 21, *Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System* (CSAT 1995); and TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT 1998*c*), provide more information.

Byrne Formula Grant Program

The Byrne Formula Grant Program awards grants to States to improve the functioning of the criminal justice system. Grants may be used to rehabilitate offenders who violate State and local laws. One of the 29 Byrne Formula Grant purposes is to provide programs that identify and meet the treatment needs of adult and juvenile offenders who are drug or alcohol dependent. However, the availability of Byrne Formula Grant funds depends on annual congressional appropriations, for which decreases have been proposed in recent years. More information is available at www.ojp.usdoj.gov/BJA/grant/ byrne.html.

Providers need to understand the culture, values, and needs of criminal and juvenile justice systems…

County and Local Governments

County and local governments in States with strong county systems, such as California, New York, and Washington, often contract for the delivery of substance abuse treatment services using locally available funds. The annual availability of these funds depends in part on State fiscal conditions.

Schools and Colleges

Local public schools may be a funding source for assessments; however, they rarely pay for ongoing treatment. Some services may be reimbursable under the special entitlements for children who are disabled. Outpatient treatment programs have been successful at locating counseling services in schools rent free.

Private Payers

Private sources of revenue include large MCOs and self-insured national or local employers. Most health plans offered by large employers operate under managed care arrangements. Sometimes a health plan may

cover substance abuse treatment under its mental health benefit portion; in others, treatment may be provided through the medical coverage component. In many cases, substance abuse treatment benefits, when offered, are provided through MBHOs (see "Working in Today's Managed Care Environment" below for a discussion of managed care arrangements). Because substance abuse treatment coverage is a minor cost to employers, accounting for about 0.4 percent of the cost of health insurance overall (Schoenbaum et al. 1998), it may be overlooked despite the high profile that substance use disorders sometimes present. In general, four broad categories of private funding can be distinguished:

- **Contracts with health plans, MCOs, and MBHOs.**
- **Direct service contracts with local employers.** Local employers may contract directly with providers of substance abuse treatment services if their health plans offer inadequate benefits.
- **Contracts with EAPs.** Some employers have EAPs that provide direct service contracts for a particular OT program.
- **Clients with indemnity or out-of-network coverage.** Clients with indemnity or out-of-network coverage may submit claims for services provided to their insurance company and receive reimbursement according to their benefit plan. Although there is no requirement for a contract with the health plan for clients to be reimbursed under such an arrangement, the services provided must be eligible for reimbursement under the provisions of the benefit plan.

Contributions

By improving relationships with people in the community, an administrator can develop sources for support. Even if a source is reluctant to provide funds to support treatment services directly, other aspects of program development, organizational growth, and operations or equipment may be eligible for support. Available support from sources in the community may range from financial support to donations of time, expertise, used or low-cost furniture and equipment, and space for activities. Potential sources include

- **Fundraisers.** People who raise funds can help the program develop a campaign. Many States and the District of Columbia require charitable organizations to register and report to a governmental authority before they solicit contributions. A list of State regulating authorities is available at www.labyrinthinc.com/index.asp.
- **Foundations and local charities.** A program may qualify as a recipient of funds for capital, operations, or other types of support such as board development from foundations, the Community Chest, United Way (www.unitedway.org), or other charities. More information is available at www.fdncenter.org.
- **Alumni.** Graduates from a program may donate money to the program or provide support for clients.
- **Internships.** Local colleges and universities may need internship slots for students planning careers in human services.
- **Volunteers.** Some programs use volunteers in various capacities. Sources include local retirement organizations and faith-based agencies.
- **Community groups.** Faith-based agencies and community centers may let the program use rooms for meetings, alumni groups, recovery support groups, or classes. Community groups can contribute reading materials, clothes, toys for clients' children, furniture, or computers.
- **Local businesses and vendors.** Local businesses may contribute useful items, such as snacks, office supplies, or computers.

Research Funding

In addition to their other roles, such as providing technical assistance, helping communities use research findings to implement effective treatment programs, and funding

prevention and treatment, SAMHSA and the Institutes of the National Institutes of Health conduct research on best practices in substance abuse treatment. The Research Assistant (www.theresearch assistant.com) provides information and tips. Information on current funding opportunities is available at SAMHSA's Web site (www.samhsa.gov), the National Institute on Drug Abuse's Web site (www.nida.nih.gov), and the National Institute on Alcohol Abuse and Alcoholism's Web site (www.niaaa.nih.gov).

Grants

Government agencies and private foundations offer funding through competitive grants. Grant money usually is designated for discrete projects, such as creating a videotape on family issues, providing childcare services in a women's program, training staff members on cultural competence, or providing treatment to underserved populations.

Writing grant applications requires special skills. A program can hire a consultant to write the application if it does not have its own planning or research staff. It is essential to involve program staff members in developing a grant application so that proposed activities are aligned with agency capabilities. Successful grant applications address areas of need, propose worthy ideas, express these ideas well, and explicitly follow the requirements of the request for application or proposal. To design a fundable project, the program may need to establish links with other resources. SAMHSA offers resources to assist community-based organizations and others in completing successful grant applications.

Information about SAMHSA grants can be found at www.samhsa.gov/grants/index.html. Information on grants throughout the Federal Government is available at www.grants.gov. The Web site www.cybergrants.com provides information about corporate foundations. The National Center on Addiction and Substance Abuse at Columbia University's Web site (www.casacolumbia.org) provides links to several helpful sites. *The Substance Abuse Funding News: Semimonthly Report on Alcohol, Drugs and Tobacco, Prevention, Treatment and Grants* focuses on public and private funding opportunities for substance abuse prevention and treatment programs. It is available by subscription in print or on the Web (www.cdpublications.com). Useful publications on grant-seeking and grant-writing can be ordered from www.grantsandfunding.com. The Grantsmanship Center at www.tgci.com offers useful information.

Self-Pay Clients

Some clients pay for some or all of a course of treatment without seeking reimbursement from a third-party payer. These clients may have no coverage or inadequate third-party coverage for substance abuse treatment and are ineligible for public sources of payment. Some clients who have coverage may prefer to pay out of their own pockets because of concerns about the confidentiality of their information with their employer or others if they seek third-party reimbursement. To maximize revenues, some organizations may wish to introduce so-called sliding-scale fee arrangements, under which the fees for self-pay clients are established according to their willingness and ability to pay.

It is essential to involve program staff members in developing a grant proposal…

Other Resources

A variety of other resources is available to help substance abuse treatment organizations succeed in today's environment. These resources include

- The Non-Profit Resource Center at www.not-for-profit.org
- SAMHSA's National Mental Health Information Center at www.mentalhealth.samhsa.gov
- SAMHSA's National Clearinghouse for Alcohol and Drug Information at www.ncadi.samhsa.gov
- SAMHSA's CSAT at www.csat.samhsa.gov
- State Alcohol and Drug Abuse Agencies at www.treatment.org/States

Working in Today's Managed Care Environment

All health care providers, including those who provide substance abuse treatment services, increasingly operate in a world in which care is managed in all sectors, public and private. Among individuals covered by employer-sponsored benefits in 2003, 95 percent were covered under managed care arrangements (Kaiser Family Foundation and Health Research and Educational Trust 2003). The incursion of managed care into employer-sponsored health plans is relatively new; as recently as 1993, 46 percent of employees were covered by indemnity plans. It is estimated that more than 160 million Americans have their behavioral health care (treatment for substance use and mental disorders) covered by an MBHO (Oss and Clary 1999). Although managed care penetration has less of a presence in public programs than in employer-sponsored programs, it is still significant; in 2002, 58 percent of the Medicaid population was enrolled in managed care (Centers for Medicare and Medicaid Services n.d.). Many States also operate managed care programs not connected with Medicaid for provision of substance abuse treatment services.

Many behavioral health care carve-outs retain substance use disorder coverage in a medical MCO.

Behavioral health care carve-outs, so named because management of substance use and mental disorder treatment benefits are separated (carved out) from the provision and management of other health care services, are now the dominant approach to managed care for mental disorder treatment. However, this is not the case for substance use disorders; many behavioral health care carve-outs retain substance use disorder coverage in a medical MCO. The carve-in approach, which theoretically integrates traditional medical services with mental and substance use disorder treatment services, is reemerging but currently is still rare. Even when health plans carve in substance abuse treatment services, they often use a subcontracted specialty vendor or a separate internal division with specialty expertise to manage the carve-in benefits.

MCOs are becoming more prevalent in the public sector. In 2002, 51 percent of all substance abuse treatment facilities had contracts with MCOs, and 39 percent of facilities owned by State and local governments had such contracts (Office of Applied Studies 2003*a*). By 1998, all but four States had implemented some form of managed behavioral health care in their public-sector treatment programs (News and Notes 1999). However, wide variation exists among States and large counties in the extent and form of reliance on managed care and in the vendors who operate such programs on behalf of government or private entities.

A distinct terminology has evolved in the managed care industry—terms such as "capitation," "network," and "staff-model," not to mention a host of acronyms. A useful set of managed care definitions can be found on SAMHSA's Web site (mentalhealth.samhsa.gov/publications/allpubs/MC98-70/default.asp).

Contracts Are Primary Tools in Managed Care

All program administrators should be familiar with four fundamental aspects of managed care arrangements:

- **A managed care contract specifies the obligations of each party.** One key aspect of any managed care contract is the financial arrangement between the parties, including the basis for payment and the amount of risk, if any, assumed by each party. Some managed care contracts are not risk based. Small community providers may have little or no negotiating leverage in the contracting process; their only decision may be whether to accept what is offered, including the rate of payment and all other contract provisions. Someone with expertise and experience in managed care contracts and financing should examine a proposed contract to make certain that the financial components of the arrangement are well understood by the program staff members who have financial responsibilities.
- **By negotiating and signing a managed care contract, an OT program or its parent agency becomes a member of an MCO's managed care network.** MCOs generally have a network of contracted and credentialed providers who provide services at a negotiated rate to members who are enrolled in the plans. Each organizational member of the network must satisfy the MCO's minimum requirements for licensure of staff, programs, and facilities to be eligible for a managed care contract.
- **Performance must be measured and reported.** MCOs apply standard performance measures to their contracted providers and may have financial or referral incentives or disincentives associated with measured performance.
- **MCO staff determines which services are medically necessary and therefore eligible for health plan reimbursements.** Utilization management and case management generally are performed by MCO staff members, typically nurses or social workers, with supervision from doctoral-level clinicians or physicians. Utilization management compares a provider's proposed treatment plan with similar or expected plans for individuals with similar conditions and diagnoses. The utilization management approach may vary not just by MCO but also by MCO customer, with some customers preferring that utilization be highly scrutinized and meet the test of medical necessity and others preferring that the MCO not manage utilization as aggressively. If a treatment plan from an OT program does not meet criteria for medical necessity, it is likely to be denied and referred to a higher level clinician for review, delaying approval and payment. An OT program should obtain each MCO's protocols, as well as any specific arrangements and benefit plans for customers whose employees or enrollees are in its client population.

  Private-sector case management programs are often utilization review programs rather than the clinical case management programs typical of the public sector. Moreover, the process of case management in the private sector often differs from that in traditional public-sector mental health or substance abuse treatment agencies, representing primarily telephone contact, usually with a nurse, in high-risk or high-cost cases. Case management usually is not performed on site or in person in an MCO, unless it is under contract to a public agency that requires this. If a client has a

Exhibit 5-1

Financial Arrangements With Providers

Method of Financial Reimbursement	Cautions/Risks for Programs
Fee-for-service agreement. Fee-for-service programs are the least risky to providers. They generally require precertification and utilization management for some or all procedures or services. The maximum amount of services that may be approved is restricted by the limits stated in the client's benefit plan document or in the public payer's contract. In a fee-for-service contract, a rate is received for the services provided, typically, a standard program session with specific services bundled in; this is referred to as an all-inclusive rate. Some common bundled services are urine drug screens and group, family, and individual counseling. The payment rate for one visit may include a 50-minute group counseling session and a urine drug screen; the rate for a day of treatment could include, for example, one-fifth of a 25-minute psychologist visit, one-half of a urine drug screen, one-half of a vocational training session, and two sessions of group counseling. The assumption is that these services occur at a specified frequency during the course of the client's treatment. Psychiatric services can be incorporated into the bundled services, but usually they are negotiated separately and treated as an addition.	When negotiating a fee-for-service contract, an administrator needs to ensure that the rate is sufficient to cover the actual costs to a program of providing the specified services. During negotiations, the MCO has the option of saying that it will not pay for some of the bundled services. All services should be costed out before negotiation so that actual costs of treatment components are known and can be compared with what are offered. Even if a fee-for-service contract is negotiated successfully, referrals may not follow.
Capitation agreement. A managed care company may establish a stipulated dollar amount to cover treatment costs for a group of people, using one per person rate for everyone, which is the MCO's capitation rate. The MCO may then subcapitate a stipulated dollar amount to a treatment provider or organization, and the MCO and the treatment provider negotiate an agreement in which the provider is paid a fixed amount per subscriber per month, rather than billed on a fee-for-service basis. Usually only large service providers have the assets and volume of services to engage in capitated agreements. The provider agrees to provide all or some treatment services for an expected number of managed care "covered lives" (e.g., for 100,000 subscribers). In one example, an OT provider received $70,000 per month for providing all OT and intensive OT services to 200,000 plan members.	The two critical elements are the per member/per month rate and the utilization rate. If many more people than are predicted require treatment, the provider may be unable to cover service delivery costs, much less make a profit or surplus. The key is to have reliable information on the historical use rates of a managed care plan's enrollees. A capitation agreement carries the risks of both overutilization (when compared with the assumed utilization rate) and a greater intensity of treatment than the capitation rate can cover. Programs may accept a speculative capitation rate to join a panel and then renegotiate that rate after they have collected data that show a higher rate is needed to cover costs. It is crucial to compare actual dollars with the budget in real time to avoid unexpected deficits.

(continued)

Exhibit 5-1 (continued)

Financial Arrangements With Providers

Method of Financial Reimbursement	Cautions/Risks for Programs
Case rate agreement. The case rate is a fixed, per client rate paid for delivery of specific services to specified types of consumers. For this fee, a provider covers all the services that a client requires for a specific period. In essence, the MCO is saying, "You provide the client what he or she needs from this set of services and I will pay you this set amount." What usually distinguishes case rate from capitation is that all the case rate clients are anticipated to receive some service (i.e., at least case management). Often those receiving services under capitation are a small minority of those covered. The case rate may be risk adjusted to compensate for the higher costs of serving clients who predictably need more services than average.	A case rate removes some of the utilization risk from the provider of services. However, the risk remains that clients will need services more frequently or at higher levels than the case rate covers. It is essential to track costs by specific client to assess the adequacy of a proposed case rate. However, it is a mistake to consider a case rate as a cap for any specific client; the goal is to ensure that the *average* cost per case is lower than the negotiated case rate, not that the cost for each case is less than the negotiated rate. Once again, it is crucial to compare actual average dollars per case with the contracted case rate in real time to avoid unexpected deficits.

public-sector and a managed care case manager, the program must interact with both to obtain initial and continuing approvals of treatment.

In general, providers are required to obtain utilization management approval or case management approval for any proposed treatment plan before they can bill an MCO. Providers bear the cost of appealing denials and requesting exceptions. The more program staff members develop relationships with the MCO's utilization management and case management staff members, the more they learn about the internal criteria and protocols that drive approval or denial decisions and the more latitude a program has in requesting special arrangements for a particular client. Most MCOs and MBHOs have Web sites with provider portals. Once an OT program identifies the name of the managed care plan from which payment is to be requested, the program should check the MCO's or MBHO's Web site. Some managed care plans offer electronic data interchange with network providers to facilitate claims submission.

Elements of Financial Risk in Managed Care Contracts

Managed care contracts vary principally by

- The method of payment and the corresponding type of risk assumed by the provider
- The amount of payment

Three major types of financial arrangements or methods of payment in managed care contracts exist; each is associated with financial risks (see exhibit 5-1). Risk, of course, is a continuous variable, and no arrangement is devoid of any risk whatsoever. Program administrators need to understand the differences among these types of arrangements so that they can manage financial risk. Technical Assistance Publication 16, *Purchasing Managed Care Services for Alcohol and Other Drug Treatment* (Kushner and Moss 1995), provides additional information about purchasing and negotiating managed care.

Administrators may think that the contract itself is the goal. However, the contract is no guarantee of a referral; it only enables referrals that are medically necessary. The closer the relationship program staff members can develop with a given MCO, the easier it will be for them to understand the MCO's clinical criteria, to obtain more than intermittent referrals, and to negotiate a financial arrangement that is reasonable and fair.

Cost of Services

To assess and negotiate a managed care contract and to monitor performance under that contract, an OT program must know the program's cost to provide each unit of service. The cost of services includes staff time spent with clients, administrative time spent on meetings and paperwork, and capital and operating expenses. Only when the actual cost of delivering a unit of a service is known can an agency negotiate a reasonable rate for specific services. The following are cost methodologies developed specifically for substance abuse treatment services:

- The first systematic cost data collection method, the Drug Abuse Treatment Cost Analysis Program (DATCAP) (French et al. 1992), was developed in the early 1990s by economists at Research Triangle Institute (French et al. 1997). The Treatment Services Review used with DATCAP provides unit service costs (French et al. 2000).
- The Uniform System of Accounting and Cost Reporting for Substance Abuse Treatment Providers (the Uniform System or the System or the Substance Abuse Treatment Cost Allocation and Analysis Template—SATCAAT) is a cost estimation method also developed in the early 1990s (Harwood et al. 2001).
- Yates (1996, 1999) has developed another estimation approach, the Cost–Procedure–Process–Outcome Analysis.
- Anderson and colleagues (1998) have developed a cost of service methodology.
- An emerging treatment services cost estimation method is called the Substance Abuse Services Cost Analysis Program (Zarkin et al. 2004).
- Several treatment studies have applied variants of these methods (Flynn et al. 2002; Koenig et al. 1999; Mojtabai and Zivin 2003).

Exhibit 5-2 provides several resources on the topic of costs of services.

Networks, Accreditation, and Credentialing

For an OT program to join an MCO's network of providers and negotiate a contract, the program must meet minimum standards for staff credentials and program accreditation. In 2002, 51 percent of substance abuse treatment facilities had managed care contracts (Office of Applied Studies 2003*a*). Each MCO has its own criteria for the credentials of network providers, and these generally are not negotiable because they are based on the MCO's accreditation requirements. The provider-credentialing requirements vary by MCO and by customers in the MCO but often include primary verification of specific academic degrees or specific levels of licensure for staff and verified minimum levels of malpractice insurance. Some MCOs use what are called independent credentialing verification organizations (CVOs) for verification. These CVOs verify the credentials of providers on behalf of MCOs to ensure, for example, that their licenses are up to date and valid.

MCOs are sometimes unfamiliar with substance abuse treatment. Because MCOs credential individual providers, not organizations, MCOs often are more willing to contract with organizations that have a facility license from the State (usually providers that are licensed in psychology, nursing, medicine, and social work) than with individual substance abuse treatment

Exhibit 5-2

Resources on Costs of Services

Anderson, D.W.; Bowland, B.J.; Cartwright, W.S.; and Bassin, G. Service-level costing of drug abuse treatment. *Journal of Substance Abuse Treatment* 15(3):201–211, 1998.

Capital Consulting Corporation. *Uniform System of Accounting and Cost Reporting for Substance Abuse Treatment Providers*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993. www.icpsr.umich.edu/SAMHDA/SATCAAT/system-accounting.pdf [accessed January 26, 2004].

Capital Consulting Corporation. *Summary Report on Assessment and Measurement of Treatment Costs*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000. www.icpsr.umich.edu/SAMHDA/SATCAAT/summaryreport.pdf [accessed January 26, 2004].

Dunlap, L.J., and French, M.T. A comparison of two methods for estimating the costs of drug abuse treatment. *Journal of Maintenance in the Addictions* 1(3):29–44, 1998.

Flynn, P.M.; Porto, J.V.; Rounds-Bryant, J.L.; and Kristiansen, P.L. Costs and benefits of methadone treatment in DATOS—Part 1: Discharged versus continuing patients. *Journal of Maintenance in the Addictions* 2(1–2):129–150, 2002.

French, M.T.; Bradley, C.J.; and Zarkin, G.A. Drug Abuse Treatment Cost Analysis Program (DATCAP): Cost interview guide for provider sites. *Drug Abuse Treatment Module*, Version 1. Research Triangle Park, NC: Research Triangle Institute, 1992.

French, M.T.; Dunlap, L.J.; Zarkin, G.A.; and Karuntzos, G.T. The costs of an enhanced employee assistance program (EAP) intervention. *Evaluation and Program Planning* 21(2): 227–236, 1998.

French, M.T.; Dunlap, L.J.; Zarkin, G.A.; McGeary, M.A.; and McLellan, A.T. A structured instrument for estimating the economic cost of drug abuse treatment: The Drug Abuse Treatment Cost Analysis Program (DATCAP). *Journal of Substance Abuse Treatment* 14(4):1–11, 1997.

French, M.T.; McCollister, K.E.; Sacks, S.; McKendrick, K.; and De Leon, G. Benefit-cost analysis of a modified therapeutic community for mentally ill chemical abusers. *Evaluation and Program Planning* 25(2):137–148, 2002.

French, M.T.; Roebuck, M.C.; McLellan, A.T.; and Sindelar, J.L. Can the Treatment Services Review be used to estimate the costs of addiction and ancillary services? *Journal of Substance Abuse* 12(4):341–361, 2000.

French, M.T.; Salome, H.J.; and Carney, M. Using the DATCAP and ASI to estimate the costs and benefits of residential addiction treatment in the State of Washington. *Social Science and Medicine* 55(12):2267–2282, 2002.

(continued)

Exhibit 5-2 (continued)

Resources on Costs of Services

Harwood, H.J.; Kallinis, S.; and Liu, C. *The Cost and Components of Substance Abuse Treatment*. Rockville, MD: Center for Substance Abuse Treatment, 2001. www.lewin.com/Lewin_Publications/Behavioral_Health/NEDSCostsSATreatment.htm [accessed February 20, 2004].

Yates, B.T. *Analyzing Costs, Procedures, Processes, and Outcomes in Human Services: An Introduction*. Thousand Oaks, CA: Sage Publications, 1996.

Yates, B.T. *Measuring and Improving Cost, Cost-Effectiveness, and Cost-Benefit for Substance Abuse Treatment Programs*. NIH Publication No. 99-4518. Bethesda, MD: National Institute on Drug Abuse, 1999.

Zarkin, G.A., and Dunlap, L.J. Implications of managed care for methadone treatment: Findings from five case studies in New York State. *Journal of Substance Abuse Treatment* 17(1–2):25–36, 1999.

Zarkin, G.A.; Dunlap, L.J.; and Homsi, G. The Substance Abuse Services Cost Analysis Program (SASCAP): A new method for estimating drug treatment services costs. *Evaluation and Program Planning* 27(1):35–43, 2004.

providers who may not possess credentials that meet licensure criteria. MCOs explain that this has to do with malpractice insurance issues. This practice has a disproportionate effect on substance abuse treatment providers who do not have as many staff members with degrees and credentials as do mental health programs. Substance abuse treatment providers often must help MCOs understand the substance abuse treatment environment, the types of providers who deliver services, and the qualifications and standards they must meet so that the MCO can modify its policies appropriately.

In addition to having its staff members credentialed, the program may have to be accredited by one of the major national health care accrediting organizations, for example, the Commission on Accreditation of Rehabilitation Facilities (www.carf.org), the National Committee for Quality Assurance (NCQA) (www.ncqa.org), or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (www.jcaho.org).

Organizational Performance Management

Performance measurement is an increasingly important component of managed and fee-for-service care in both the public and private sectors. SAMHSA's SAPT Block Grants increasingly demand that programs measure program performance and outcomes. MCOs have performance measures established by their accreditation agencies, such as NCQA and JCAHO. Their customers, employers, or public purchasers may use performance adequacy on these measures in their decisions to acquire or retain their plans for their employees. NCQA recently established a set of measures specifically for substance use and mental

disorder treatment services for all MCOs that it accredits, including new measures of the identification of enrollees with substance use disorder diagnoses, the rate of treatment initiation, and a measure of treatment engagement. Measuring these indicators and reporting them to the MCO are conditions of most contracts. Good performance may earn an OT program an additional fee from the MCO.

MCOs evaluate the performance of the members in their network of providers. Each MCO has measures and procedures for implementation, some of which are prescribed by the organizations that accredit them. Not all MCOs are diligent about this provider evaluation process. Only a few MCOs have implemented sophisticated measurement systems; some methods used today are rudimentary. The results of external performance measures implemented by MCOs can be extremely important to the OT program's financial and organizational success, affecting its ability to remain a viable, respected network provider. Some performance management systems implemented by MCOs also use financial incentives or disincentives keyed to measures of performance.

Regardless of the specific measures implemented by MCOs, well-managed organizations develop and use their internal performance measures and constantly strive to improve their performance. MCOs should measure both processes and outcomes, such as the following:

- Percentage of clients who complete a defined treatment regimen that meets their individual needs
- Percentage of clients who drop out of treatment in the first 7 days following treatment initiation
- Percentage of clients who remain in documented but less intensive treatment 30 days after discharge from the program
- Percentage of clients who are employed or attending school 6 months after discharge from the program

When using measures of performance, it is important to account for differences among clients that may affect measured results, such as medical conditions or clients' previous history of abuse.

A primary independent entity involved in the construction of national performance measures for substance abuse treatment is the Washington Circle Group (WCG) (www.washingtoncircle.org). NCQA's new substance abuse treatment performance measures on identification and initiation of treatment and treatment engagement were developed by WCG over a 4-year period. WCG has identified four major domains for substance abuse treatment measures:

1. Prevention or education
2. Recognition or identification of substance abuse
3. Treatment
    - Initiation of alcohol and other plan services
    - Linkage of detoxification and drug and alcohol plan services
    - Treatment engagement
    - Use of interventions for family members and significant others
4. Maintenance of treatment effects

These and other substance abuse performance measures now are used in NCQA's MCO accreditation process. WCG and others have defined a variety of such measures. Administrators should consider these measures as ways to improve their program's performance, essential elements in the reporting system, and a means for documenting success to their customers and other stakeholders. Chapter 6 provides more information on performance and outcomes measurement.

Performance measurement is becoming increasingly important outside managed care contracts as well as inside them. For example, SAMHSA began integrating performance measurement into the SAPT Block Grant in 2004. States expect providers to understand

Program staff members must understand what their MCO counterparts do…

and to be able to measure the required indicators accurately and punctually.

Recordkeeping and Management Information Systems

MCOs also require detailed records of services provided to clients to pay for services received. The program's accounting system needs to track counselors' time spent on the phone, on paperwork, and directly with clients. Clinical records should reflect accurately the claims records submitted to the MCO. Payers and MCOs may audit the clinical records to ensure that the services billed for have been provided. Failure to document clinical services adequately can result in nonpayment and jeopardize a contract. In addition, individuals' private information and identity must be handled confidentially pursuant to the Health Information Portability and Accountability Act and Federal confidentiality requirements for persons with substance use disorders (CSAT 2004). More information is available at www.hhs.gov/ocr/hipaa.

Managing multiple contracts requires a sophisticated management information system (MIS) and constant scrutiny. The need for information is even more crucial in capitation-based arrangements that place risk on the service provider than it is for fee-for-service arrangements. In essence, the OT program's MIS needs to be capable of two-way information transfer between the MCO and the program. Data such as membership, benefits, copays, deductibles, and other financial information must be passed between the program and the insured entity or payer. The MIS also should be able to analyze key performance data for internal and external reports. The MIS must pass useful data to staff members responsible for managing benefits and providing services. Programs must provide data that meet State and payer requirements, while respecting confidentiality.

Managing Payment From Multiple Funding Streams

Especially in the public arena, multiple contracts with and grants from several funding streams and payers may be used to support services for just one client. These contracts specify order of payment. The provider needs to manage the funds carefully and appropriately to be in compliance with contracts and grants. For example, a contract with a drug court may specify that Medicaid be billed as payer #1 and the drug court as payer #2. Any unpaid portion might be billed to the block grant agency as payer of last resort, if the service is eligible under the block grant. Some providers have used successfully the strategy of first drawing on the reimbursement of those payers with the most restrictive array of services; later, the more flexible funds are used to cover the remaining services. A clearly documented strategy for managing payment that is communicated effectively to the accounts payable staff is critical and helps programs succeed in this important area.

Utilization and Case Management

Utilization and case management cannot proceed if a program is not recognized as an eligible network provider. Because OT is a rela-

tively new treatment modality, MCO coverage may not yet include reviewers, and an MCO may not yet have recognized OT programs as eligible providers. Providers need to ensure that they are accepted network providers before participating in the utilization management or case management process.

All MCOs use some methods to manage their members' service utilization to ensure that they are receiving the most appropriate array of services in the most appropriate environment or level of care for the appropriate length of time. Although utilization management focuses on a single type of service and case management focuses on the coordination of an array of services needed by a specific individual, in practice the same professionals may be responsible for both types of management. Utilization and case management staff members at an MCO authorize specific services for payment. Criteria and protocols may be used to determine whether services may be authorized for substance abuse treatment; typically they include the American Society of Addiction Medicine patient placement criteria (Mee-Lee et al. 2001) and other level-of-care or diagnosis-based criteria. Successfully addressing the needs of the MCO utilization and case management staff members who are responsible for authorizing client care is a critical element in a program's relationship with the MCOs and in maintaining clinical and financial viability. Program staff members must understand what their MCO counterparts do, be well trained in conducting professional relationships over the telephone, be familiar with the criteria and protocols employed by the MCOs with which the program has contracts, and have easy access to the clinical and service information required by the MCOs to complete a review and authorize services. Excellent records are essential. Staff members also should be familiar with each MCO's appeal or exceptions process when the outcome of a first-level review is unsatisfactory.

Strengthening the Financial Base and Market Position of a Program

The following strategies may strengthen the market position of an OT program and lead to increases in clients and revenues per client:

- **Achieve recognition for quality and effectiveness of services.** If a program has a reputation for providing effective care, managed care enrollees and other potential clients will want to use it. A program can be of value to a client, a purchaser, and an MCO if it can reduce repeated detoxification, repeated treatment, and readmissions and reduce costs and interventions. Prompt, effective substance abuse treatment may reduce medical care and hospitalization costs in the long run. An effective program manages the care of clients who use substance abuse treatment services often. These effective programs provide psychiatric treatment, case management, and housing support and are good candidates for "preferred" or "core" status with one or several MCOs or MBHOs. Of course, the additional costs of these services need to be a component of a program's rate and contract. Having highly reputable, recognized, and efficient providers is a major marketing and regulatory advantage for the health plan, as well as for the OT program. These program characteristics can be marketing advantages. Programs can enhance their reputations by applying to SAMHSA's National Registry of Effective Programs, which identifies evidence-based programs. Information on how to apply for this status is available at modelprograms.samhsa.gov.
- **Serve special populations.** Providing low-cost and high-quality treatment to a population no other program serves (e.g., adolescents; clients with HIV/AIDS, co-occurring mental disorders, or disabilities; preg-

nant women; women with young children; clients from the Deaf community) is a possible marketing advantage. Treating these clients can result in client referrals from a large geographic area and multiple sources. Such clients may bring with them higher reimbursement rates, but this also simply may reflect higher costs to provide care to the special population. Using special capabilities to attract clients is a good idea but not at the cost of inadequate payment for services.

- **Develop economies of scale.** Adding clinic sites or increasing the number of branch clinics may allow programs to spread some fixed costs, such as management, information and financial systems, and executive staff, among a larger number of clients, driving down a program's per capita costs. However, large size requires increased administrative coordination, which can be costly.
- **Gain community visibility and support.** Including governmental officials, community agency executives, or political leaders (the mayor or council members) as board members, for example, raises the program's profile in the community. Board members who have specific skills and connections can advance the purposes of the OT program.
- **Form alliances with other treatment providers.** Setting up coalitions to compete with or work with managed care companies and other purchasers such as Medicaid may be useful. However, consultation with an attorney is advised strongly before developing such a coalition or other collaboration with local treatment providers because the laws regarding antitrust and other matters related to such relationships are complex. For programs serving publicly funded clients, technical assistance is available through CSAT; the SSA can provide details.

Preparing for the Future

Major forces that shape and limit provider financing are unlikely to change substantially in the near future. Careful strategic planning and assurance of funding from reputable and varied referral sources are essential for new and existing programs. As a buffer against shrinking budgets, all programs should consider broadening their funding streams and referral sources, expanding the range of clients they can serve, and promptly referring clients for other services not provided on site. Partnerships can be critical to the financial success of a program. To operate effectively, administrators and staff must understand thoroughly the managed care and community political environment—terminology, contracts, negotiations, payments, appeals, and priority populations. A successful working relationship with an MCO, a health plan, other purchasers, or another agency or group of agencies depends on day-to-day interactions in which staff members serve as informed, professional advocates for their clients and the program.

6 Performance Improvement and Outcomes Monitoring

In This Chapter...

Increasing Importance of Outcomes Measures in Today's Funding Environment

Improving Performance and Monitoring Outcomes

Measuring Performance and Outcomes

Outcomes Measuring Instruments

Program Monitoring for Special Purposes

Working With Staff on Performance and Outcomes Improvement

Costs and Funding of Outcomes Improvement

Using Performance Data To Promote the Program

A program executive director was talking with a member of her clinical staff one afternoon. In the course of the conversation, she asked the supervising counselor, "So tell me, how's your group doing?" The supervising counselor replied, "Oh, they're doing really great." The director then asked, "How do you know?" This question stumped both the director and counselor because, as in many programs, they relied on intuitive assessments of clinical performance—they had no objective way of monitoring performance.

Without objective indicators of performance, it is difficult to know how effective a treatment program is, whether its performance is improving or worsening. This chapter examines approaches for measuring and improving the performance of outpatient treatment (OT) and intensive outpatient treatment (IOT) programs, using objective performance data.

The term "performance improvement" is used in this chapter to include similar approaches, such as "quality improvement," "continuous quality improvement," "quality assurance," "total quality management," and "human performance technology."

Performance improvement, which is a set of processes used to improve a clinic's outcomes, need not be complex or expensive. Providers need to consider how they can integrate commonsense performance improvement into their daily treatment activities. Some providers may not realize that they probably are collecting data already that can be used to conduct performance improvement.

Performance improvement and outcomes monitoring are becoming required elements in health service delivery. Outcomes monitoring has long been important to industry and health care because it provides an excellent and efficient mechanism for improving productivity and care (Mecca 1998). Performance improvement can increase revenues by improving service delivery, reducing costs, and increasing client satisfaction (Deming 1986).

An emphasis on performance improvement ought not to be considered a burden. The viability of the substance abuse treatment field depends on establishing the effectiveness of its services. Performance improvement has a critical mission: to use objective information to improve outcomes continually by

- Identifying opportunities for improvement
- Testing innovations
- Reporting the results to the relevant stakeholders

Program and management staffs should consider making performance improvement a central element of their program's administrative plan.

This chapter focuses on

- Types of instruments and measures that are useful for providers in improving treatment outcomes
- How to establish an ongoing performance improvement program for staff and the clinic as a whole
- How to involve program staff in a collaborative and positive way as an outcomes improvement plan is being designed and implemented
- Positive actions that can be taken in response to performance evaluation findings

Increasing Importance of Outcomes Measures in Today's Funding Environment

As financial support from Federal and State sources, insurance companies, and managed care organizations (MCOs) has diminished, funding sources and taxpayers increasingly are demanding that money be spent only on the most effective programs. Although there have been many discussions about outcomes over the last 20 years, several forces are now at work that will make performance outcomes monitoring and improvement priorities for providers and payers.

Today, licensing and credentialing bodies and payers have prioritized performance improvement initiatives. The two major accreditation bodies in the addictions field—the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF)—have made performance and quality improvement initiatives a cornerstone of their accreditation processes. CARF expects agencies to measure efficiency, effectiveness, and client satisfaction. Both bodies have published manuals on performance improvement for behavioral programs (Joint Commission on Accreditation of Healthcare Organizations 1998; Wilkerson et al. 1998).

Some States include outcomes monitoring as part of their licensing procedures, and a few States—California, Connecticut, Delaware, Illinois, and New York—are establishing permanent statewide outcomes monitoring systems. Some funding sources, such as MCOs, consider performance monitoring an important part of contract oversight and are finding ways to provide incentives for improving performance outcomes. Other payers are developing incentives and sanctions that are dependent on outcomes; private organizations are developing recommendations for performance improvement in behavioral health organizations (McCorry et al. 2000).

States are required by the Government Performance and Results Act of 1993 to implement procedures for funding public programs based on their performance. The Federal Government and the States are developing the indicators and procedures for a performance-based system.

Since the mid-1990s, the U.S. Department of Health and Human Services, particularly through the Center for Substance Abuse Treatment (CSAT), has sponsored and funded major initiatives and pilot studies

designed to help States and the field develop substance abuse treatment performance indicators, databases, and information systems that can be used in outcomes monitoring and performance improvement. Some of these Federal initiatives include the Methadone Treatment Quality Assurance System (Phillips et al. 1995), National Treatment Outcomes Monitoring System (NTOMS), and Drug Evaluation Network System (Carise et al. 1999).

The Institute of Medicine has published reports on performance measures in behavioral health (Institute of Medicine 1997*a*, 1997*b*). A National Research Council report, based on extensive research and regional meetings with representatives of the treatment field, recommends that the activation of the State performance-based compensation system be delayed in behavioral health care until appropriate performance indicators are developed (Perrin and Kostel 1997). Clearly, performance-based compensation is likely to be adopted as a central part of how treatment is funded.

Improving Performance and Monitoring Outcomes

The relationship between performance improvement and outcomes monitoring is illustrated best with an example. The general public is interested in reducing the number of highway deaths that occur each year. To achieve this end, it is necessary to conduct performance improvement and outcomes monitoring. To monitor improvement, it is necessary to track the number of highway deaths that occur annually. However, simply monitoring the increases and decreases in the number of yearly deaths tells little about whether specific initiatives undertaken by States, Federal agencies, car manufacturers, and drivers are reducing the rate of highway mortality.

Because the goal is to reduce the number of highway deaths, it is critical to assess *specific initiatives* aimed at eliminating highway deaths. To determine which initiatives are most effective, and therefore worthy of replication, it is necessary to isolate a specific initiative to observe its effect on outcomes. For example, public service announcements encouraging seatbelt use air nationally on TV and radio for 6 months. At the end of this period, outcomes monitoring determines whether the ad campaign affected the number of highway deaths. Performance improvement is the process of developing and testing the effectiveness of specific initiatives (e.g., promoting increased seatbelt use) that are designed to achieve the desired outcomes (e.g., lowering the number of highway deaths).

> …performance-based compensation is likely to be adopted as a central part of how treatment is funded.

Trying new solutions to problems and monitoring the results of the new approaches are the essence of performance improvement. The desired outcome for most substance abuse treatment programs is to increase the number of individuals who achieve abstinent, productive, and healthy lives. This broad outcome needs to be broken into components, such as reductions in HIV-risk behavior, increases in employment, and reductions in arrests. To achieve these outcomes, programs need to test whether their clinical and administrative initiatives are effective in producing improvements on key performance indicators. *Performance indicators* are criteria that can be measured to indicate whether the desired outcomes have been

achieved. Performance indicators include client persistence in treatment (engagement), client ratings of therapeutic alliance, client attendance rates, success of transfer from intensive outpatient treatment to outpatient treatment, satisfaction of referral sources, client satisfaction, and client self-reported abstinence.

Programs can measure their efforts at helping clients achieve the desired outcomes by identifying specific performance indicators, measuring them regularly, and testing whether specific initiatives lead to improvements in those performance indicators.

Measuring Performance and Outcomes

Currently, no objective national standards exist for average rates of engagement, retention, and abstinence in different types of treatment programs. The Federal Government is attempting to set up national databases that will help establish standards and ranges of acceptable outcome rates. NTOMS is a CSAT initiative to provide periodic reporting on access to and effectiveness of drug abuse treatment, using a nationally representative sample of clients. NTOMS plans to collect information from 84,000 clients and 250 treatment facilities; data should be available after 2006.

Types of Outcome and Performance Measures

This section describes selected performance indicators, how they are calculated, and special considerations associated with each. A discussion of how executives can use these data to help manage their clinics follows later in the chapter.

Engagement rate

A critical performance measure is a clinic's rate of engagement for new clients. About 50 percent of clients in outpatient treatment drop out within the first month (Fishman et al. 1999), and many clients are no longer in treatment by their third, fourth, or fifth scheduled appointment. For both financial and clinical reasons, many programs monitor how effective the program and its clinicians are in engaging clients.

Because treatment programs expend disproportionate resources during the first few sessions, clients who drop out after only one to three sessions adversely affect the financial status of a program. In addition, early client dropout represents a lost opportunity to help a client and to affect the incidence of substance abuse in a community. Retention in treatment has been linked to better long-term outcomes (Fishman et al. 1999). At the first session, the client expresses an interest (regardless of the source of motivation) in participating in treatment. The client's "disappearance" before session four or five raises important questions: Why didn't the client return? What changed? and How can the program reduce the incidence of such premature disengagement from treatment?

Clinicwide engagement rate. The engagement rate at the clinic level is a simple calculation. The calculation is the total number of clients who attend the third (or fourth or fifth) treatment session, divided by the total number of clients who were admitted into treatment at an initial intake evaluation. This calculation can be completed weekly, monthly, quarterly, or annually.

$$\text{Clinic engagement rate} = \frac{\text{Total number of clinic clients attending their third scheduled session}}{\text{Total number of clients admitted into the clinic}}$$

The more frequently a program measures its engagement rate, the better able staff and management will be to track the performance measure. Any trend toward increased dropouts over time should lead management and staff members to examine carefully the contributing factors. If a program determines the engagement rate only annually, it will not be able to identify or respond to trends. However, if a provider does not have a management information system designed to collect and calculate engagement rates automatically, measuring this outcome on a weekly basis may be a burden. Monthly monitoring of the engagement rate may be a reasonable balance between burden and benefit.

Counselor-specific engagement rates. It is even more useful to look at how engagement rates differ among clinicians. Monitoring and reporting engagement rates to clinicians enable them to determine whether changes in their approach result in improved retention rates.

The calculation equals the total number of clients initially seen by a clinician who attended the third (or fourth or fifth) treatment session, divided by the total number of newly admitted clients assigned to that clinician.

$$\text{Counselor-specific engagement rate} = \frac{\text{Total number of clinic clients attending third scheduled session with counselor X}}{\text{Total number of clients admitted into counselor X's caseload}}$$

It would be misleading to compare engagement rates for one clinic or clinician with those of another without adjusting for the case mix. Dramatic differences will be found between clinics and between clinicians, and these differences may be due largely to client characteristics rather than differences in clinic quality or clinician skill levels. For example, engagement rates (and other performance indicators and outcomes) vary depending on client characteristics and other factors:

- The clients' living arrangements (e.g., clients living in shelters tend to do less well than those with stable housing)
- Employment status
- Co-occurring conditions (e.g., clients with significant mental disorders in addition to their substance use disorder tend to do less well)
- The substance abused

By providing clinicians with information they can use to guide their improvement efforts, executives empower their staff members to improve their own performance.

Attendance rate

The clinic's attendance rate consists of the total number of treatment program sessions that are attended by clients in a given period, divided by the total number of treatment sessions that were scheduled for those clients in that period.

As an example, if the clinic had 300 client encounters scheduled over a 1-month period,

$$\text{Attendance rate} = \frac{\text{Total number of sessions attended}}{\text{Total number of sessions scheduled}}$$

but clients actually attended only 90 treatment encounters, the retention rate would be 90 divided by 300 or 30 percent.

Administrators may find it useful to monitor attendance rates for individual counselors as well as for the clinic as a whole. Observations of who is achieving the highest and lowest attendance rates may identify treatment strategies and clinical styles that are more or less effective, counselors who need closer clinical supervision or additional training, and case mixes that are inequitable. This information should be used to help all clinicians improve, regardless of their attendance rates.

Retention rate

A retention rate indicates what percentages of clients remain in treatment.

$$\text{Retention rate} = \frac{\text{Total number of weeks clients remained in treatment}}{\text{Total number of clients admitted}}$$

Step 1. For each client who entered treatment during the period under consideration (e.g., the first quarter of the year), determine how long that client remained active in treatment. It is important to select an objective measure for "active in treatment," such as "attended at least one or more treatment sessions within 2 weeks." For each client admitted during the period under study, calculate the total number of weeks in treatment.

Step 2. Add the total number of weeks clients remained in treatment and divide by the total number of clients admitted.

A clinic might be interested in knowing what percentage of clients stay in treatment for 3 months. This measure might identify a program that is successful at achieving a high engagement rate but is losing many clients after the fifth or later treatment session. For example, if 100 clients entered treatment between January 1 and March 31, the clinic would add the total number of weeks that each client remained in treatment during that period and divide that number by 100 (the total number of clients).

It may be valuable to know the differences in retention rates among groups of particular interest, such as clients referred by the criminal justice system versus all other referred clients, women versus men, or payer X versus payer Y. Such studies can have important implications for resource allocation, funding, and staffing.

Abstinence rate

Rigorous monitoring of abstinence depends on reliable tests, such as the urine drug screen, Breathalyzer™ test, or saliva test. Each test has costs associated with it, which may preclude its use. It is important for clinics to track the abstinence rate because a clinic could have extremely high engagement or retention rates while its clients are still using substances. Abstinence can be measured easily, so long as objective measures, such as urine drug screens, are being used with some frequency.

The abstinence rate is arrived at by dividing the total number of negative test results obtained during a specified period by the total number of tests administered in that period. If during January a clinic administered 200 urine drug screens and 88 tested negative, the abstinence rate would be 88 divided by 200 or 44 percent.

$$\text{Clinic abstinence rate} = \frac{\text{Total number of negative test results}}{\text{Total number of tests administered}}$$

In monitoring abstinence rates, it is best to apply a specific timeframe to the client group being assessed. For example, a clinic may wish to calculate abstinence rates only for clients who have been in treatment at least 2 weeks. It may take that long for clients to begin achieving abstinence and for most drugs to clear from their systems. (Marijuana is eliminated from the body slowly, so clients who have been abstinent and in treatment for less than 1 month could still test positive.) Together clinic staff and management need to develop abstinence rate timeframes appropriate for their facility. One approach is to compare the abstinence rates of clients who have been in treatment for 2 weeks with those who have been in treatment for 6 weeks or longer.

Abstinence rates should increase with more time in treatment.

Drug screens should be administered consistently to all eligible clients. For example, if a clinic gives drug screens only to clients who are doing poorly, the clinic will have abstinence rates that reflect the performance of its most challenged (and challenging) clients. If drug screens are given to all clients equally, the abstinence rate obtained will reflect more accurately the clinicwide abstinence rate. (For more information on drug screens, see appendix B in TIP 47, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* [CSAT 2006*b*].)

For some clinics, the costs of administering drug screens may be prohibitive. Although drug screens objectively measure abstinence, self-reported abstinence can be useful under certain conditions. The accuracy of self-reported data varies depending on the consequences associated with reporting current substance use (Harrison 1997). For example, a client will underreport drug use if use can result in being returned to jail, losing custody of a child, or being terminated from employment. Although self-reported abstinence alone is a less than ideal measure of abstinence, for many treatment programs it may be the only basis available for an abstinence outcome measure.

For long-term rates, self-reported abstinence may be determined during a followup telephone interview, perhaps 6 months after discharge. If the followup call is made by the client's former counselor, the client may be more reluctant to admit use than if the call is made by a staff member or researcher with whom the client has no history. Clients often do not wish to disappoint their former counselor by acknowledging that they are having difficulty and have relapsed.

Quality-of-life indicators

Problem-specific monitoring. It is important to know whether treatment has not just influenced clients' substance use problems but also positively influenced other areas of their lives.

Problem-specific monitoring may be particularly important if the mission or funding of the clinic is associated with behavioral domains. For example, a treatment facility connected with Treatment Accountability for Safer Communities or a drug court might be interested in the extent to which its program is reducing clients' criminal activities. A treatment program also might be concerned with whether its interventions are reducing behaviors that put clients at high risk for contracting infectious diseases. In either case, assessments might be administered at different points during the treatment process and after discharge to see how well clients are functioning and to track changes in behavior or status.

A program might track information needed by its funding or referral sources (e.g., drug court). Improvements in clients' employment, education, and family relationships can be important to funders and the public. The more a program is able to document the positive effect of its efforts, the better it will be able to justify its funding and argue for additional funding. It is most impressive if a program is able to establish that treatment still is having an effect several months after a client's discharge. But the followup monitoring required to obtain these data is more expensive and difficult to do than monitoring while the client is in treatment.

Support group participation. Involvement in support groups, such as 12-Step programs and other mutual-help groups, is another way of measuring continued sobriety and a client's determination to remain abstinent. Followup calls may include questions about the number of support group meetings a client has attended in the previous week or month, whether the client has spoken with his or her sponsor in the previous month, and whether the client has a home group. Programs can monitor whether their efforts lead to improvements in

these important performance indicators by quarterly or biannually assessing the rate of self-reported meeting attendance.

Other quality-of-life indicators. The following quality-of-life indicators often are included on existing statewide databases and can be monitored with varying degrees of difficulty:

- Reductions in arrests, convictions, and incarcerations
- Reductions in hospitalization for mental illness
- Increased participation in afterschool programs
- Decreases in school dropout rates
- Reductions in use of welfare benefits and food stamps and in open child welfare cases
- Reductions in emergency room visits and other hospitalizations
- Increases in employability; increases in wages and number of days worked
- Reductions in social costs caused by intoxicated drivers and lost workdays
- Increases in the rates of birth of healthy, drug-free babies
- Improvements in school participation

These indicators usually are not generated on an individual clinic level but are of interest to many stakeholders.

Client satisfaction

For decades, businesses and industry have focused on measuring customer satisfaction, and this information can be valuable for OT programs. Client satisfaction provides information about the performance of both individual staff members and the clinic as a whole. For example, increasing client satisfaction may be a way to increase treatment engagement, attendance, and retention. In addition, health service providers, including treatment providers, increasingly are called on to monitor client satisfaction. Client satisfaction data point to possible causes and solutions for substandard performance. Surveys showing that clients are dissatisfied may help staff members and managers understand why retention or even abstinence rates have decreased. No nationally recognized client satisfaction survey currently exists for substance abuse treatment providers. Appendix 6-A on page 113 presents a client satisfaction form that has been designed specifically for use with IOT clients. Client satisfaction forms usually are divided into three sections:

- **Client satisfaction with clinic services**, such as client education materials, counseling groups and educational sessions, adequacy of the facility, individual attention, and overall benefit of treatment. Clinic administrators and staff members should decide which items to include, choosing those perceived as most important to the quality of care and those of greatest concern in their service delivery.
- **Client satisfaction with the counselors,** which asks the client to identify his or her counselors by name and provide feedback on their effectiveness. Areas to explore include each counselor's warmth, empathy, insight, knowledge and competence, attentiveness, and responsiveness. Staff members *and clients* should help select and word the criteria by which counselors will be rated.
- **Confidential descriptive (demographic) information about the respondent**, including age, gender, ethnicity, and sexual orientation. The information from this section can help a clinic determine such factors as whether women are more satisfied with a program than are men or whether clients with a disability are as satisfied with treatment as are other clients. The survey should be administrated to a specific client population. Programs can use the findings to guide changes in training, staffing, or programming.

Satisfaction of referral sources

Conducting a structured telephone interview with the program's key referral and funding sources at 3-month intervals can elicit considerable information about how the program and staff are viewed. Such calls can be a check on whether the program is providing each referral source with the information the agency needs in a timely, helpful fashion. The interviews can identify areas of complaint or potential friction before difficulties or misunderstandings escalate into problems. These telephone calls also can be used to explore new opportunities for expanding or refining services. (See appendix 6-B on page 114 for a sample form.)

Success of client transfer

An important measure of a program's effectiveness is the percentage of clients who have transferred successfully to and been retained in long-term, low-intensity outpatient services following completion of an IOT program.

Client dropout rate

Another valuable approach to performance improvement is to conduct studies of clients who have dropped out of treatment. Because early treatment sessions are the most expensive, clients who drop out of treatment represent, in many ways, the greatest loss to a program. A study designed to understand better who drops out of treatment and why can help guide changes in the program that ultimately yield great benefit.

To conduct such a study, the program can conduct telephone interviews of the last 50 or 100 clients who dropped out of treatment. The interviews should be done by an independent (noncounseling) staff member, such as a student intern or an assistant. The caller states that the purpose of the call is to

- Determine what factors led the client to leave treatment
- Gather information for a program evaluation
- Help the program be more effective and responsive to the needs of its clients

One result of open-ended interviews is that patterns of comments often emerge. A preponderance of similar responses can indicate that changes are needed. For example, a program whose client population was overwhelmingly male conducted a study of women who had dropped out. The study confirmed that the women had dropped out because group sessions were dominated by male viewpoints, and the women felt their concerns were not being addressed.

When conducting a dropout study, the caller should include an invitation to each client to return to treatment. The invitation may be all that is needed to reengage a client in the recovery process.

Important Considerations When Measuring Performance

Programs might examine any performance measures that will provide meaningful and helpful information about how the clinic, individual clinicians, and clients are doing. Outcomes can be calculated based on drug of choice, referral source, funding source, housing status, gender, co-occurring conditions, or other factors. Exhibit 6-1 describes two evaluation resources.

It is also important to consider the timeframe over which the program will measure outcomes. Attendance and engagement

…increasing client satisfaction may…increase treatment engagement, attendance, and retention.

Exhibit 6-1

Evaluation Resources

Demystifying Evaluation: A Manual for Evaluating Your Substance Abuse Treatment Program, Volume 1 (CSAT 1997*a*), is a CSAT publication designed to help administrators understand and undertake the evaluation process. It includes useful examples of surveys and evaluation instruments, as well as a general discussion of the evaluation process. The book is set up in self-study modules that cover

- **Evaluation strategies.** Models of outcome evaluation based on differing levels of available resources
- **Strategies for measuring effort.** Techniques for describing and quantifying treatment services
- **Ways to understand substance abuse in the community.** Strategies for assessing the extent to which clients' substance use problems are typical of the community's substance use problems
- **Resources available.** Evaluation aids that are available locally and nationally

Measuring and Improving Cost, Cost-Effectiveness, and Cost-Benefit for Substance Abuse Treatment Programs: A Manual (Yates 1999) is a National Institute on Drug Abuse publication that includes step-by-step instructions, exercises, and worksheets to guide executives through collection and analysis of data. The manual is designed to be used by people from a variety of educational and professional backgrounds who have little or no training in accounting. It explores several ways to determine cost-effectiveness, from educated estimates to sophisticated computer models.

measures might be obtained monthly because they have a major effect on a clinic's revenues.

No matter which performance criteria the program chooses to track, it is not wise to begin by focusing on all measures simultaneously. Performance measures should be phased in, starting with monitoring engagement, followed by other measures selected by the clinical team.

Outcomes Measuring Instruments

Different measurement instruments are needed for special populations, general treatment populations, and treatment services.

Special Population Measures

Program and client outcome indicators will be different for different treatment groups. Clients with co-occurring disorders may have a different threshold for attendance than clients without these disorders. Other

meaningful outcomes for this group include medication compliance, decrease or increase in psychiatric symptoms, and rehospitalization. Similarly, special outcomes indicators may be appropriate for pregnant women (e.g., delivery complications and birth outcomes).

General Treatment Population Measures

Addiction Severity Index

The Addiction Severity Index (ASI) is a useful outcome measurement tool (McLellan et al. 1992*b*) that helps assess a client's treatment needs. Free copies of the ASI and guidelines for using it can be downloaded from www.tresearch.org. The ASI is a standardized instrument that has good reliability and validity and can be used to collect information for comparison across sites and at different points in time.

Trained staff members should administer the ASI

- On client intake to provide baseline status and aid in treatment planning
- At meaningful intervals during treatment to measure progress (e.g., after 3 months)
- At discharge to assess outcomes in seven key areas of a client's life, including recent substance use and legal, occupational, medical, family/social, and psychiatric statuses
- At 3 months after discharge to measure long-term change in the client's status and behavior

The ASI provides programs with

- A subjective client evaluation and an interviewer evaluation of problem severity; both can provide indications of client treatment priorities
- An easy-to-use monitoring tool for clinical supervision; severity scores in each problem domain can be checked quickly to ensure adequate treatment planning
- The capability to monitor outcomes of discharged clients through followup; clients can be reevaluated using the ASI followup interview
- A research tool to derive objective and subjective measures of need and improvement
- A rich database through which issues such as the relationship between client characteristics and outcome data can be examined
- A standardized assessment instrument that permits comparisons across programs and levels of care

Risk Assessment Battery

A frequently used measure for risk of infectious disease is the Risk Assessment Battery (RAB), which is self-administered. Monitoring of risk reduction for infectious diseases might involve administering the RAB at intake, after 2 months of treatment, at discharge, and then 1 to 3 months after discharge. (Visit the Treatment Research Institute Web site at www.tresearch.org to download this instrument.)

Treatment Services Measures

The Treatment Services Review (TSR), developed to complement the ASI, corresponds to ASI categories (McLellan et al. 1992*a*). This instrument is a 5- to 10-minute structured interview designed to provide information on the number and frequency of services received in each area. It yields a rating of the services delivered. Other important measures of client-level service delivery include the number of individual counseling sessions, number of group counseling sessions, number of urine tests and Breathalyzer checks, and length of stay.

Program Monitoring for Special Purposes

Monitoring New Treatment Interventions or Program Services

Program management and staff may be particularly interested in monitoring performance before and shortly after implementing new components, approaches, or initiatives. Program administrators may use the ASI, RAB, TSR, or specialized measures designed to capture the effect of program innovations. For example, if a program is developing a 24-hour oncall service, the administrators may want to know whether the service increases the number of new clients. The study might track intakes for 3 months before implementation of the new service and at 3 to 6 months after implementation of the service and compare results.

The rates for attendance, engagement, and abstinence are appropriate measures to apply to new services. Similarly, feedback from referral sources and clients who dropped out can be valuable for assessing a new service.

Monitoring in Response to Program Difficulties

When managers notice a problem (e.g., an increase in client complaints) or are made aware of the occurrence of even a single adverse event (e.g., a client complaint of sexual harassment), they might begin monitoring key indicators. These adverse events are sometimes referred to as "sentinel events." For example, if a woman reports that she finds the treatment environment "hostile toward women," a clinic might begin evaluating client satisfaction by gender weekly or monthly. Similarly, programs might monitor engagement and attendance rates after a clinic has moved or there has been high staff turnover. These changes are likely to disrupt operations, so monitoring might be particularly helpful at these times.

Once staff members and managers have collected data, they can analyze them objectively, develop solutions to problems, and refine policies and practices.

Accreditation Issues

Some States have adopted performance outcomes monitoring programs, and treatment programs in those States presumably already are aware of State requirements. Programs accredited by CARF or JCAHO will need to meet specific requirements. However, because both accrediting organizations are emphasizing quality assurance or performance improvement activities, staff and management may wish to visit the Web sites of these organizations to learn about their specific requirements (www.carf.org and www.jcaho.org).

Implementation of the ASI, RAB, or TSR will help a provider fulfill the requirements of the accreditation bodies.

Working With Staff on Performance and Outcomes Improvement

Before initiating performance outcomes and improvement processes, program administrators should meet with staff members to discuss the importance of monitoring. The rationale for performance monitoring should be clear. Collecting and analyzing performance data have a practical benefit for the program and will improve service to clients.

All staff members should know that performance monitoring can identify needs for additional training, resources, policy changes, and staff support—improvements the organization needs to make as a *system*. It is impor-

tant for staff members to understand that the objective measures are being implemented to improve treatment outcomes and, wherever possible, to make it easier for staff members to work efficiently and effectively. Management should make clear that the results of the monitoring will *not* be used to punish employees: The program is initiating monitoring to receive feedback that will enable staff members and managers to improve.

Case Mix Effect

Performance outcomes may vary from clinic to clinic and from counselor to counselor—and for the same clinic and counselor over time. For example, one clinic may work primarily with employed clients who have stable families and a low incidence of co-occurring mental disorders. Another clinic may serve clients who are homeless, are dependent on crack, and have co-occurring mental disorder diagnoses. These two clinics likely will have different outcome rates on most dimensions. It should not be assumed that the clinic working with employed clients is better even though its objective outcomes are superior. The differences may be due exclusively to the clinic's case mix. Likewise, case mix differences between counselors can result in very different outcomes even for clinicians with comparable skills and experience.

Performance outcomes data should be used to improve the performance of all staff members—including managers and administrative support personnel. Staff members need to be confident that the administration understands the effects of different case mixes and other influences on performance. It is essential that an atmosphere of trust and partnership be created. A critical step in creating such an atmosphere is to ensure that staff members know why data will be collected and what will be done with them. This communication should take place before data collection begins; staff should be informed orally and in writing during an orientation session.

When data collection is complete, it is extremely important that data be handled with sensitivity, particularly considering differences in the case mix from therapist to therapist. When administrators acknowledge the effects of case mix, it is possible to present data about performance to therapists. Because the data are objective, they are often superior to the subjective performance monitoring measures that supervisors traditionally have used.

> …feedback from referral sources and clients who dropped out can be valuable for assessing a new service.

Avoiding Premature Actions

An administrator conducting performance improvement studies may be tempted to act prematurely based on initial results. Depending on the indicator (e.g., attendance), it is wise to wait several months before drawing any conclusions. If initial data are to be shared with staff, the administrator needs to emphasize that these data are preliminary and advise staff that the data themselves are not important but the *process* of collecting, discussing, and working to improve them is. The act of collecting and sharing outcome data with staff members improves performance without other interventions by management.

Dissemination of Study Findings

When introducing a performance improvement system, managers should create a team consisting of clinical, administrative, and support staff. In small organizations, all staff

members are on the team. Large organizations can form a performance improvement team or quality council with staff, management, board, and payers. Program alumni representatives can be a valuable part of a performance improvement team. This team will identify the performance indicators that will be studied and will review and interpret the results. This group may recommend systemwide actions to improve outcomes.

Handling data in a confidential and sensitive manner

It is important to show sensitivity toward staff by handling data confidentially. This usually is done by presenting only clinicwide data—not data on individual performance—to the staff and the public at staff meetings or in reports to funders. For example, an administrator might discuss changes in risk-reduction measures at the level of the clinic, not for individual therapists.

Types of comparisons

It is natural and, under some conditions, beneficial for staff members to compare their performance with that of other staff members. However, counselors achieving the highest performance rates may be scoring well because of experience, training, case mix, random fluctuation, or unique talent. The goal is to help every counselor in the clinic improve over time. In other words, a counselor whose engagement rate has been 30 percent should be acknowledged for increasing the rate to 50 percent (even though the average rate in the clinic is 60 percent). Comparing a counselor who has a low engagement rate to the clinic average can lead to discouragement and even poorer performance (Kluger and DeNisi 1996). Such comparisons should be avoided. Administrators should focus on clinicwide data and improvement initiatives. Counselor-specific data should be released confidentially to individual counselors.

Performance monitoring can reduce the frequency of disciplinary job actions…

Strategies to encourage staff members' improvement

Effective strategies to improve performance include

- Providing individualized confidential feedback about performance
- Tracking changes in performance over time

Kluger and DeNisi (1996) reviewed more than 2,500 papers and 500 technical reports on feedback intervention conducted in a variety of settings. They noted that performance feedback interventions are most effective if the feedback is provided in an objective manner and focuses on the tasks to be improved. Feedback should address only things that are under counselors' control. Interventions that make the feedback recipients compare themselves with others can result in worse performance. (Data on the individual performance of counselors should be confidential and secured; these data can be presented as counselor A, B, C, etc.)

Feedback data can be used to encourage staff members who have shown exceptional improvement. Identifying a staff member of the month can be an incentive for achievement. The key is to recognize improvement publicly, based on objective data. This kind of recognition encourages new staff members to learn from their high-performing colleagues. Those who are performing consistently at the highest levels (known as positive outliers) can be acknowledged formally. These high achievers can be invited to give presentations, provide training, or recommend ways to improve the organization's performance. Under certain circumstances,

arrangements can be made for counselors to observe productive counseling sessions. This kind of recognition should not be made too quickly; it should be based on at least 3 months to a year of performance data. Case mix could account for a counselor's consistently superior performance (e.g., the counselor treats the highest functioning clients).

Sharing the performance results

Once a performance improvement system is in place, the findings provide important information for three groups:

- For the clinic, information about overall performance
- For the counselor, information about individual performance
- For the program's funding sources and other groups in the community, information about overall clinic performance

What should a program do if the monitoring system identifies less than satisfactory performance? This can be interpreted as good news in many ways. Knowing a problem exists is the first step in solving it. Clinic management can introduce interventions to improve performance, and the data collected will allow the effectiveness of the new interventions to be monitored. Moreover, because many programs do not have a rigorous performance improvement system, a program can distinguish itself by having these data—a potential advantage in securing funding.

Performance monitoring can reduce the frequency of disciplinary job actions (e.g., terminating someone for poor performance) because it focuses on objective measures. Performance monitoring results can lead to program changes, reallocation of resources, targeted training, and skills development. More important, when objective data are made available to all staff members, improvements may occur without any additional intervention—simply because people generally want to perform well (Deming 1986).

Taking Action To Improve Performance

Once data have been collected and shared with staff as a whole, decisions can be made about how to improve. All staff members can be involved in identifying strategies or interventions for improvement. Staff should focus on

- **Resource allocation.** A reallocation of resources or funds could make a difference. For example, providing tokens for public transportation could help clients attend more sessions. Evaluations should include an examination of administrative issues. Adequate resources should be allocated to administrative needs.
- **Conditions causing differences in therapist outcomes.** When a significant range of client outcomes among therapists exists, it is reasonable to look for explanations. If the conditions causing the variation can be identified, then ameliorating action can be taken. For example, monitoring the size of treatment groups may reveal that early dropouts usually occur when a group exceeds a certain size. Conditions to explore include client case mix, size of caseloads, adequacy of resources provided to counselors, and sufficiency of training available to counselors.
- **Factors that indicate program success.** Measurement of the effectiveness of the program should be based on such variables as the length of client retention, the level of client participation, and the frequency and patterns of attendance. Measurement also includes monitoring client information, such as discharge status and program completion, relapse, and return to treatment.
- **Improvements in program structure.** A sudden decrease in performance outcomes is a warning sign that suggests structural change needs to be—and can be—made. The program itself may be setting up obstacles to client retention. The performance improvement team might brainstorm to

find strategies for systemwide improvement. Although the client is the most obvious customer, referral sources, funding sources, ancillary care providers, and clients' employers are customers as well. Soliciting feedback from these groups can provide useful information about strengths and weaknesses and recommendations for improvement.

- **A retrospective study.** When a problem is identified, a retrospective study is an excellent and inexpensive method for exploring its causes and uncovering solutions to it. (The client dropout study mentioned earlier is an example of a retrospective study.) It can provide both qualitative and quantitative data and provides the clients' perspective. Exhibit 6-2 describes a retrospective study. Programs can gather data to help determine which variables accurately predict whether a client will stay in treatment and progress therapeutically. For example, programs can compare the baseline assessments of clients who complete treatment with the assessments of clients who drop out. All program participants, including those who have dropped out, should be assessed. In a State system with many types of treatment programs, cross-program analyses can be performed. When this is done, covariates such as case mix should be considered.

Costs and Funding of Outcomes Improvement

Funds allocated to performance monitoring are an excellent investment because monitoring can lead to better treatment for clients, improved attendance and retention rates, increased revenue, and decreased program costs. Simple performance improvement studies can be conducted at little or no cost. Administrators might consider including client monitoring efforts in counselor job descriptions and providing time in counselors' schedules for followup calls to collect data. More ambitious assessments can be conducted inexpensively if the right staff members are recruited.

Programs may find assistance in conducting studies from local colleges or universities. Graduate students, people applying to graduate programs, or established researchers may be interested in working with programs. Faculty members at universities often know of graduate students who are competent to conduct such studies.

If the study is conducted well and proper consents and approvals are obtained, data from the study may be worthy of publication. For academics, the opportunity to conduct publishable research is often an inducement for conducting a study. However, a modest cash offer may increase graduate students' interest and guarantee that the study will be conducted professionally and run to completion. (It is advisable to withhold part of the payment until the study is completed.) A program in Philadelphia found that about $2,000 was sufficient incentive for a doctoral candidate to conduct a simple series of yearlong monitoring studies.

The use of independent researchers also can help assuage concerns about staff bias and conflicts of interest. When performance outcomes data have been analyzed by an independent body (such as a university researcher), the findings may be viewed as more objective and credible than if the data were analyzed in house. This is important for an organization that is using the data to demonstrate to funding sources that the program is achieving positive outcomes.

Finally, using independent researchers to study performance improvements may help bridge the gap that exists between academics and practitioners. Involving researchers in the improvement of treatment programs allows both groups to benefit from each other's expertise.

Exhibit 6-2

An IOT Program Outcomes Study: Findings and Actions

Rationale for the study. An urban IOT program was disturbed to find a low rate of retention and high rate of initial dropouts for all clinic therapists.

Study methods. A local university graduate student was hired to telephone 100 former clients who had dropped out of the program before their fourth session. Using a protocol, the graduate student conducted 5-minute interviews to find out why the clients had changed their minds about treatment and dropped out before completion.

Significant findings. Data analysis indicated the following:

- **Objection to rigid policy requirements.** The program rigidly required that all clients come to four sessions; some clients who were referred for driving while intoxicated (DWI) felt that they did not need that many sessions.
- **Some clients inappropriately assigned to an IOT program.** Many clients who dropped out had been referred to the clinic to fulfill requirements of a DWI violation and felt out of place among clients with long-term addictions.
- **Early dissatisfaction among clients with severe substance use disorders.** Clients with serious drug use problems (those with heroin and crack dependence) were the most likely to drop out. These clients strongly objected to the first admission session that was devoted to completing extensive paperwork needed to meet financial and admission requirements.

Significant actions taken. The program made the following changes, which increased the clinic's retention rate by 30 percent. Subsequently, 87 percent of clients admitted to the program completed their treatment—an extraordinary improvement.

- **Rigid attendance requirements were eliminated.** The four-session per week requirement was dropped; some clients did not need this level of care.
- **A separate DWI program was established.** Another program was set up for those needing only a brief substance abuse awareness program rather than IOT; these clients no longer participated in the more extensive program and were more likely to complete treatment.
- **A special admission session was instituted.** The new session for clients likely to drop out focused solely on the clients' needs. New clients meeting the high dropout profile (those injecting opioids and using crack cocaine) were offered a free 1½-hour session. No paperwork was done except to obtain legal informed consent. The session was designed specifically to identify and meet the clients' needs. This format increased the retention rate for this group.

Using Performance Data To Promote the Program

In addition to providing information for making needed changes in the program, results of a performance improvement study can be used both as a fundraising and as a public relations tool. As Yates (1999) states,

> Having solid reports of the effectiveness and cost-effectiveness of your program will assure donors that their contributions will have the maximum impact possible.... If your program saves substantially more money than it consumes, it will be easier to defend as a form of social investment that may deserve more attention and additional funds. (pp. 1–2)

One treatment provider invited the program's 50 primary funding and referral sources to a presentation of performance improvement study findings. The first year, some of the data were not encouraging, suggesting areas for improvement. However, the administrator was committed to using the results to improve program performance and continuing an objective, open evaluation process. The somewhat negative results demonstrated commitment to accurate presentations. The funding sources stayed committed. The next year the study results were compiled by an academic resource—an objective, respected researcher in the treatment field. Over the next 8 years, the performance measures steadily improved, demonstrating improved client outcomes.

Appendix 6-A. Satisfaction Form for Clients

Confidential—Please do not write your name on this form. This survey is designed to give you a chance to tell us what you think about the care you are receiving. After you have completed this form, please return it to a staff member. Thank you.

How satisfied have you been with…	Not at all	Slightly	Moderately	Considerably	Extremely
The individual attention you are receiving from your counselor?	0	1	2	3	4
The information you are receiving about recovery?	0	1	2	3	4
The encouragement you are receiving from your counselor?	0	1	2	3	4
The support you are receiving from your counselor?	0	1	2	3	4
The services you are receiving from your counselor?	0	1	2	3	4
The way you are being treated by your counselor?	0	1	2	3	4
The written materials you are being given?	0	1	2	3	4
Your counselor is…					
Warm, caring, and respectful.	0	1	2	3	4
Knowledgeable about recovery.	0	1	2	3	4
Helpful to you.	0	1	2	3	4

In your own words, tell us what you think would improve our program. Use the other side of the page if you need more space to write your answer.

What do you like least about our program? _____

What do you like best about our program? _____

About how many sessions have you attended here? _____

Today's date: _____ /_____ /_____

Your counselor's name:

_____

We want to know whether people are receiving different treatment because of their race, gender, or sexual orientation. If you are uncomfortable with any of these questions, please feel free to skip them. **Are you:**

____ Male ____ Female

____ White ____ African-American
____ Hispanic ____ Other

____ Heterosexual ____ Gay
____ Lesbian ____ Bisexual

Appendix 6-B. Satisfaction Form for Referral Sources

Name: _____

Referral Source Contacted: _____

Phone: (_____) _____ – _____

Date Contacted: ____ / ____ / ____

1. How would you rate our oral communications (e.g., telephone calls, face-to-face interactions)?

   excellent very good average below average poor

   Comments: _____

   _____

2. How would you rate our written communications?

   excellent very good average below average poor

   Comments: _____

   _____

3. How would you rate our admissions process?

   excellent very good average below average poor

   Comments: _____

   _____

4. How would you rate the professionalism and helpfulness of the program staff with whom you interacted?

   excellent very good average below average poor

   Comments: _____

   _____

5. How would you rate our treatment program compared with other treatment programs you have used?

   excellent very good average below average poor

   Comments: _____

   _____

Appendix A—Bibliography

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CSAT TIPs and Publications Based on TIPs

What Is a TIP?

Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under CSAT's Knowledge Application Program to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

What Is a Quick Guide?

A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

What Are KAP Keys?

Also based on TIPs, KAP Keys are handy, durable tools. Keys may include assessment or screening instruments, checklists, and summaries of treatment phases. Printed on coated paper, each KAP Keys set is fastened together with a key ring and can be kept within a treatment provider's reach and consulted frequently. The Keys allow you—the busy clinician or program administrator—to locate information easily and to use this information to enhance treatment services.

TIP 1 **State Methadone Treatment Guidelines**—Replaced by TIP 43

TIP 2* **Pregnant, Substance-Using Women**—*BKD107*

Quick Guide for Clinicians *QGCT02*

KAP Keys for Clinicians *KAPT02*

TIP 3 **Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents**—Replaced by TIP 31

TIP 4 **Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents**—Replaced by TIP 32

TIP 5 **Improving Treatment for Drug-Exposed Infants**—*BKD110*

TIP 6 **Screening for Infectious Diseases Among Substance Abusers**—*BKD131*

Quick Guide for Clinicians *QGCT06*

KAP Keys for Clinicians *KAPT06*

TIP 7 **Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 8 **Intensive Outpatient Treatment for Alcohol and Other Drug Abuse**—Replaced by TIPs 46 and 47

TIP 9 **Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse**—Replaced by TIP 42

TIP 10 **Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients**—Replaced by TIP 43

TIP 11 **Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases**—*BKD143*

Quick Guide for Clinicians *QGCT11*

KAP Keys for Clinicians *KAPT11*

TIP 12 **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 13 **Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders**—*BKD161*

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Quick Guide for Administrators *QGAT13*

KAP Keys for Clinicians *KAPT13*

TIP 14 **Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment**—*BKD162*

TIP 15 **Treatment for HIV-Infected Alcohol and Other Drug Abusers**—Replaced by TIP 37

TIP 16 **Alcohol and Other Drug Screening of Hospitalized Trauma Patients**—*BKD164*

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KAP Keys for Clinicians *KAPT16*

TIP 17 **Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 18 **The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers**—*BKD173*

Quick Guide for Clinicians *QGCT18*

KAP Keys for Clinicians *KAPT18*

TIP 19 **Detoxification From Alcohol and Other Drugs**—Replaced by TIP 45

TIP 20 **Matching Treatment to Patient Needs in Opioid Substitution Therapy**—Replaced by TIP 43

TIP 21 **Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System**—*BKD169*

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TIP 22 **LAAM in the Treatment of Opiate Addiction**—*Replaced by TIP43*

TIP 23 **Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing**—*BKD205*

Quick Guide for Administrators *QGAT23*

TIP 24 **A Guide to Substance Abuse Services for Primary Care Clinicians**—*BKD234*

Concise Desk Reference Guide *BKD123*

Quick Guide for Clinicians *QGCT24*

KAP Keys for Clinicians *KAPT24*

TIP 25 **Substance Abuse Treatment and Domestic Violence**—*BKD239*

Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Treatment Providers *MS668*

Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Administrators *MS667*

Quick Guide for Clinicians *QGCT25*

KAP Keys for Clinicians *KAPT25*

**Under revision*

TIP 26 **Substance Abuse Among Older Adults—*BKD250***

Substance Abuse Among Older Adults: A Guide for Treatment Providers *MS669*

Substance Abuse Among Older Adults: A Guide for Social Service Providers *MS670*

Substance Abuse Among Older Adults: Physician's Guide *MS671*

Good Mental Health is Ageless *PHD881* (English), ***PHD881S*** (Spanish)

Aging, Medicines and Alcohol *PHD882* (English), PHD***882S*** (Spanish)

Quick Guide for Clinicians *QGCT26*

KAP Keys for Clinicians *KAPT26*

TIP 27 **Comprehensive Case Management for Substance Abuse Treatment—*BKD251***

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Case Management for Substance Abuse Treatment: A Guide for Administrators *MS672*

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TIP 30 **Continuity of Offender Treatment for Substance Use Disorders From Institution to Community—*BKD304***

Quick Guide for Clinicians *QGCT30*

KAP Keys for Clinicians *KAPT30*

TIP 31 **Screening and Assessing Adolescents for Substance Use Disorders—*BKD306***

See companion products for TIP 32.

TIP 32 **Treatment of Adolescents With Substance Use Disorders—*BKD307***

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KAP Keys for Clinicians *KAP312*

TIP 33 **Treatment for Stimulant Use Disorders—*BKD289***

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TIP 35 **Enhancing Motivation for Change in Substance Abuse Treatment—*BKD342***

Quick Guide for Clinicians *QGCT35*

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Faces of Change *PHD1103*

TIP 36 **Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues—*BKD343***

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KAP Keys for Clinicians *KAPT36*

Helping Yourself Heal: A Recovering Woman's Guide—*PHD981* (English), ***PHD981S*** (Spanish)

Helping Yourself Heal: A Recovering Man's Guide—*PHD1059 (English), PHD1059S (Spanish)*

TIP 37 **Substance Abuse Treatment for Persons With HIV/AIDS—*BKD359***

HIV/AIDS: Is Your Client at Risk? *MS965*

Drugs, Alcohol and HIV/AIDS: A Consumer Guide *PHD1126*

Quick Guide for Clinicians *MS678*

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TIP 38 **Integrating Substance Abuse Treatment and Vocational Services—*BKD381***

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TIP 39 **Substance Abuse Treatment and Family Therapy—*BKD504***

Quick Guide for Clinicians *QGCT39*

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TIP 40 **Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction—*BKD500***

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TIP 43 **Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs—*BKD524***

Quick Guide for Clinicians *QGCT43*

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Substance Abuse:
Administrative Issues in Outpatient Treatment

This TIP, *Substance Abuse: Administrative Issues in Outpatient Treatment*, was written to help administrators address the changing environment in which outpatient treatment programs operate. The TIP provides basic information about running an outpatient treatment program, including strategic planning, working with a board of directors, relationships with strategic partners, hiring and retaining employees, staff supervision, continuing education and training, performance improvement, outcomes monitoring, and promotion of the program to potential clients, funding agencies, and government officials. More specialized sections address challenges that have emerged and gathered importance in the last decade: preparing a program to provide culturally competent treatment to an increasingly diverse client population, succeeding in a managed care-dominated world by diversifying the funding sources a program draws on, and understanding privacy and confidentiality requirements imposed by Federal legislation.

Collateral Product
Based on TIP 46

Quick Guide for Administrators

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